

NEXTGEN NEXTPEN DEMONSTRATION

This demonstration reviews how to use the NextPen program to capture data from handwritten forms. Details of the workflow will likely vary somewhat, depending on practice policy & clinic layout, though this should give you a good idea of NextGen functionality.

This has been prepared with EHR 5.8 & KBM 8.3. Subsequent updates may display cosmetic & functional changes.

Use the keyboard or mouse to pause, review, & resume as necessary.

Introduction

NextPen is an optional NextGen system that combines a special pen & some additional programs to allow patients or users to capture data on handwritten forms, & to transfer at least some of that to the appropriate place within a NextGen chart.

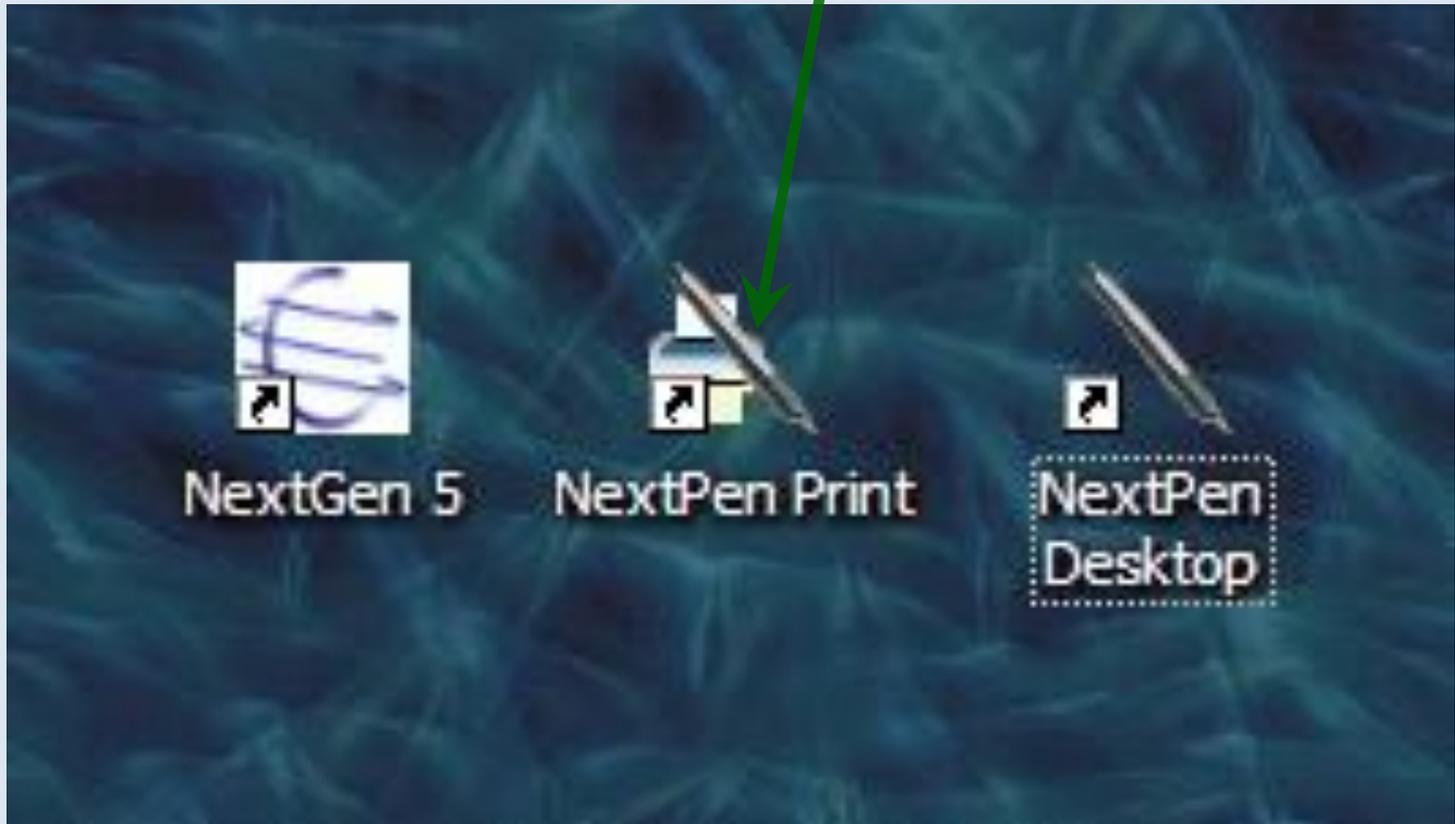
A common use for this would be to collect medical history information from new patients, so we'll use that as the example in this demonstration.

Users in clinics that have NextPen will see a couple additional program icons on the desktop: **NextPen Print** & **NextPen Desktop**.



First, we need to print a form; this will usually be done by someone in the front office. The best time to do this is at the end of the day, looking at tomorrow's appointments. In whatever fashion is easiest, print a list of tomorrow's new patient appointments. Make note of who are children & who are adults, since we have both pediatric & adult history forms. For NextPen purposes, you should use the **adult** medical history form for anyone beyond the 13th birthday.

Then double-click **NextPen Print**. (If you're not already logged on to NextGen EHR or PM, you'll see a sign-on screen.)





NextPen Print opens. You'll probably find it helpful to maximize this window.

At the bottom you'll see a list of available forms. While we'll probably add more over time, the only ones we're using at the time of this writing are **Adult Medical History Form - USA** & **Pediatric Medical History Form - USA**.



	Form Name	Form File
▶ <input type="checkbox"/>	Adult Medical History Form - USA	Adult Medical Hx USA.xdp
<input type="checkbox"/>	Pediatric Medical History Form - USA	Peds Medical Hx USA.xdp
<input type="checkbox"/>	Patient Starter v1.12	Starter Form - Patient History - v1.12.xdp
<input type="checkbox"/>	HIPAA - English	HIPAA - English.xdp
<input type="checkbox"/>	Dem Bodies Images v1.1	Dem Bodies Images v1.1.xdp
<input type="checkbox"/>	Review of Systems v1.1	Review of Systems v1.1.xdp
<input type="checkbox"/>	Starter Form - Pediatric Patient History k8.3 - v1.2.xdp	Starter Form - Pediatric Patient History k8.3 - v1.2.xdp

Appointment Date	MRN	Rendering Provider	Patient Last Name	Patient First Name	Gender	Date Of Birth
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Now we need to see a list of scheduled appointments to find who needs to have a form printed. Click **Query**.

	Form Name	Form File
<input type="checkbox"/>	Adult Medical History Form - USA	Adult Medical Hx USA.xdp
<input type="checkbox"/>	Pediatric Medical History Form - USA	Peds Medical Hx USA.xdp
<input type="checkbox"/>	Patient Starter v1.12	Starter Form - Patient History - v1.12.xdp
<input type="checkbox"/>	HIPAA - English	HIPAA - English.xdp
<input type="checkbox"/>	Dem Bodies Images v1.1	Dem Bodies Images v1.1.xdp
<input type="checkbox"/>	Review of Systems v1.1	Review of Systems v1.1.xdp
<input type="checkbox"/>	Starter Form - Pediatric Patient History k8.3 - v1.2.xdp	Starter Form - Pediatric Patient History k8.3 - v1.2.xdp

Query

Appointment Date :

< **October, 2014** >

Sun	Mon	Tue	Wed	Thu	Fri	Sat
28	29	30	1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	1
2	3	4	5	6	7	8

Today: 10/14/2014

Location :

USA Family Medicine

Physician :

- DOTSON, CANDES
- DOUGLAS, ZAKIYA
- DRINKARD, CAMMIE
- DUFFY, ROBERT
- DYESS, DONNA
- ECKSTEIN, CHRISTOPHER
- EDLER, MELISA
- EL ZARIF, SAMER
- ELKINS, MABLE
- ELTAHA, CHADI
- ENDO NURSE, CHRISTINA HAIR

OK

Cancel

Begin by selecting **Location** (though for providers who only work in one location this is not really necessary).

Then select **Providers**. Go ahead & check all providers in your clinic. This way from day-to-day you won't have to do this again unless a new provider is added.

Query

Appointment Date :

< **October, 2014** >

Sun	Mon	Tue	Wed	Thu	Fri	Sat
28	29	30	1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	1
2	3	4	5	6	7	8

Today: 10/14/2014

Location :

USA Family Medicine

Physician :

- DOTSON, CANDES
- DOUGLAS, ZAKIYA
- DRINKARD, CAMMIE
- DUFFY, ROBERT
- DYESS, DONNA
- ECKSTEIN, CHRISTOPHER
- EDLER, MELISA
- EL ZARIF, SAMER
- ELKINS, MABLE
- ELTAHA, CHADI
- ENDO NURSE, CHRISTINA HAIR

OK

Cancel

Then select the Date.
As mentioned above, most of the time you'll want to print a batch of these for tomorrow's new patients, but you can also print one at a time if a same-day appointment is made with a new patient.

When done, click **OK**.

You'll see a list of all appointments for the selected day. Scroll through & check all of the new adult patients (age 13 & over).

	Appointment Date	MRN	Rendering Provider	Patient Last Name	Patient First Name	Gender	Date Of Birth
<input type="checkbox"/>	Oct 14, 2014 9:15 AM	██████████	LAM	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 9:45 AM	██████████	LAM	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 10:00 AM	██████████	LAM	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 10:15 AM	██████████	LAM	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 10:30 AM	000900058325	DUFFY	AATESTDUFFY	CANDELABRA	Female	Jan 03, 1966
<input type="checkbox"/>	Oct 14, 2014 10:30 AM	██████████	LAM	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 10:45 AM	██████████	LAM	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 11:00 AM	██████████	LAM	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 11:00 AM	██████████	LAM	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 1:30 PM	██████████	ISLAM	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 1:30 PM	██████████	ATKINSON	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 1:30 PM	██████████	KAYL	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 2:00 PM	██████████	KAYL	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 2:00 PM	██████████	ATKINSON	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 2:00 PM	██████████	ISLAM	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 2:15 PM	██████████	ISLAM	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 2:15 PM	██████████	ATKINSON	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 2:15 PM	██████████	KAYL	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 2:30 PM	██████████	KAYL	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 2:45 PM	██████████	KAYL	██████████	██████████		██████████
<input type="checkbox"/>	Oct 14, 2014 2:45 PM	██████████	ATKINSON	██████████	██████████		██████████

Then check Adult Medical History Form - USA.

	Form Name	Form File
<input type="checkbox"/>	Adult Medical History Form - USA	Adult Medical Hx USA.xdp
<input type="checkbox"/>	Pediatric Medical History Form - USA	Peds Medical Hx USA.xdp
<input type="checkbox"/>	Patient Starter v1.12	Starter Form - Patient History - v1.12.xdp
<input type="checkbox"/>	HIPAA - English	HIPAA - English.xdp
<input type="checkbox"/>	Dem Bodies Images v1.1	Dem Bodies Images v1.1.xdp
<input type="checkbox"/>	Review of Systems v1.1	Review of Systems v1.1.xdp
<input type="checkbox"/>	Starter Form - Pediatric Patient History k8.3 - v1.2.xdp	Starter Form - Pediatric Patient History k8.3 - v1.2.xdp

NextPen Print

File Help

Query Print Print Blank Select All Clear Selection

	Appointment Date	MRN	Rendering Provider	Patient Last Name	Patient First Name	Gender	Date Of Birth
<input type="checkbox"/>	Oct 14, 2014 9:15 AM		LAM				
<input type="checkbox"/>	Oct 14, 2014 9:30 AM		LAM				
<input type="checkbox"/>	Oct 14, 2014 9:35 AM		LAM				
<input checked="" type="checkbox"/>	Oct 14, 2014 10:30 AM	000500058325	DUFFY	AATEST	CANDELABRA	Female	Jan 03, 1966
<input type="checkbox"/>	Oct 14, 2014 10:30 AM		LAM				
<input type="checkbox"/>	Oct 14, 2014 10:45 AM		LAM				
<input type="checkbox"/>	Oct 14, 2014 10:45 AM		LAM				
<input type="checkbox"/>	Oct 14, 2014 11:00 AM		LAM				
<input checked="" type="checkbox"/>	Oct 14, 2014 1:30 PM		ATKINSON				
<input type="checkbox"/>	Oct 14, 2014 1:30 PM		KAYL				
<input type="checkbox"/>	Oct 14, 2014 1:30 PM		KAYL				
<input type="checkbox"/>	Oct 14, 2014 2:00 PM		ATKINSON				
<input type="checkbox"/>	Oct 14, 2014 2:00 PM		ISLAM				
<input type="checkbox"/>	Oct 14, 2014 2:15 PM		ISLAM				
<input type="checkbox"/>	Oct 14, 2014 2:15 PM		ATKINSON				
<input type="checkbox"/>	Oct 14, 2014 2:15 PM		KAYL				
<input type="checkbox"/>	Oct 14, 2014 2:30 PM		KAYL				
<input checked="" type="checkbox"/>	Oct 14, 2014 2:45 PM		KAYL				
<input type="checkbox"/>	Oct 14, 2014 2:45 PM		ATKINSON				

Then click Print. An adult history form will print for each selected patient.

You would next clear all of those selections, & in a similar fashion print a **Pediatric Medical History Form - USA** for all new pediatric patients.

	Form Name	Form File
<input checked="" type="checkbox"/>	Adult Medical History Form - USA	Adult Medical Hx USA.xdp
<input type="checkbox"/>	Pediatric Medical History Form - USA	Ped Medical Hx USA.xdp

There are some printer setup steps that will be performed for you at the time the program is installed, so you shouldn't generally have to deal with that on a day-to-day basis.

A form resembling this will print. When patients arrive for their appointments, give them the form to fill out (front & back), using the special NextPen. When the patient is done, dock the NextPen in the cradle you'll have at your workstation. Send the paper copy back to the nurse who is rooming the patient; it will be convenient (though not necessary) to have on hand, & you DO NOT need to scan it into the chart.

Patient Name: AATESTDUFFY, CANDELABRA

Adult Medical History Form

Birth Date: Jan 03, 1966

Gender: Female

MRN: 000900058325

Please print clearly & avoid stray marks

Rendering Provider: DUFFY

Appt Date: Oct 14 2014 10:30:00AM

Past Medical History

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Allergies (hay fever) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Coronary (heart) disease | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Peptic (stomach) ulcers |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Prostate enlargement |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irritable bowel disease | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke (CVA) |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> GERD (acid reflux) | <input type="checkbox"/> Migraine headaches | |

Other medical history not listed above:

Past Surgical History

Angioplasty

Colostomy

LASIK

Appendectomy

Cesarean Section

Ear Plugs

Each printed page has a faint pattern of dots in the background that the NextPen reads, so that it can transfer the information to the correct patient & encounter.

Patient Name: AATESTDUFFY, CANDELABRA

Adult Medical History Form

Birth Date: Jan 03, 1966

Gender: Female

MRN: 000900058325

Please print clearly & avoid stray marks

Rendering Provider: DUFFY

Appt Date: Oct 14 2014 10:30:00AM

Past Medical History

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Allergies (hay fever) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Coronary (heart) disease | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Aortic | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Psoriasis (skin) / ulcers |

If a patient no-shows or cancels, discard the paper form. A new form will need to be printed should the appointment be rescheduled later.

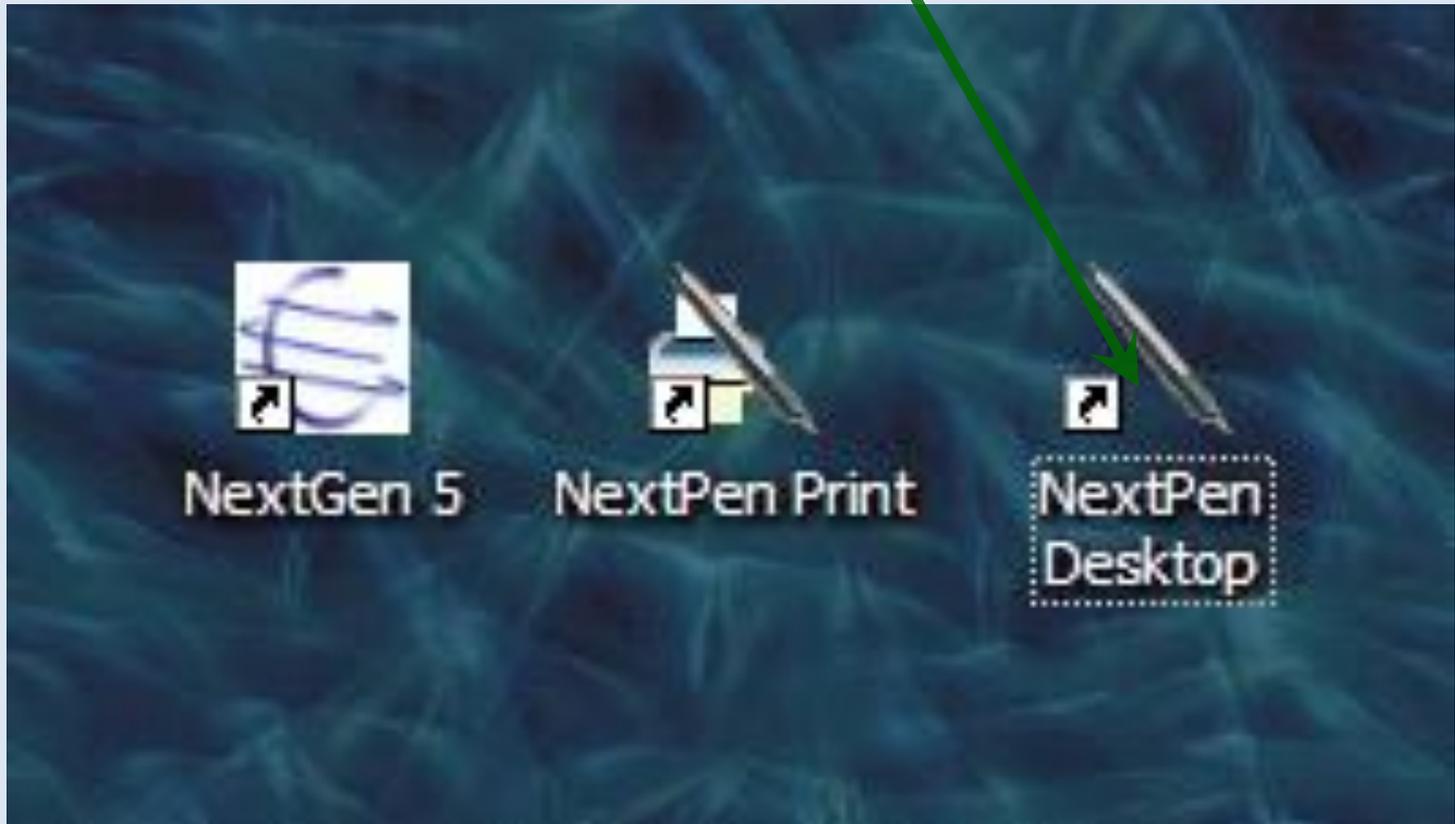
Past Surgical History

- | | Year | | Year | | Year |
|--|----------------------|---|----------------------|--|----------------------|
| <input type="checkbox"/> Angioplasty | <input type="text"/> | <input type="checkbox"/> Colostomy | <input type="text"/> | <input type="checkbox"/> LASIK | <input type="text"/> |
| <input type="checkbox"/> Angioplasty w/ stent | <input type="text"/> | <input type="checkbox"/> Fracture surgery | <input type="text"/> | <input type="checkbox"/> Liver biopsy | <input type="text"/> |
| <input type="checkbox"/> Appendectomy | <input type="text"/> | <input type="checkbox"/> Gallbladder removal | <input type="text"/> | <input type="checkbox"/> Pacemaker | <input type="text"/> |
| <input type="checkbox"/> Arthroscopy of knee | <input type="text"/> | <input type="checkbox"/> Gastric bypass | <input type="text"/> | <input type="checkbox"/> Small bowel resection | <input type="text"/> |
| <input type="checkbox"/> Back surgery | <input type="text"/> | <input type="checkbox"/> Heart bypass surgery | <input type="text"/> | <input type="checkbox"/> Thyroid removal | <input type="text"/> |
| <input type="checkbox"/> Carpal tunnel release | <input type="text"/> | <input type="checkbox"/> Hernia repair | <input type="text"/> | <input type="checkbox"/> Tonsillectomy | <input type="text"/> |
| <input type="checkbox"/> Cataract surgery | <input type="text"/> | <input type="checkbox"/> Hip replacement | <input type="text"/> | | |
| <input type="checkbox"/> Colon resection | <input type="text"/> | <input type="checkbox"/> Knee replacement | <input type="text"/> | | |

Other surgical history not listed above:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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As the nurse is rooming the patient, in addition to having NextGen running, open **NextPen Desktop**.



Last	First	Form Name
AAT...	CANDEL...	Adult Medica...
█	█	Adult Medica...

Patient Name: AATESTDUFFY, CANDELABRA **Adult Medical History Form**
Birth Date: Jan 03, 1966 **Gender:** Female **MRN:** 000900058325 **Please print clearly & avoid stray marks**
Rendering Provider: DUFFY **Appt Date:** Oct 14 2014 10:30:00AM

Past Medical History

<input checked="" type="checkbox"/> Allergies (hay fever)	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Coronary (heart) disease	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Angina	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Peptic (stomach) ulcers
<input type="checkbox"/> Anxiety	<input checked="" type="checkbox"/> Depression	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Prostate enlargement
<input type="checkbox"/> Arthritis	<input checked="" type="checkbox"/> Diabetes	<input type="checkbox"/> Irritable bowel disease	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Stroke (CVA)
<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Liver disease	<input checked="" type="checkbox"/> Thyroid disease
<input type="checkbox"/> Blood clots	<input type="checkbox"/> GERD (acid reflux)	<input type="checkbox"/> Migraine headaches	

Other medical history not listed above:
 Typhus

Past Surgical History

<input type="checkbox"/> Angioplasty	Year	<input type="checkbox"/> Colostomy	Year	<input type="checkbox"/> LASIK	Year
<input type="checkbox"/> Angioplasty w/ stent		<input type="checkbox"/> Fracture surgery		<input type="checkbox"/> Liver biopsy	
<input type="checkbox"/> Appendectomy		<input checked="" type="checkbox"/> Gallbladder removal	1996	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Arthroscopy of knee		<input checked="" type="checkbox"/> Gastric bypass	2009	<input type="checkbox"/> Small bowel resection	
<input type="checkbox"/> Back surgery		<input type="checkbox"/> Heart bypass surgery		<input type="checkbox"/> Thyroid removal	
<input checked="" type="checkbox"/> Carpal tunnel release	2007	<input type="checkbox"/> Hernia repair		<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Cataract surgery		<input type="checkbox"/> Hip replacement			
<input type="checkbox"/> Colon resection		<input type="checkbox"/> Knee replacement			

Other surgical history not listed above:
 Melanoma removed left forearm 2011

Patient Name: AATESTDUFFY, CANDELABRA **Adult Medical History Form**
Birth Date: Jan 03, 1966 **Gender:** Female **MRN:** 000900058325 **Please print clearly & avoid stray marks**
Rendering Provider: DUFFY **Appt Date:** Oct 14 2014 10:30:00AM

Past Medical History

<input checked="" type="checkbox"/> Allergies (hay fever)	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Coronary (heart) disease	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Angina	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Peptic (stomach) ulcers
<input type="checkbox"/> Anxiety	<input checked="" type="checkbox"/> Depression	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Prostate enlargement
<input type="checkbox"/> Arthritis	<input checked="" type="checkbox"/> Diabetes	<input type="checkbox"/> Irritable bowel disease	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Stroke (CVA)
<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Liver disease	<input checked="" type="checkbox"/> Thyroid disease
<input type="checkbox"/> Blood clots	<input type="checkbox"/> GERD (acid reflux)	<input type="checkbox"/> Migraine headaches	

Other medical history not listed above:
 Typhus

Past Surgical History

<input type="checkbox"/> Angioplasty	Year	<input type="checkbox"/> Colostomy	Year	<input type="checkbox"/> LASIK	Year
<input type="checkbox"/> Angioplasty w/ stent		<input type="checkbox"/> Fracture surgery		<input type="checkbox"/> Liver biopsy	
<input type="checkbox"/> Appendectomy		<input checked="" type="checkbox"/> Gallbladder removal	1996	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Arthroscopy of knee		<input checked="" type="checkbox"/> Gastric bypass	2009	<input type="checkbox"/> Small bowel resection	
<input type="checkbox"/> Back surgery		<input type="checkbox"/> Heart bypass surgery		<input type="checkbox"/> Thyroid removal	
<input checked="" type="checkbox"/> Carpal tunnel release	2007	<input type="checkbox"/> Hernia repair		<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Cataract surgery		<input type="checkbox"/> Hip replacement			
<input type="checkbox"/> Colon resection		<input type="checkbox"/> Knee replacement			

Other surgical history not listed above:
 Melanoma removed left forearm 2011

Family History Indicate any diseases in your immediate family:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Coronary (heart) disease	<input type="checkbox"/> Hearing deficiency	<input type="checkbox"/> Migraines
<input type="checkbox"/> Allergies (hay fever)	<input type="checkbox"/> Before age 50?	<input checked="" type="checkbox"/> High blood pressure	<input type="checkbox"/> Obesity
<input checked="" type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Cancer	<input checked="" type="checkbox"/> High cholesterol	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Arterial disease (poor circulation)	<input type="checkbox"/> Depression	<input type="checkbox"/> Irritable bowel disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Developmental delay	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Attention deficit disorder	<input checked="" type="checkbox"/> Diabetes	<input type="checkbox"/> Learning disability	<input type="checkbox"/> Stroke (CVA)
<input type="checkbox"/> Blood disease	<input type="checkbox"/> Eczema	<input type="checkbox"/> Mental illness	

Other family: Leprosy

NextPen Desktop opens (you'll see this is also called FusionForm). On the right you'll see a copy of the handwritten form completed by the patient, & on the left you'll see the program's interpretation of the form after checkbox & handwriting recognition.

Last	First	Form Name
AAT...	CANDEL...	Adult Medica...
█	█	Adult Medica...

Patient Name: AATESTDUFFY, CANDELABRA **Adult Medical History Form**
Birth Date: Jan 03, 1966 **Gender:** Female **MRN:** 000900058325 **Please print clearly & avoid stray marks**
Rendering Provider: DUFFY **Appt Date:** Oct 14 2014 10:30:00AM

Past Medical History

<input checked="" type="checkbox"/> Allergies (hay fever)	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Coronary (heart) disease	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Angina	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Peptic (stomach) ulcers
<input type="checkbox"/> Anxiety	<input checked="" type="checkbox"/> Depression	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Prostate enlargement
<input type="checkbox"/> Arthritis	<input checked="" type="checkbox"/> Diabetes	<input type="checkbox"/> Irritable bowel disease	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Stroke (CVA)
<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Liver disease	<input checked="" type="checkbox"/> Thyroid disease
<input type="checkbox"/> Blood clots	<input type="checkbox"/> GERD (acid reflux)	<input type="checkbox"/> Migraine headaches	

Other medical history not listed above:
 Typhus

Past Surgical History

<input type="checkbox"/> Angioplasty	Year	<input type="checkbox"/> Colostomy	Year	<input type="checkbox"/> LASIK	Year
<input type="checkbox"/> Angioplasty w/ stent		<input type="checkbox"/> Fracture surgery		<input type="checkbox"/> Liver biopsy	
<input type="checkbox"/> Appendectomy		<input checked="" type="checkbox"/> Gallbladder removal	1996	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Arthroscopy of knee		<input checked="" type="checkbox"/> Gastric bypass	2009	<input type="checkbox"/> Small bowel resection	
<input type="checkbox"/> Back surgery		<input type="checkbox"/> Heart bypass surgery		<input type="checkbox"/> Thyroid removal	
<input checked="" type="checkbox"/> Carpal tunnel release	2007	<input type="checkbox"/> Hernia repair		<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Cataract surgery		<input type="checkbox"/> Hip replacement			
<input type="checkbox"/> Colon resection		<input type="checkbox"/> Knee replacement			

Other surgical history not listed above:
 Melanoma removed left forearm 2011

Family History Indicate any diseases in your immediate family:

Patient Name: AATESTDUFFY, CANDELABRA **Adult Medical History Form**
Birth Date: Jan 03, 1966 **Gender:** Female **MRN:** 000900058325 **Please print clearly & avoid stray marks**
Rendering Provider: DUFFY **Appt Date:** Oct 14 2014 10:30:00AM

Past Medical History

<input checked="" type="checkbox"/> Allergies (hay fever)	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Coronary (heart) disease	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Angina	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Peptic (stomach) ulcers
<input type="checkbox"/> Anxiety	<input checked="" type="checkbox"/> Depression	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Prostate enlargement
<input type="checkbox"/> Arthritis	<input checked="" type="checkbox"/> Diabetes	<input type="checkbox"/> Irritable bowel disease	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Stroke (CVA)
<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Liver disease	<input checked="" type="checkbox"/> Thyroid disease
<input type="checkbox"/> Blood clots	<input type="checkbox"/> GERD (acid reflux)	<input type="checkbox"/> Migraine headaches	

Other medical history not listed above:
 Typhus

Past Surgical History

<input type="checkbox"/> Angioplasty	Year	<input type="checkbox"/> Colostomy	Year	<input type="checkbox"/> LASIK	Year
<input type="checkbox"/> Angioplasty w/ stent		<input type="checkbox"/> Fracture surgery		<input type="checkbox"/> Liver biopsy	
<input type="checkbox"/> Appendectomy		<input checked="" type="checkbox"/> Gallbladder removal	1996	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Arthroscopy of knee		<input checked="" type="checkbox"/> Gastric bypass	2009	<input type="checkbox"/> Small bowel resection	
<input type="checkbox"/> Back surgery		<input type="checkbox"/> Heart bypass surgery		<input type="checkbox"/> Thyroid removal	
<input checked="" type="checkbox"/> Carpal tunnel release	2007	<input type="checkbox"/> Hernia repair		<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Cataract surgery		<input type="checkbox"/> Hip replacement			
<input type="checkbox"/> Colon resection		<input type="checkbox"/> Knee replacement			

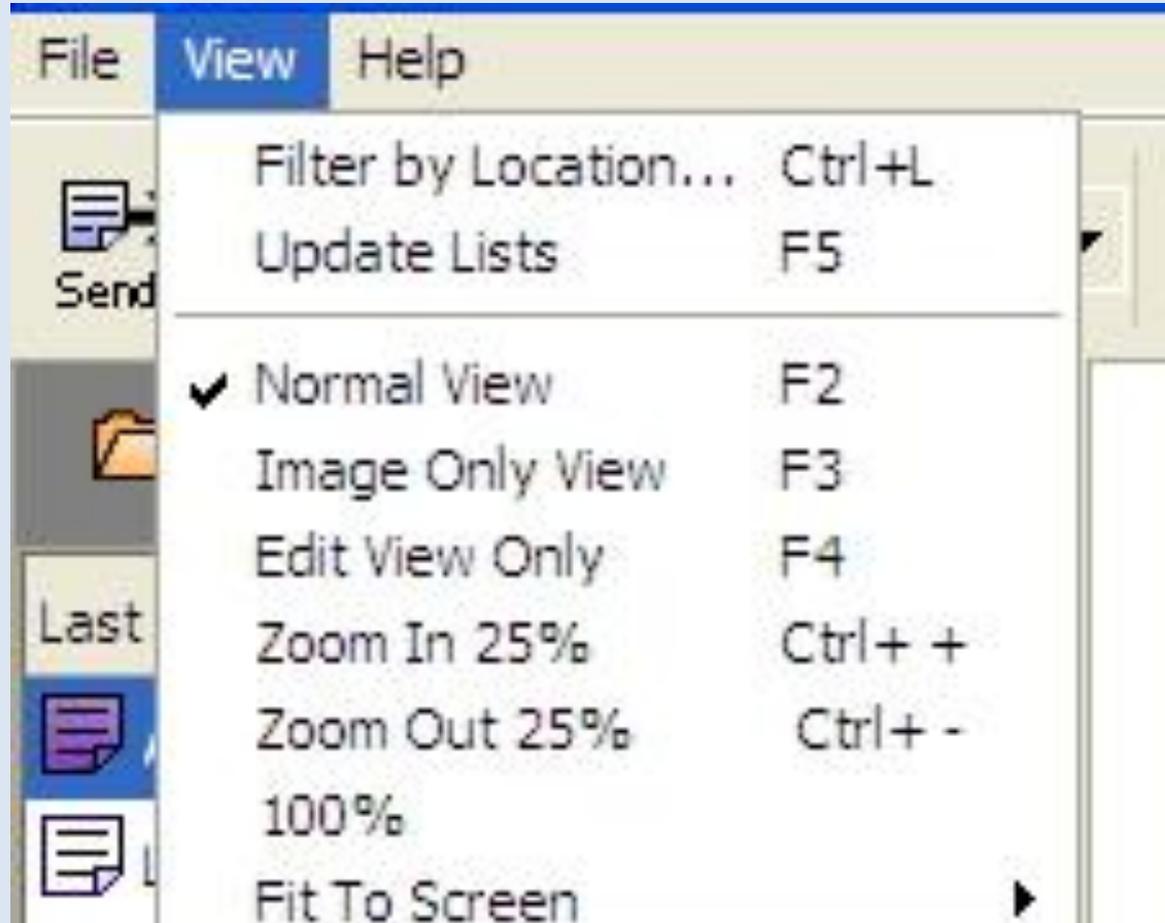
Other surgical history not listed above:
 Melanoma removed left forearm 2011

Family History Indicate any diseases in your immediate family:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Coronary (heart) disease	<input type="checkbox"/> Hearing deficiency	<input type="checkbox"/> Migraines
<input type="checkbox"/> Allergies (hay fever)	<input type="checkbox"/> Before age 50?	<input checked="" type="checkbox"/> High blood pressure	<input type="checkbox"/> Obesity
<input checked="" type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Cancer	<input checked="" type="checkbox"/> High cholesterol	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Arterial disease (poor circulation)	<input type="checkbox"/> Depression	<input type="checkbox"/> Irritable bowel disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Developmental delay	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Attention deficit disorder	<input checked="" type="checkbox"/> Diabetes	<input type="checkbox"/> Learning disability	<input type="checkbox"/> Stroke (CVA)
<input type="checkbox"/> Blood disease	<input type="checkbox"/> Eczema	<input type="checkbox"/> Mental illness	

Other family history: Leprosy

You can resize & scroll the two sides as necessary, & you may want to maximize this screen. But since you should also have the paper copy of the form on hand, you can focus on the left screen here.



In fact, you can change the view if desired through the **View Menu**. **Normal View** shows the two images side-by-side as above. **Image Only** shows only the handwritten version. **Edit View** shows only the converted digital version; since you have a paper copy of the handwritten version, you may prefer **Edit View**, especially on computers with smaller screens.

Past Medical History

- | | | | |
|---|---|--|---|
| <input checked="" type="checkbox"/> Allergies (hay fever) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Coronary (heart) disease | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Peptic (stomach) ulcers |
| <input type="checkbox"/> Anxiety | <input checked="" type="checkbox"/> Depression | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Prostate enlargement |
| <input type="checkbox"/> Arthritis | <input checked="" type="checkbox"/> Diabetes | <input type="checkbox"/> Irritable bowel disease | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke (CVA) |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Liver disease | <input checked="" type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> GERD (acid reflux) | <input type="checkbox"/> Migraine headaches | |

Other medical history not listed above:

Typhus

Past Surgical History

- | | | | | | |
|---|------|---|------|--|------|
| <input type="checkbox"/> Angioplasty | Year | <input type="checkbox"/> Colostomy | Year | <input type="checkbox"/> LASIK | Year |
| <input type="checkbox"/> Angioplasty w/ stent | | <input type="checkbox"/> Fracture surgery | | <input type="checkbox"/> Liver biopsy | |
| <input type="checkbox"/> Appendectomy | | <input checked="" type="checkbox"/> Gallbladder removal | 1996 | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Arthroscopy of knee | | <input checked="" type="checkbox"/> Gastric bypass | 2009 | <input type="checkbox"/> Small bowel resection | |
| <input type="checkbox"/> Back surgery | | <input type="checkbox"/> Heart bypass surgery | | <input type="checkbox"/> Thyroid removal | |
| <input checked="" type="checkbox"/> Carpal tunnel release | 2007 | <input type="checkbox"/> Hernia repair | | <input type="checkbox"/> Tonsillectomy | |
| <input type="checkbox"/> Cataract surgery | | <input type="checkbox"/> Hip replacement | | | |
| <input type="checkbox"/> Colon resection | | <input type="checkbox"/> Knee replacement | | | |

Other surgical history not listed above:

Melanoma removed left forearm 2011

Family History

Indicate any diseases in your immediate family:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Coronary (heart) disease | <input type="checkbox"/> Hearing deficiency | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Allergies (hay fever) | <input type="checkbox"/> Before age 50? | <input checked="" type="checkbox"/> High blood pressure | <input type="checkbox"/> Obesity |
| <input checked="" type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Cancer | <input checked="" type="checkbox"/> High cholesterol | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Arterial disease (poor circulation) | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritable bowel disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Developmental delay | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Attention deficit disorder | <input checked="" type="checkbox"/> Diabetes | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Stroke (CVA) |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Eczema | <input type="checkbox"/> Mental illness | |

Other family Leprosy

Reviewing page 1, all marks & handwriting conversion on this page appear the same as the handwritten version. If there were something wrong or incomplete, the nurse would ask the patient to clarify, & enter changes here. But since things look good, just click **Next** to move on to page 2.

Social History

Marital status: Married Single Divorced Widowed Life partner

Race: White African-American Hispanic Asian Other:

Language: English Spanish Chinese French Other:

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Hand dominance Left Right Ambidextrous

Exercise frequency: 2-3 times/week 3-4 times/week Daily Occasionally Never

Tobacco history Have you ever used tobacco? No/Never Yes Unknown

Please check any of the below that you have ever used:

	Use daily?	Amount per day:	Number of Years:	Age started:	Age stopped:
<input checked="" type="checkbox"/> Cigarettes	<input checked="" type="checkbox"/>	45 Packs	31		
<input type="checkbox"/> Cigar	<input type="checkbox"/>	Cigars			
<input type="checkbox"/> Pipe	<input type="checkbox"/>	Pipes			
<input type="checkbox"/> Chewing	<input type="checkbox"/>	Ounces			
<input type="checkbox"/> Snuff	<input type="checkbox"/>	Ounces			
<input type="checkbox"/> Smokeless (Electronic)	<input type="checkbox"/>	Units			

Second-hand smoke exposure: Yes No

Other substances

Do you drink caffeine? Yes No

Do you drink alcohol? Yes No Formerly

How often? Daily Weekly Monthly Occasionally Rarely

Do you use recreational or street drugs? Yes No Formerly

If so, what drugs?

Amount per day:	Number of Years:
1.5	31

Let's look at the **Social History** section first. Comparing the handwritten & digital versions, we see that the program erroneously interpreted 1.5 PPD as 45.

Hand dominance Left Right Ambidextrous

Exercise frequency: 2-3 times/week 3-4 times/week Daily Occasionally Never

Tobacco history Have you ever used tobacco? No/Never Yes Unknown

Please check any of the below that you have ever used:



Cigarettes

Use daily?



Amount per day:

1.5

packs

Number of Years:

31

Age started:

Age stopped:



Cigar



Cigars

Simply click in the box & type over 45 to change it to 1.5. Do this for any other erroneous transcriptions you see.

Medications You Take (including doses if known)

Note: Meds must be manually reviewed & entered into EHR.

Flowage 1 spray each nostril daily

Fluoxetine 10mg daily

Synthroid 125 micrograms daily

Metformin wooting twice daily

Allergies (and reactions you had)

Note: Allergies must be manually reviewed & entered into EHR.

Bactrrm-rasb

Social History

All of the data we've seen so far can be passed directly into the EHR. But look at the **Medications & Allergies** sections. Notice there are warnings that these entries must be manually entered into the EHR.

Please check any of the below that you have ever used:



Cigarettes

Use daily?



Amount per day:

1.5
Packs

Number of Years:

31

Age started:

Age stopped:

Medications You Take (including doses if known)

Flonase 1 spray each nostril daily

Fluoxetine 10mg daily

Synthroid 125 micrograms daily

Metformin wooing twice daily

Allergies (and reactions you had)

Bactrim-rash

Medications You Take (including doses if known)

Flonase 1 spray each nostril daily

Fluoxetine 10mg daily

Synthroid 125 micrograms daily

Metformin 1000mg twice daily

Allergies (and reactions you had)

Bactrim - rash



Clearly there are some pretty significant transcription errors here—which illustrates why there is no attempt to pass this data over to the EHR by default. You can click in the transcribed fields & type corrections if you like, but there isn't much reason to; when you're in the EHR you'll just make your entries there.

78%

Open Forms

Last	First	Form Name
AATESTDUFFY	CANDELABRA	Adult Medical Hx USA
██████	██████	Adult Medical Hx USA

Medications You Take (including doses if known) Note: Meds must be manually reviewed & entered into EHR.

Flowage 1 spray each nostril daily

Fluoxetine 10mg daily

Synthroid 125 micrograms daily

Metformin wooting twice daily

Allergies (and reactions you had) Note: Allergies must be manually reviewed entered into EHR.

Bactrrm-rasb

Social History

Marital status: Married Single Divorced Widowed Life partner

Race: White African-American Hispanic Asian Other:

Language: English Spanish Chinese French Other:

Ethnicity: Hispanic or Latino Not Hispanic or Latino

Hand dominance Left Right Ambidextrous

After reviewing (& correcting, if necessary) all of the fields except **Meds & Allergies**, you're ready to transfer this data to the EHR. Click **Send**.

Send Copy Move Update 78% Zoom Zoom

Open Forms

Last	First	Form Name
[Redacted]	[Redacted]	Adult Medical Hx USA

Patient Name: [Redacted] **Adult Medical History Form**
Birth Date: [Redacted] **Gender:** Female **MRN:** 00000 [Redacted] *Please print clearly & avoid stray marks*
Rendering Provider: [Redacted] **Appt Date:** Oct 14 2014 [Redacted] 0PM

Past Medical History

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Allergies (hay fever) | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Coronary (heart) disease | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Peptic (stomach) ulcers |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Prostate enlargement |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irritable bowel disease | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke (CVA) |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> GERD (acid reflux) | <input type="checkbox"/> Migraine headaches | |

Other medical history not listed above:

Past Surgical History

	Year		Year		Year
<input type="checkbox"/> Angioplasty	<input type="text"/>	<input type="checkbox"/> Colostomy	<input type="text"/>	<input type="checkbox"/> LASIK	<input type="text"/>
<input type="checkbox"/> Angioplasty w/ stent	<input type="text"/>	<input type="checkbox"/> Fracture surgery	<input type="text"/>	<input type="checkbox"/> Liver biopsy	<input type="text"/>
<input type="checkbox"/> Appendectomy	<input type="text"/>	<input type="checkbox"/> Gallbladder removal	<input type="text"/>	<input type="checkbox"/> Pacemaker	<input type="text"/>
<input type="checkbox"/> Arthroscopy of knee	<input type="text"/>	<input type="checkbox"/> Gastric bypass	<input type="text"/>	<input type="checkbox"/> Small bowel resection	<input type="text"/>

The form you just completed drops off the Open Forms list. You can minimize NextPen Desktop (FusionForm), & go to the EHR.

Medical/Surgical/Interim

 No relevant past medical/surgical history

All History/Review details are to be reviewed and included in visit note unless user indicates otherwise History R

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome
Typhus							
Thyroid disease							
Diabetes							
Depression							
Allergies							
			Melanoma removed left forearm		2011		
			gastric bypass		2009		
			carpal tunnel release		2007		

Interim History

Add

Edit

Remo

Social

 Last documented All ⓘ

Some basics appear in visit notes; further details appear only if popups reviewed History R

Substances	Encounter Date	Smoking Status	Ever Used Tobacco?	Tobacco Type	Usage Per Day	Pack Years	Date Quit
Tobacco	10/14/2014	Heavy tobacco smoker	Yes	cigarette	1.5 Packs	46.50	

The nurse rooms the patient as usual, entering vital signs, reason for visit, meds, & allergies. But when you get to the Histories tab, you'll see that all of the past medical/social/family history on the NextPen form is already here. Cool, huh? Make any further additions & changes as necessary.

 No relevant family history Adopted - no family history known

All History/Review details are to be reviewed and included in visit note unless user indicates otherwise History R

Relationship	Family Member Name	Deceased	Age at Death	Condition	Onset Age	Cause of Death	Comments
Family h/o				Leprosy			
Family h/o				Diabetes			
Family h/o				Alzheimer's Disease			
Family h/o				Hypertension			
Family h/o				Hyperlipidemia			

10/14/2014 10:30 AM: *USA Histories 836 10/14/2014 10:30 AM "Patient Intake" 612 x 792 - 24 BPP x

1 of 2 100%

Patient Name: AATESTDUFFY, CANDELABRA **Adult Medical History Form**
Birth Date: Jan 03, 1966 Gender: Female MRN: 000900058325 Please print clearly & avoid stray marks
Rendering Provider: DUFFY Appt Date: Oct 14 2014 10:30:00A

Past Medical History

<input checked="" type="checkbox"/> Allergies (hay fever)	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Coronary (heart) disease	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Angina	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Peptic (stomach) ulcers
<input type="checkbox"/> Anxiety	<input checked="" type="checkbox"/> Depression	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Prostate enlargement
<input type="checkbox"/> Arthritis	<input checked="" type="checkbox"/> Diabetes	<input type="checkbox"/> Irritable bowel disease	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Stroke (CVA)
<input type="checkbox"/> Atrial fibrillation	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Liver disease	<input checked="" type="checkbox"/> Thyroid disease
<input type="checkbox"/> Blood clots	<input type="checkbox"/> GERD (acid reflux)	<input type="checkbox"/> Migraine headaches	

Other medical history not listed above:

Typhus

Past Surgical History

<input type="checkbox"/> Angioplasty	Year	<input type="checkbox"/> Colostomy	Year	<input type="checkbox"/> LASIK	Year
<input type="checkbox"/> Angioplasty w/ stent		<input type="checkbox"/> Fracture surgery		<input type="checkbox"/> Liver biopsy	
<input type="checkbox"/> Appendectomy		<input checked="" type="checkbox"/> Gallbladder removal	1996	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Arthroscopy of knee		<input checked="" type="checkbox"/> Gastric bypass	2009	<input type="checkbox"/> Small bowel resection	

Patient History
Patient H... Patient D... Categories
New Lock Search
10/14/2014 10:30 AM DUFFY, P
Patient Intake
*USA Intake 836
*USA Histories 836

Notice that a copy of the handwritten form is saved to the encounter in case you need to refer to it later. So again, there is no need to scan the paper forms, & they can be discarded after the visit.

Note To Providers: Entries from the NextPen form are added to the **Medical/Surgical/Interim** section; nothing is added to the **Problem List**. It is up to you to enter diagnoses on the **Problem List** as you deem appropriate.

Problem List 0

Show chronic Show my tracked problem

No active problems Reviewed

Problem Description	Side	Notes	Addtl
---------------------	------	-------	-------

Refresh Add Edit

Medical/Surgical/Interim

No relevant past medical/surgical history

All History Review details are to be reviewed and included in visit note unless user indicates otherwise [History Review](#)

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome
Typhus							
Thyroid disease							
Diabetes							
Depression							
Allergies							
			Melanoma removed left forearm		2011		
			gastric bypass		2009		
			carpal tunnel release		2007		

Interim History Add Edit Remove

There is no harm leaving all entries on the **Medical/Surgical/Interim List** as well, but we suggest avoiding redundant entries to keep the chart as concise as possible. So entries like "Diabetes" that are added to the **Problem List** can be deleted from the **Medical/Surgical/Interim List** unless you have a specific reason to keep them there.

Care Guidelines | Global Days | **History Review** All History Review details are to be reviewed and included in visit note unless user indicates otherwise Panel Control:

Problem List 0

Show chronic Show my tracked problem No active problems Reviewed

Problem Description	Side	Notes	Addtl
---------------------	------	-------	-------

Medical/Surgical/Interim

No relevant past medical/surgical history All History Review details are to be reviewed and included in visit note unless user indicates otherwise [History Review](#)

Disease/Disorder	Side	Onset Date	Management	Side	Date	Encounter Type	Outcome
Typhus							
Thyroid disease							
Diabetes							
Depression							
Allergies							
			Melanoma removed left forearm		2011		
			gastric bypass		2009		
			carpal tunnel release		2007		

This concludes the
NextGen NextPen demonstration.

“Meaningful Use” sometimes feels like
a paradigm shifting without a clutch.