

Summary Sheet

Adding a Coded Diagnosis (Past History)

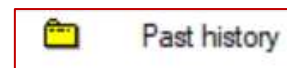
Diagnoses are added using the **Past history** screen or via the **Reason for Visit** button in the Progress Notes tab of Medical Director Clinical. The diagnosis should always be chosen from a coded list rather than using free text.

The Past History section of the electronic medical record is used to record only:

- Chronic conditions
- Significant events in the patient's medical history

Adding a coded diagnosis in the patient record / consultation:

1. Open the patient record 'F2'.
2. Select the 'Past history' tab.
3. Select the red '+' button in the top left of the screen.
4. Enter the date the condition was first diagnosed in the date field. If a specific date is not known, enter the year it was first diagnosed.
5. Enter the first few characters of the condition in the 'Pick from List' field then double click on the relevant diagnosis to select.
6. Tick 'Active Problem' if a current condition.
7. Tick 'Summary' to include the diagnosis on health summaries and referrals.
8. Tick 'Confidential' to exclude the diagnosis from health summaries.
9. Enter Comment/s as required.
10. OK to save.



New History Item

Year: Date:

Condition

Pick from list (coded)

ck
 CK raised
 CKD (Chronic Kidney Disease) Stage 1
 CKD (Chronic Kidney Disease) Stage 2
 CKD (Chronic Kidney Disease) Stage 3
 CKD (Chronic Kidney Disease) Stage 4
 CKD (Chronic Kidney Disease) Stage 5

Free text (uncoded)

Left Active problem Confidential Summary

Right

Comment:

10/6.2018 eGFR = 59 ACR <1.7mg/mmol

Year	Date	Condition	Side	Status	Summary	Confidential	Coded
1996	10/02/96	Asthma		Inactive	Yes	No	Yes
2000	03/02/2000	Lump breast	Left	Inactive	Yes	No	Yes
2001		Stroke		Active	Yes	No	Yes
2018	24/07/2018	Headache - Migraine		Active	Yes	No	Yes