

# Adding Family History to a Patient's Chart

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You can add your patient's family history to their chart. Once entered into the chart, this data is included in the clinical summary with referrals and C-CDA files for the patient.

**Note:** Family history can also be documented in the clinical note or through OnPatient and the Check-In App. However, that information is not automatically added to the patient's chart. It remains in the note, but that information can be entered into the chart with these steps.

1. To add a patient's family history to their chart and select **Family History**.

The screenshot shows the patient chart for Laurie Sample. The left sidebar contains a list of menu items, with 'Family History' highlighted in green. A green box labeled 'Family History' is positioned over the sidebar item, with an arrow pointing to it. The main content area shows the patient's profile and a table of family history entries.

Name	Relation	Race	Ethnic Group	Status	Action
Father Sample	Father			1 observation(s)	Action
Mother Sample	Mother			1 observation(s)	Action
Grandpa Sample	Maternal Grandfather			1 observation(s)	Action

2. Click **Add Family Member**.

The screenshot shows the same patient chart as above. A green box labeled '+ Add family member' is positioned in the bottom right corner, with an arrow pointing to the corresponding button in the 'Family History' section of the chart.

3. Select the relationship of the family member to the patient.

## Add Family Member

×

Relation to patient:  Father  
 Mother  
Name:  Daughter  
 Son  
Family name:  Granddaughter  
Prefix:  Grandson  
 Brother  
Age:  Sister  
Deceased age:  Half Brother  
 Half Sister  
Races:  Nephew  
 Niece  
Ethnicities:  Maternal Grandfather  
 Maternal Grandmother  
Gender:  Maternal Aunt  
 Maternal Uncle  
 Maternal Cousin  
 Paternal Grandfather  
 Paternal Grandmother  
 Paternal Uncle  
 Paternal Aunt  
 Paternal Cousin

4. Enter the rest of the information and **Save**.

## Add Family Member

×

Relation to patient:

Name:

Family name:

Prefix:  Suffix:


Age:  Birth date:

Deceased age:

Races:

Ethnicities:

Gender:



5. Click **+Add Observation** to add a clinical observation to the family member.

Grandma Sample      Paternal Grandmother      0 observation(s)      Action ▾

→ Edit  
+ Add Observation  
? Report health history unknown  
Delete

6. Use the search field to find the condition you need to document.

**Add Observation** ×

Clinical observation

Age (optional)

Observation	Age	SnoMED Concept ID
No observations		

Close Save

**Add Observation** ×

Clinical observation

Age (optional)

- Erythrocytosis due to cyanotic congenital heart disease
- Acute heart disease
- Specimen from heart
- Suspended heart syndrome
- Acute left-sided heart failure
- Heart valve disorder
- Heart valve disorder, NOS
- Valvular heart disease, NOS
- Heart valve disease, NOS
- Valvular heart disease

Close

7. Once you have selected the observation, you have the option of entering an age. Click **Save** when finished.

**Add Observation** ×

Clinical observation

Age (optional)

Observation	Age	SnoMED Concept ID
No observations		

Close Save

8. Select **Edit** under the **Action** menu to edit the family member's information. You can also add additional observations.

Grandma Sample      Paternal Grandmother      1 observation(s)      Action ▾

→ Edit  
+ Add Observation  
Delete

Click on the icon (



) next to the family member's name to view, edit or delete existing observations.

Grandma Sample      Paternal Grandmother      1 observation(s)      Action ▾

Age	Observation	SnoMED Concept ID	
53	Heart-congenital defect	156911006	Edit Delete

The data will appear under **Family History** with C-CDA files and referrals.

### Family History

Father

Diagnosis	Age At Onset
Benign essential hypertension	None

Mother

Diagnosis	Age At Onset
Latent diabetes	42

Maternal Grandfather

Diagnosis	Age At Onset
Hypertensive heart disease with congestive heart failure	42

Paternal Grandmother

Diagnosis	Age At Onset
Heart-congenital defect	53

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