ADDING PROCEDURE HISTORY

1.	The procedure history tab allows you to document procedures or surgeries that have happened prior to the current encounter during the lifetime of the patient. These can be viewed across all encounters. Procedures are automatically added to this tab if they are recorded during an encounter and the 'add to history' box is ticked at the time, for example during documentation of an operation note for a total hip replacement, the surgeon will tick the 'add to history' box when recording the procedure SNOMED term as it is relevant for future encounters.
2.	Click on the **Histories** main menu option and then click on the Procedure tab. **Procedure**
3.	Click on ✚ Add
4.	Search for the procedure term (similar to Procedures recording detailed earlier), select the term and click OK (add to favourites can be used here) ***Procedure** hip replacement 🔍
5.	Complete relevant information (e.g. date or laterality) ***Procedure** Hip replacement 🔍 ☐ Free Text Laterality Left ▾ Clinical Staff Parsons , Samue 🔍 ☐ Free Text Display As Hip replacement At: Age _Age_ 75 Years ▾ Date _Year_ 2005 Comments Location ☑ Free Text If the patient is unclear as to the year of the procedure, enter their age and the year will calculate automatically. If they don't know the exact date, switch the date function to be 'year' rather than 'date' Date Da▾ 03/02/1! Date / Week Of / Month / Year
6.	Click OK or OK and add new to add further procedures.