Instant Medical History is patient interview software that organizes patient concerns and begins the subjective history before the encounter. Patients respond to multiple choice questions that branch based on their responses.

Patients do this …

In the background, the software translates the interview summary into clinical terminology and organizes the positives and negatives according to the pertinent organ system, before passing the details to an Electronic Medical Record.

Enabling patients to enter the data to populate the subjective portion of the medical record makes the encounter time more efficient. Both the patient and the doctor are focused on the health concerns presented at the start of the encounter.

… Physicians get this.

With this information in advance, physicians can quickly review the information and conduct a more efficient and informed patient interview, reducing the patient office visit time by 3-4 minutes while increasing the documentation quality significantly.

You Need IMH If You Answer “Yes” to Any of the Following

- Could I charge for the work that I am actually doing if I documented more accurately?
- Would unique documentation on every patient better withstand an audit?
- Is fear of losing productivity the main reason I don’t have an EMR?
- Would I be more efficient with patients completing a medical history before they see me?
- Could I treat Hispanic patients better with Spanish questionnaires and English output?
- Is it important to my family that I leave the office at 5PM? With a complete chart?
- Am I taking better care of my patients than I am able to record in the chart?
Enable patients to begin their own HPI, ROS, and other relevant medical history before the encounter from the waiting room or over the web.

- Encounters become more efficient; physicians can see more patients each day.
- The level and accuracy of your E/M codes is increased.
- Data entry time for over 40 EMRs is reduced dramatically.
- Patients are comforted their relevant symptoms are elicited and considered.

**Chief Complaint**
Shawn Sample is a 30 year old male. His chief complaint is "cough".

**History of Present Illness**
He reported: cough productive of sputum, dyspnea, wheezing, symptoms present for 4 to 7 days, recent coryza  
**Severity:** He reported: continuous cough, exertional dyspnea severe, sputum increasing in quantity, more than 30 cc sputum in 24 hour.  
**Duration:** He reported: cough for 1 week.  
**Timing:** He reported: recent onset cough, nocturnal cough.  
**Context:** He reported: pleuritic chest pain, exertional dyspnea.  
**Associated Signs and Symptoms:** He reported: yellow or green sputum, brown sputum, foul smelling sputum

**Past, Family, and Social History**

**Past Medical History**
History of chest radiograph less than 1 year ago,  

**Social History**

**Tobacco Use**
History of: smoking cigarettes.

**Review of Systems**

**Constitutional**
He reported: night sweats, fever in the past week.

Contact us at (803) 796-7980 or [www.medicalhistory.com](http://www.medicalhistory.com) to learn more about how Instant Medical History can enhance the efficiency and profitability of your practice.