How to add medications in eClinicalWorks: manage current medications in a progress note

This guide explains how to add medications in eClinicalWorks and keep a patient's medication list accurate. You review the **Current Medication** section of a progress note, reconcile medication statuses, add a new medication, and verify the final list. The guide also covers how to document past medical history and allergies.

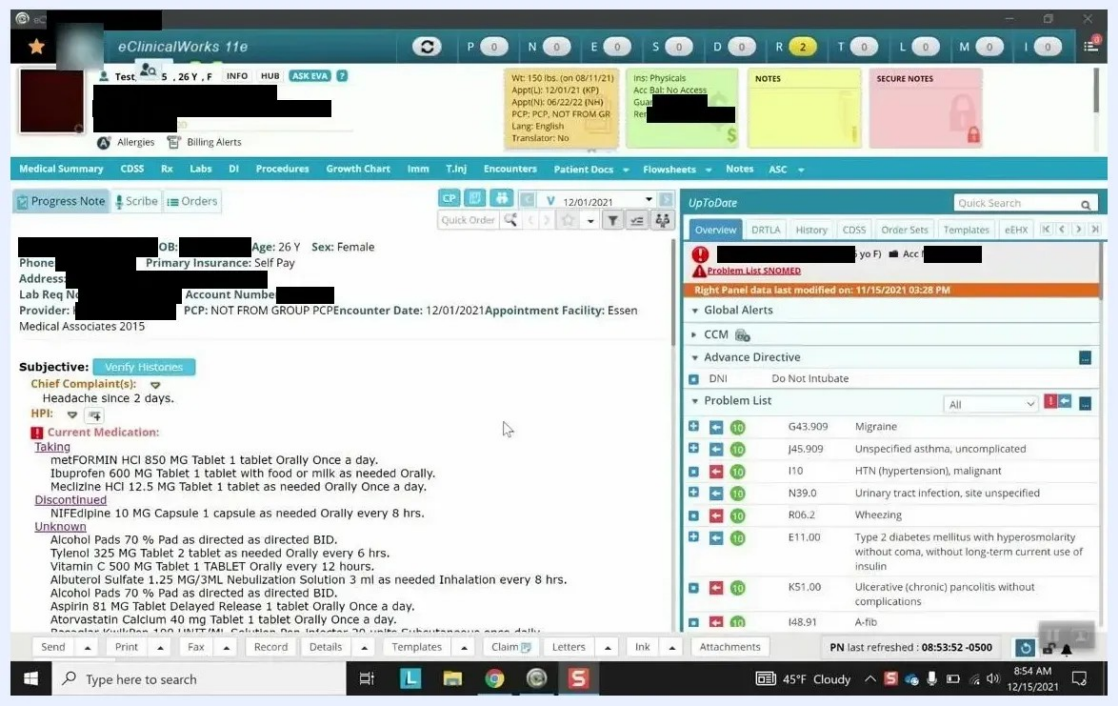
Prerequisites

- Access to the patient's progress note in eClinicalWorks.
- A patient medication list to review, such as medications from a previous provider.

Step 1: Locate the current medications section

1. Open the patient's progress note.
2. Scroll to the **Subjective** section.
3. Find **Current Medication** under HPI (History of Present Illness).

The medication list is divided into three headings: **Taking**, **Discontinued**, and **Unknown**.



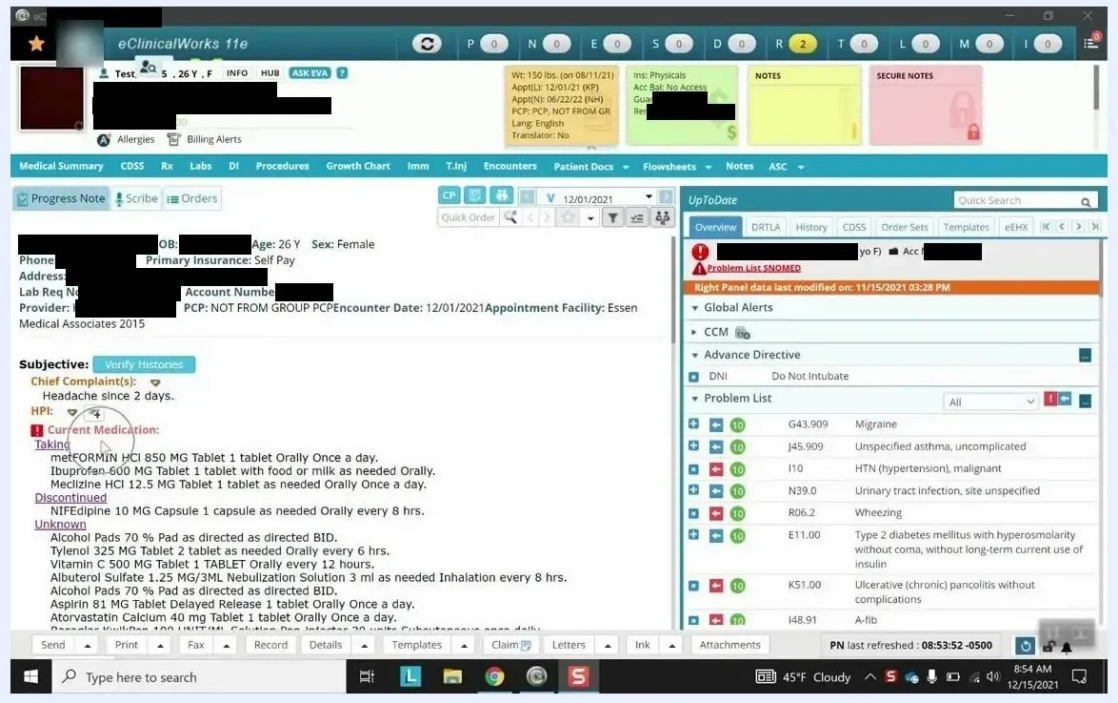
Progress note screen showing patient demographics, HPI, and the Current Medication section with Taking, Discontinued, and Unknown headings

Step 2: Understand the medication status headings

The headings organize and clarify the patient's medication history:

- **Taking**: medications the patient is currently taking.
- **Discontinued**: medications that have been stopped.

- **Unknown**: medications with an unclear status.



Current Medication section with Taking, Discontinued, and Unknown lists clearly separated

Step 3: Open the Medication Reconciliation tab

Click the **Current Medication** or **Medication Reconciliation** tab to open a detailed view. This tab gives you a structured interface for reviewing and updating medication statuses.

The interface includes:

- Tabs for different sections (Pt. Info, Encounter, Physical, Hub, and others).
- Filters for **Taking**, **Not Taking**, **Discontinued**, and **Unknown Status**.
- **Mark all as** options: T (Taking), N (Not Taking), U (Unknown), and D (Discontinued).
- Fields for start and stop dates, notes, and source for each medication.

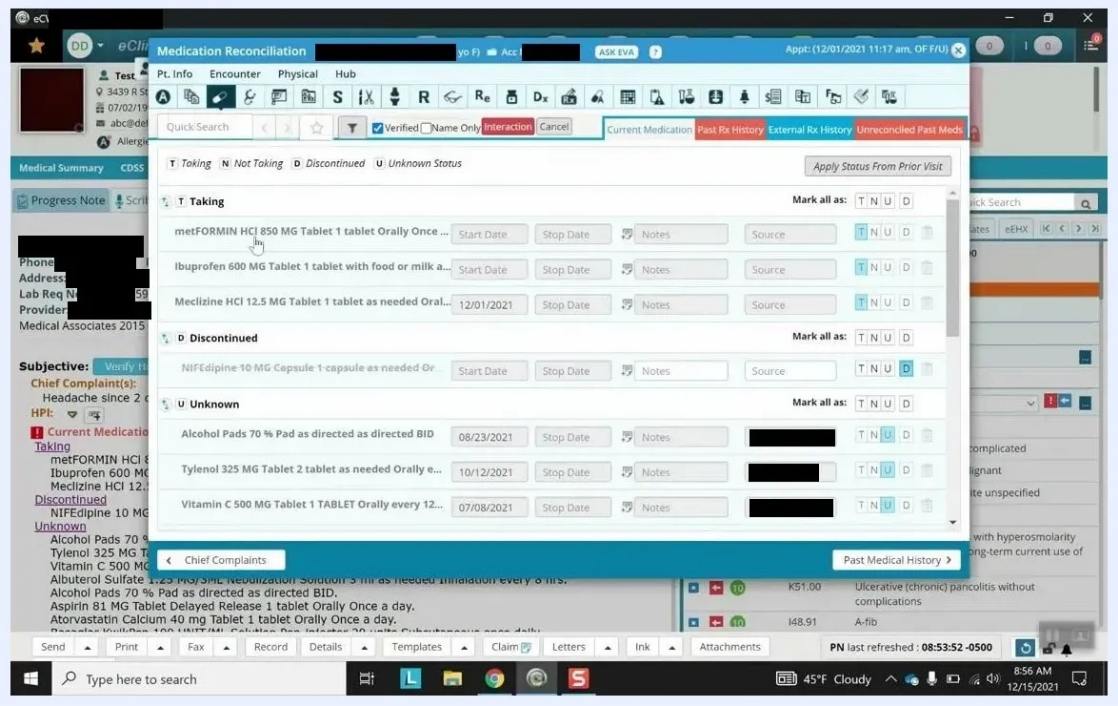
Step 4: Review medication attributes

For each medication, confirm the following:

- Name and strength (for example, "Ibuprofen 600 MG Tablet").

- Dosage and frequency (for example, "1 tablet with food or milk as needed Orally").
- Status: Taking, Discontinued, or Unknown.
- Additional details such as start and stop dates, notes, and source provider.

Make sure all information is up to date and reflects the patient's current regimen.

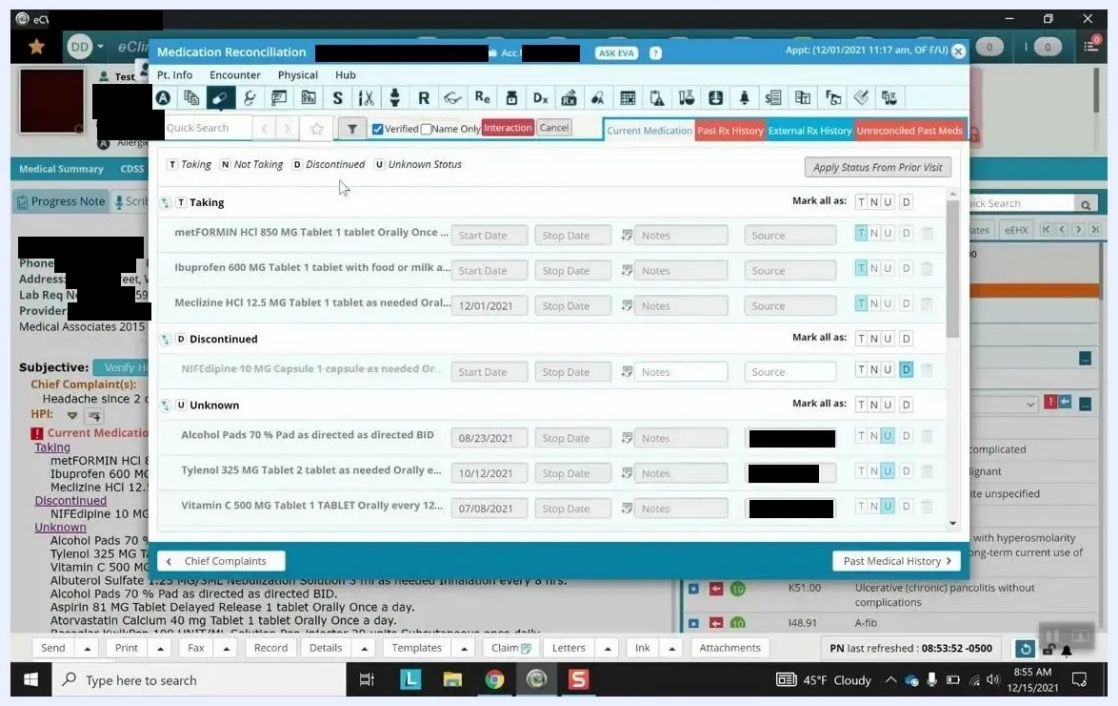


Medication Reconciliation screen with medication details, including name, strength, instructions, and editable fields

Step 5: Set the starting status for a new patient

When you see a new patient with medications from a previous provider, select **Mark all as Unknown**. This sets every medication to unknown status at the start.

As you review each medication with the patient, update its status to Taking, Not Taking, or Discontinued as appropriate. This keeps the list accurate even if you do not review every medication during the visit.



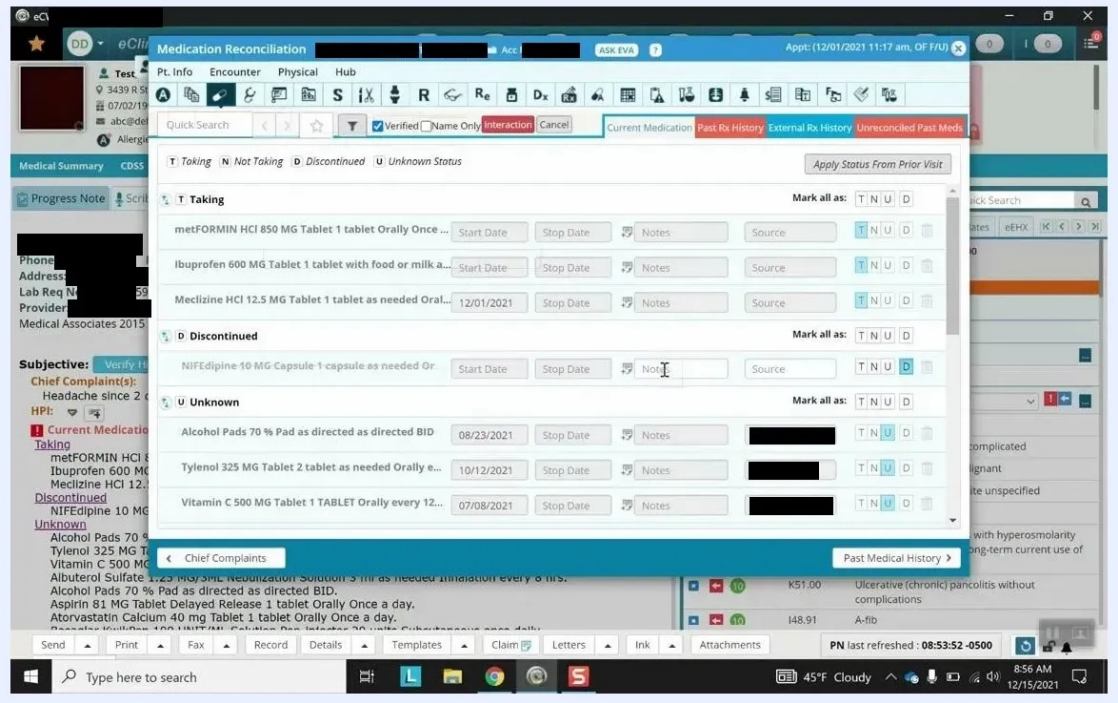
Medication Reconciliation screen with the Mark all as options highlighted for Taking, Not Taking, Unknown, and Discontinued

Step 6: Review the medication entry fields

In the Medication Reconciliation window, review the fields for each medication:

- **Start Date** and **Stop Date**: Fill these in if known. They are not always required.
- **Notes**: Rarely used, but you can add extra information if needed.

- **Source**: Typically the provider who prescribed the medication.



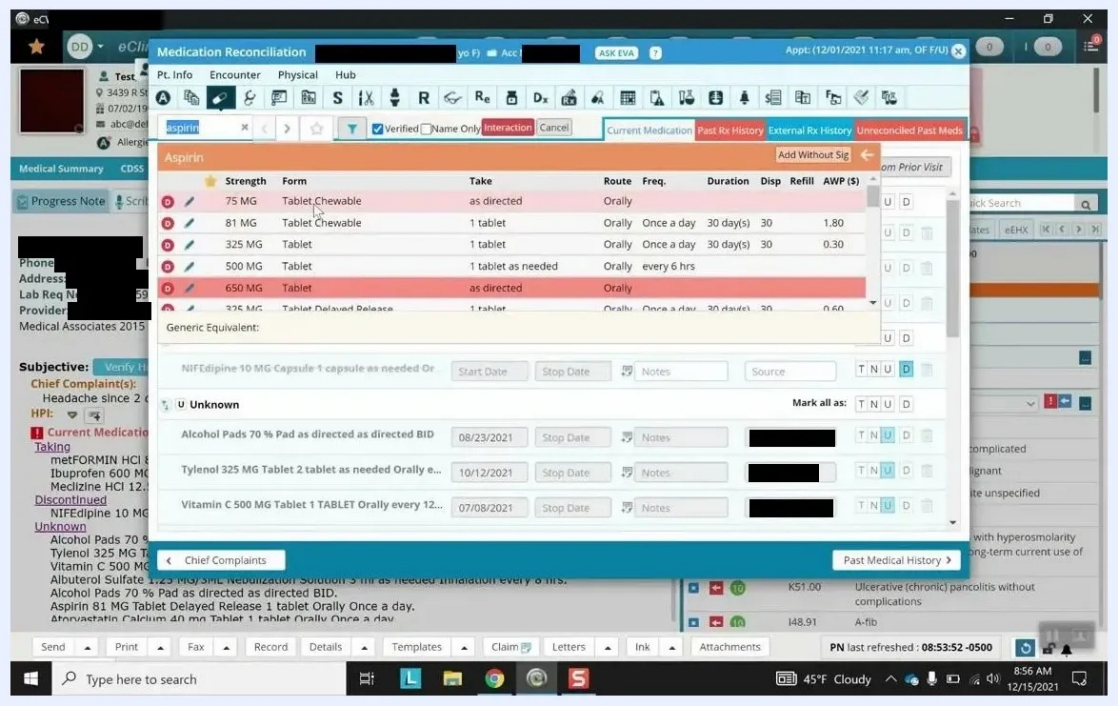
Medication Reconciliation screen showing editable Start Date, Stop Date, Notes, and Source fields for each medication

Step 7: Add a new medication

Here is how to add medications in eClinicalWorks from the Medication Reconciliation window:

1. Begin typing the medication name (for example, "aspirin") in the search bar.
2. Select the medication from the list that appears.
3. Choose the appropriate **strength** (for example, 325 MG or 500 MG).
4. Select the correct **form** (for example, Tablet, Chewable Tablet, Capsule, or Powder).
5. Specify the **instructions**, **route** (for example, Orally), **frequency** (for example, Once a day or every 6 hrs), **duration**, **dispense quantity**, and **refills** as needed.
6. Review the **AWP ($)** (Average Wholesale Price) if it is displayed.
7. Click **Add** to include the medication in the patient's list.

If a warning appears, such as "Already on the list," you can still proceed to add the medication.



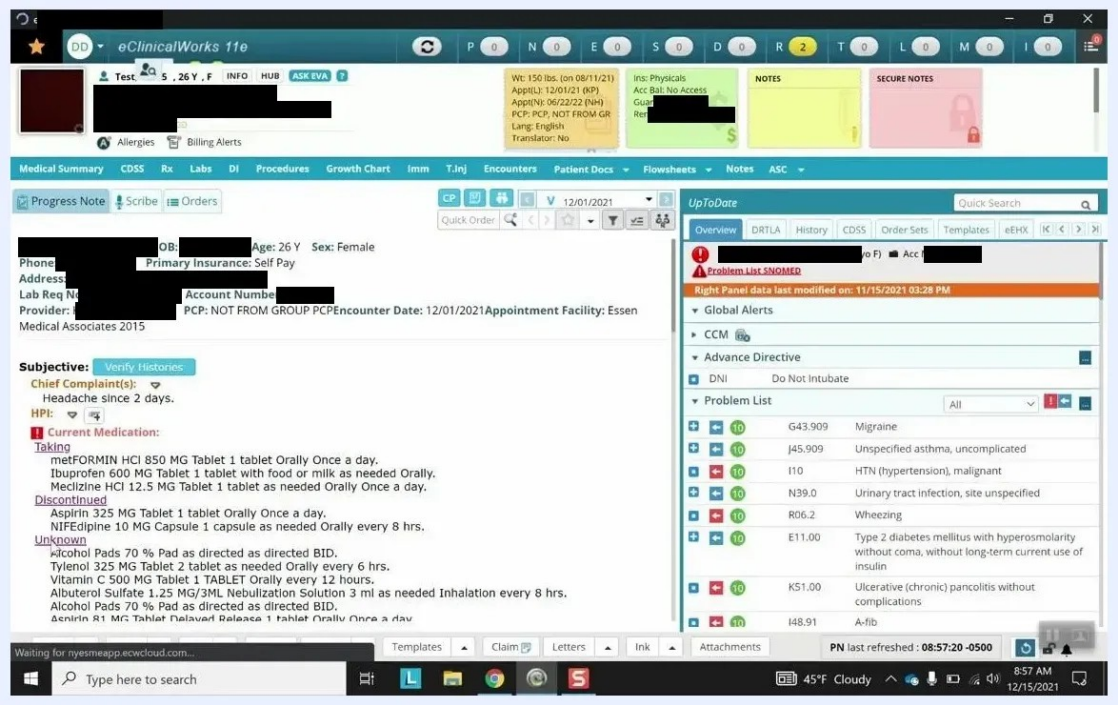
Medication selection screen showing multiple strengths, forms, and dosing options for aspirin

Step 8: Update a medication's status

A newly added medication appears under **Taking** by default. To change its status, click the matching button:

- **T** (Taking)
- **N** (Not Taking)
- **U** (Unknown)
- **D** (Discontinued)

For example, to discontinue a medication, click **D** next to it. A warning or confirmation may appear, and the medication moves to the **Discontinued** section. You can move medications between Taking, Discontinued, and Unknown by selecting the corresponding status button.



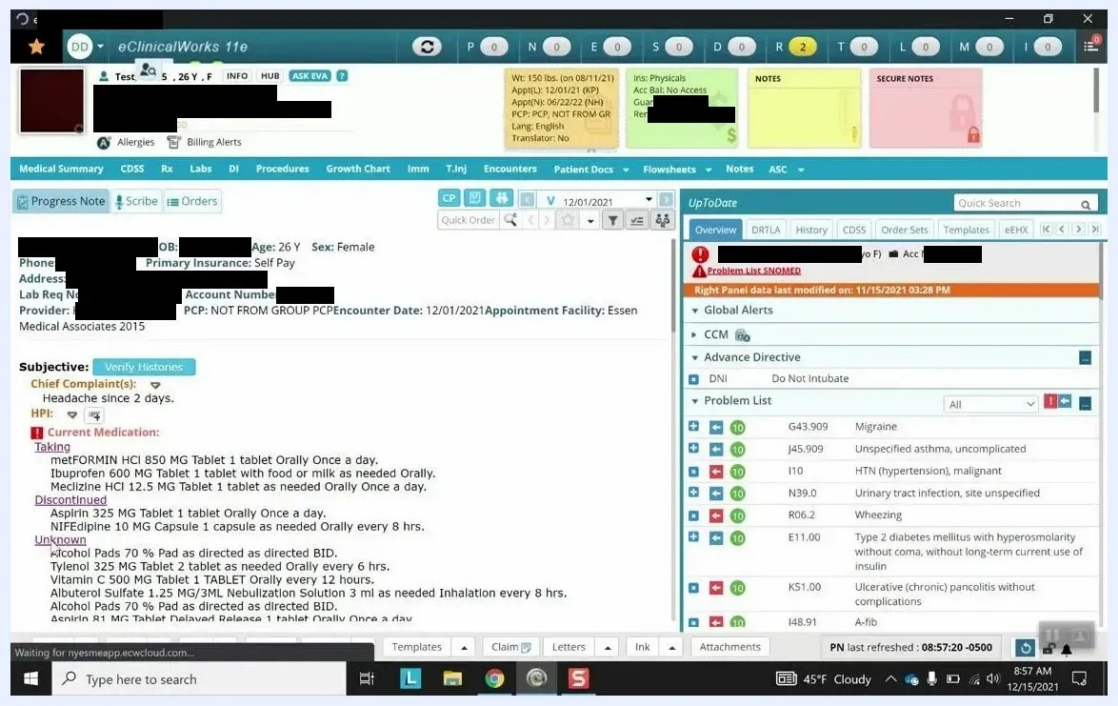
Medication Reconciliation screen with Aspirin 325 MG Tablet moved to Discontinued and a green confirmation banner

Step 9: Verify the medication list in the progress note

After you update the statuses, return to the main progress note screen. Review the **Current Medication** section and confirm the following:

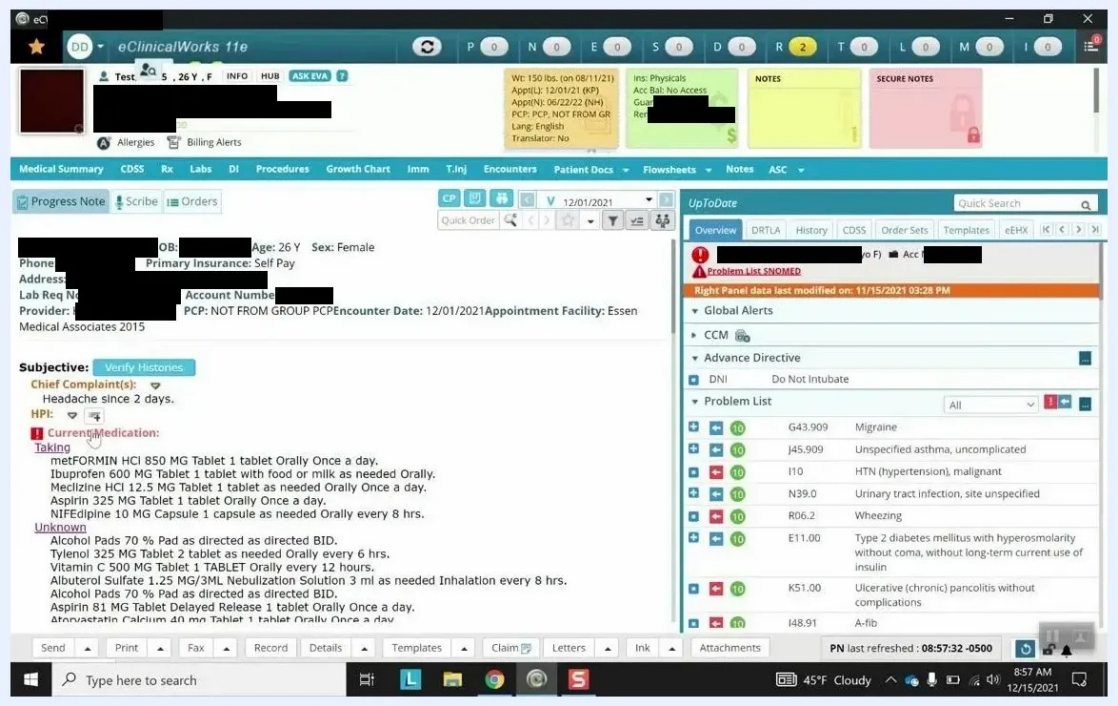
- Medications are correctly listed under **Taking**, **Discontinued**, and **Unknown**.

- Recent changes, such as newly discontinued medications, are accurately reflected.



Progress note screen showing the updated Current Medication section with new status assignments

Always verify the medication list for accuracy before you finalize the note. Verify it with the patient and make sure all entries are up to date. This step is critical for patient safety and accurate documentation.



Progress note screen with the Current Medication section highlighted to emphasize verification

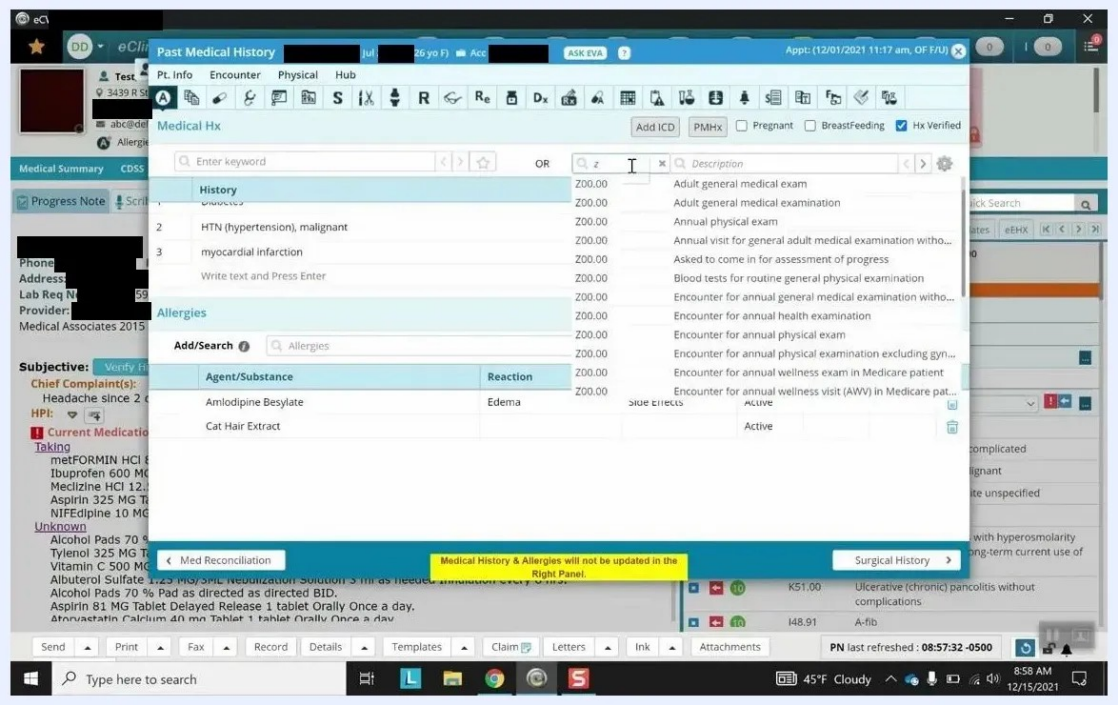
Step 10: Enter past medical history

Open the **Past Medical History** window to document or update a patient's medical history and allergies. In the **Medical Hx** section:

1. Locate the **Enter keyword** field.
2. Type the condition directly (for example, "Diabetes", "HTN (hypertension), malignant", or "myocardial infarction").
3. Press **Enter** after each condition to add it to the list.

Alternatively, type a code in the **ICD** field. A dropdown list of matching codes and descriptions appears, and you select the appropriate code. ICD entries support later documentation and standardized coding.

An entry created with an ICD code is locked for editing to maintain coding integrity. Free-text entries remain fully editable. To remove an entry, click the **waste bin** icon next to it. Select the **Hx Verified** checkbox to confirm you reviewed the history with the patient.

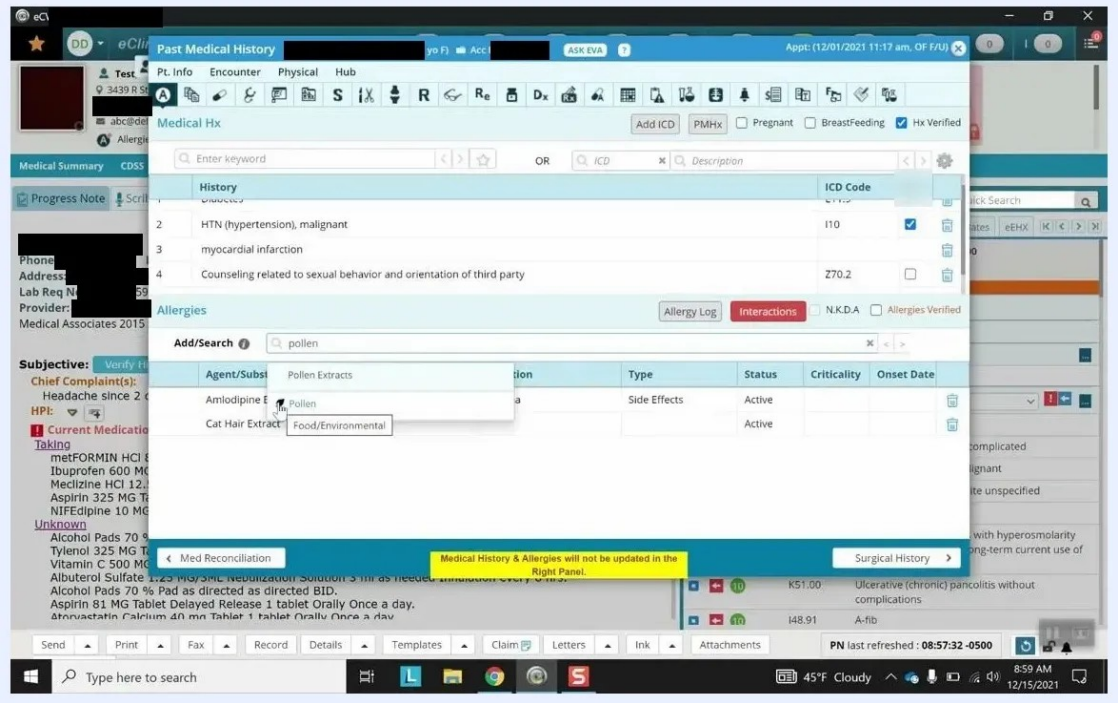


Past Medical History screen showing free-text and ICD-coded entries, with the Hx Verified checkbox highlighted

Step 11: Add an allergy

1. In the **Allergies** section, click the **Add/Search** field and begin typing the allergen (for example, "pollen").
2. Review the list of matching allergens. Prefer options with a **leaf icon**, which are official or more established entries.

3. Select the allergen from the dropdown.



Allergy search dropdown showing options for "pollen", with a leaf icon marking official entries

After you select an allergen, additional fields appear:

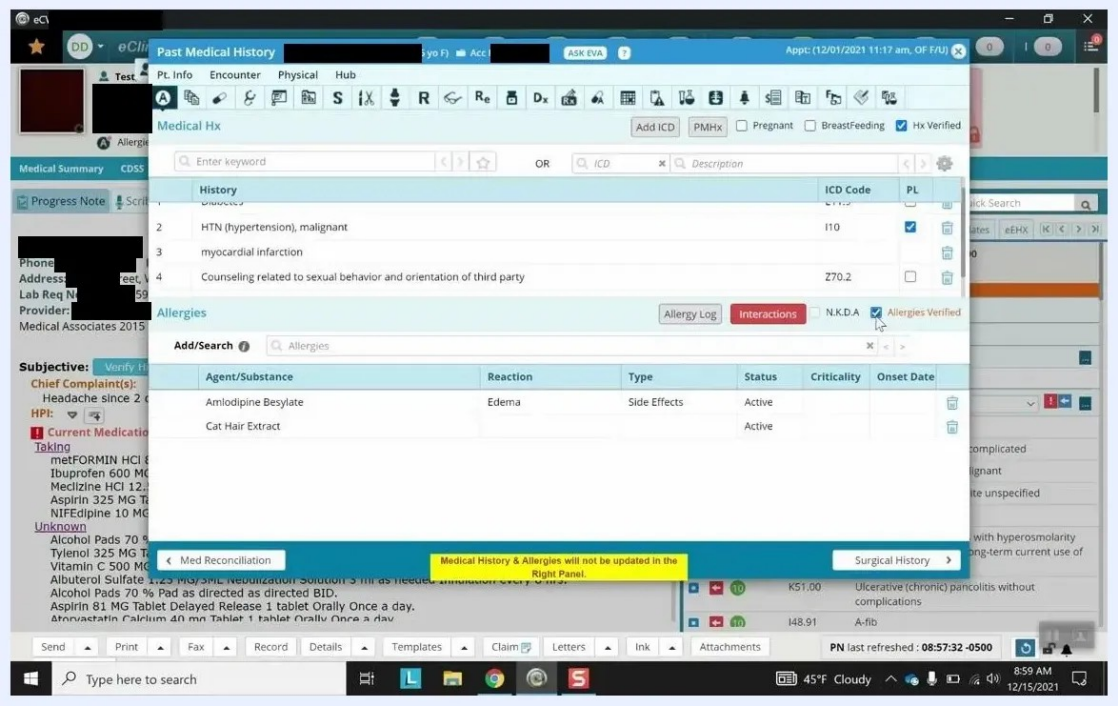
- **Reaction**: the patient's reaction (for example, "Edema").
- **Type**: "True Allergy" or "Side Effect".
- **Status**: "Active" or "Inactive".
- **Criticality**: the severity, if required.
- **Onset Date**: the date the allergy was first noted, if known.

Press **OK** to add the allergy to the patient's record.

Step 12: Finalize and verify allergies

- If you make a mistake, click the **waste bin** icon next to the entry to delete it, then re-enter it as needed.
- If the patient has no known drug allergies, select the **N.K.D.A.** checkbox. This option is available only when no allergy entries exist. If allergies are already listed, N.K.D.A. is disabled.

- Select the **Allergies Verified** box to confirm the allergy list has been reviewed and is accurate.



Allergies section with entries, the N.K.D.A. and Allergies Verified checkboxes, and waste bin icons for deletion

Best practices for history and allergies

- Use free text for flexibility, but prefer ICD-coded entries for standardized documentation.
- Verify the medical history and allergies with the patient, and select both the **Hx Verified** and **Allergies Verified** boxes.
- Prefer official allergy entries (with a leaf icon) for consistency and interoperability.

Summary

You now know how to add medications in eClinicalWorks, set and change their statuses, and verify the list in the progress note. You also know how to document past medical history and allergies. Verify every list with the patient before you finalize the note, so the patient's records are complete and accurate for each encounter.