NAMCS-73
(3-6-2014)

SAMPLE

NATIONAL AMBULATORY MEDICAL CARE SURVEY
2014 PATIENT RECORD

Form Approved: OMB No. 0920-0234; Expiration date 12/31/2014

NOTICE – Public reporting burden of this collection of information is estimated to average 14 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0234).

Assurance of confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential; will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls; and will not be disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

PATIENT INFORMATION

Patient medical record No.

Date of visit
Month | Day | Year: 2 0 1

ZIP Code *Enter "1" if homeless*

Date of birth
Month | Day | Year

Age ____ 1 ☐ Years 2 ☐ Months 3 ☐ Days

Sex
1 ☐ Female – Is patient pregnant?
- 1 ☐ Yes - *Specify gestation week – Gestation week refers to the number of weeks plus 2 that the offspring has spent developing in the uterus* → ____
- **OR**
- *LMP* Month | Day | Year: 2 0 1
- 2 ☐ No
- 3 ☐ Unknown

2 ☐ Male

Ethnicity
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

Race – *Mark (X) all that apply.*
1 ☐ White
2 ☐ Black or African American
3 ☐ Asian
4 ☐ Native Hawaiian or Other Pacific Islander
5 ☐ American Indian or Alaska Native

Expected source(s) of payment for this visit – *Mark (X) all that apply.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid or CHIP or other state-based program
4 ☐ Workers' compensation
5 ☐ Self-pay
6 ☐ No charge/Charity
7 ☐ Other
8 ☐ Unknown

Tobacco use
1 ☐ Never smoker
2 ☐ Former smoker
3 ☐ Current smoker
4 ☐ Unknown

BIOMETRICS/VITAL SIGNS

Height: ____ ft ____ in **OR** ____ cm

Weight: ____ lb ____ oz **OR** ____ kg ____ gm

Temperature: ____ ☐ °C ☐ °F

Blood pressure: Systolic ____ / Diastolic ____
If multiple measurements are taken, record the last measurement.

REASON FOR VISIT

List the first 5 reasons for visit (i.e., symptoms, problems, issues, concerns of the patient) in the order in which they appear. Start with the chief complaint and then move to the patient history for additional reasons.

(1) Most important ____
(2) Other ____
(3) Other ____
(4) Other ____
(5) Other ____

Major reason for this visit
1 ☐ New problem (<3 mos. onset)
2 ☐ Chronic problem, routine
3 ☐ Chronic problem, flare-up
4 ☐ Pre surgery
5 ☐ Post surgery
6 ☐ Preventive care (e.g., routine prenatal, well-baby, screening, insurance, general exams)

INJURY/POISONING/ADVERSE EFFECT

Is this visit related to an injury, poisoning, or adverse effect of medical treatment?
1 ☐ Yes, injury
2 ☐ Yes, poisoning
→
3 ☐ Yes, adverse effect of medical/surgical care or adverse effect of medicinal drug *SKIP to Cause of injury, poisoning, or adverse effect*
4 ☐ No
5 ☐ Unknown

Did the injury or poisoning occur within 72 hours prior to the date and time of this visit?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown
4 ☐ Not applicable

Is this injury or poisoning intentional or unintentional?
1 ☐ Intentional
2 ☐ Unintentional (e.g., accidental)
3 ☐ Intent unclear

Cause of injury, poisoning, or adverse effect – *Describe the place and circumstances that preceded the injury, poisoning, or adverse effect. Examples:* **1 –** *Injury (e.g., patient fell while walking down stairs at home and sprained her ankle; patient was bitten by a spider);* **2 –** *Poisoning (e.g., 4 year old child was given adult cold/cough medication and became lethargic; child swallowed large amount of liquid cleanser and began vomiting);* **3 –** *Adverse effect (e.g., patient developed a rash on his arm 2 days after taking penicillin for an ear infection).*

CONTINUITY OF CARE

Are you the patient's primary care physician?
1 ☐ Yes – *SKIP to* →
2 ☐ No
3 ☐ Unknown

Was patient referred for this visit?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

Has the patient been seen in this practice before?
1 ☐ Yes, established patient –
How many past visits to this practice in the last 12 months? *Exclude this visit.*
____ Visits
2 ☐ No, new patient

DIAGNOSIS

As specifically as possible, list diagnoses related to this visit including chronic conditions.

(1) Primary diagnosis ____
(2) Other ____
(3) Other ____
(4) Other ____
(5) Other ____

Regardless of the diagnoses previously entered, does the patient now have – *Mark (X) all that apply.*

1 ☐ Alcohol misuse, abuse or dependence
2 ☐ Alzheimer's disease/Dementia
3 ☐ Arthritis
4 ☐ Asthma
5 ☐ Cancer
6 ☐ Cerebrovascular disease/stroke (CVA) or transient ischemic attack (TIA)
7 ☐ Chronic kidney disease (CKD)
8 ☐ Chronic obstructive pulmonary disease (COPD)
9 ☐ Congestive heart failure (CHF)
10 ☐ Coronary artery disease (CAD), ischemic heart disease (IHD) or history of myocardial infarction (MI)
11 ☐ Depression
12 ☐ Diabetes mellitus (DM), Type 1
13 ☐ Diabetes mellitus (DM), Type 2
14 ☐ Diabetes mellitus (DM), Type unspecified
15 ☐ End-stage renal disease (ESRD)
16 ☐ History of pulmonary embolism (PE) or deep vein thrombosis (DVT)
17 ☐ HIV Infection/AIDS
18 ☐ Hyperlipidemia
19 ☐ Hypertension
20 ☐ Obesity
21 ☐ Obstructive sleep apnea (OSA)
22 ☐ Osteoporosis
23 ☐ Substance abuse or dependence
24 ☐ None of the above

Asthma severity:
1 ☐ Intermittent
2 ☐ Mild persistent
3 ☐ Moderate persistent
4 ☐ Severe persistent
5 ☐ Other – *Specify* ____
6 ☐ None recorded

Asthma control:
1 ☐ Well controlled
2 ☐ Not well controlled
3 ☐ Very poorly controlled
4 ☐ Other – *Specify* ____
5 ☐ None recorded

SERVICES

Enter all Examinations/Screenings, Laboratory tests, Imaging, Procedures, Treatments, Health education/Counseling, and Other services not listed ORDERED OR PROVIDED.

1 ☐ NO SERVICES

Examinations/Screenings:

2 ☐ Alcohol misuse screening (includes AUDIT, MAST, CAGE, T-ACE)
3 ☐ Breast
4 ☐ Depression screening
5 ☐ Domestic violence screening
6 ☐ Foot
7 ☐ Neurologic
8 ☐ Pelvic
9 ☐ Rectal
10 ☐ Retinal/Eye Exam
11 ☐ Skin
12 ☐ Substance abuse screening (includes NIDA/NM ASSIST, CAGE-AID, DAST-10)

Laboratory tests:

13 ☐ Basic metabolic panel
14 ☐ CBC
15 ☐ Chlamydia test
16 ☐ Comprehensive metabolic panel
17 ☐ Creatinine/Renal function panel
18 ☐ Culture, blood
19 ☐ Culture, throat
20 ☐ Culture, urine
21 ☐ Culture, other
22 ☐ Glucose, serum
23 ☐ Gonorrhea test
24 ☐ HbA1c (Glycohemoglobin)
25 ☐ Hepatitis testing/Hepatitis panel
26 ☐ HIV test
27 ☐ HPV DNA test
28 ☐ Lipid profile
29 ☐ Liver enzymes/Hepatic function panel
30 ☐ Pap test
31 ☐ Pregnancy/HCG test
32 ☐ PSA (prostate specific antigen)
33 ☐ Rapid strep test
34 ☐ TSH/Thyroid panel
35 ☐ Urinalysis
36 ☐ Vitamin D test

Imaging:

37 ☐ Bone mineral density
38 ☐ CT scan
39 ☐ Echocardiogram
40 ☐ Ultrasound
41 ☐ Mammography
42 ☐ MRI
43 ☐ X-ray

Procedures:

44 ☐ Audiometry
45 ☐ Biopsy
Biopsy provided?
1 ☐ Yes
2 ☐ No
46 ☐ Cardiac stress test
47 ☐ Colonoscopy
Colonoscopy provided?
1 ☐ Yes
2 ☐ No
48 ☐ Cryosurgery (cryotherapy)/ Destruction of tissue
49 ☐ EKG/ECG
50 ☐ Electroencephalogram (EEG)
51 ☐ Electromyogram (EMG)
52 ☐ Excision of tissue
Excision of tissue provided?
1 ☐ Yes
2 ☐ No
53 ☐ Fetal monitoring
54 ☐ Peak flow
55 ☐ Sigmoidoscopy
Sigmoidoscopy provided?
1 ☐ Yes
2 ☐ No
56 ☐ Spirometry
57 ☐ Tonometry
58 ☐ Tuberculosis skin testing/PPD
59 ☐ Upper gastrointestinal endoscopy/EGD

Treatments:

60 ☐ Cast/splint/wrap
61 ☐ Complementary and alternative medicine (CAM)
62 ☐ Durable medical equipment
63 ☐ Home health care
64 ☐ Mental health counseling, excluding psychotherapy
65 ☐ Occupational therapy
66 ☐ Physical therapy
67 ☐ Psychotherapy
68 ☐ Radiation therapy
69 ☐ Wound care

Health education/Counseling:

70 ☐ Alcohol abuse counseling
71 ☐ Asthma
72 ☐ Asthma action plan given to patient
73 ☐ Diabetes education
74 ☐ Diet/Nutrition
75 ☐ Exercise
76 ☐ Family planning/Contraception
77 ☐ Genetic counseling
78 ☐ Growth/Development
79 ☐ Injury prevention
80 ☐ STD prevention
81 ☐ Stress management
82 ☐ Substance abuse counseling
83 ☐ Tobacco use/Exposure
84 ☐ Weight reduction

Other services not listed:

85 ☐ Other service – *Specify*

Up to 5 other services can be listed.

MEDICATIONS & IMMUNIZATIONS

Were any prescription or non-prescription drugs ORDERED or PROVIDED (by any route of administration) at this visit? *Include Rx and OTC drugs, immunizations, allergy shots, oxygen, anesthetics, chemotherapy, and dietary supplements that were ordered, supplied, administered, or continued during this visit. Include drugs prescribed at a previous visit if the patient was instructed at THIS VISIT to continue with the medication.*

1 ☐ Yes
2 ☐ No

		New	Continued
(1)		1 ☐	2 ☐
(2)		1 ☐	2 ☐
(3)		1 ☐	2 ☐
(4)		1 ☐	2 ☐
(5)		1 ☐	2 ☐
		1 ☐	2 ☐
		1 ☐	2 ☐
(30)	Up to 30 medications can be listed.	1 ☐	2 ☐

PROVIDERS

Mark (X) all providers seen at this visit.

1 ☐ Physician
2 ☐ Physician assistant
3 ☐ Nurse practitioner/ Midwife
4 ☐ RN/LPN
5 ☐ Mental health provider
6 ☐ Other
7 ☐ None

TIME SPENT WITH PROVIDER

Minutes

Enter estimated time spent with sampled provider – Enter 0 if no provider seen

VISIT DISPOSITION

Mark (X) all that apply.

1 ☐ Return to referring physician
2 ☐ Refer to other physician
3 ☐ Return in less than 1 week
4 ☐ Return in 1 week to less than 2 months
5 ☐ Return in 2 months or greater
6 ☐ Return at unspecified time
7 ☐ Return as needed (p.r.n.)
8 ☐ Refer to ER/Admit to hospital
9 ☐ Other

TESTS

	Was blood for the following laboratory tests drawn on the day of the sampled visit or during the 12 months prior to the visit?	Most recent result	Date of test
1	Total Cholesterol — 1 ☐ Yes → 2 ☐ None found	mg/dL	Month Day Year 2 0 1
2	High density lipoprotein (HDL) — 1 ☐ Yes → 2 ☐ None found	mg/dL	Month Day Year 2 0 1
3	Low density lipoprotein (LDL) — 1 ☐ Yes → 2 ☐ None found	mg/dL	Month Day Year 2 0 1
4	Triglycerides (TGs) — 1 ☐ Yes → 2 ☐ None found	mg/dL	Month Day Year 2 0 1
5	HbA1c (A1C) (Glycohemoglobin) — 1 ☐ Yes → 2 ☐ None found	. %	Month Day Year 2 0 1
6	Blood glucose (BG) — 1 ☐ Yes → 2 ☐ None found	mg/dL	Month Day Year 2 0 1
7	Serum creatinine — 1 ☐ Yes → 2 ☐ None found	. mg/dL	Month Day Year 2 0 1

CPT CODES

Enter Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Up to 18 CPT codes can be listed.