NAMCS-73
(12-17-2014)

SAMPLE

NATIONAL AMBULATORY MEDICAL CARE SURVEY
2015 PATIENT RECORD

Form Approved: OMB No. 0920-0234; Expiration date 12/31/2017

NOTICE – Public reporting burden for 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 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* →
- 2 ☐ No

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 ☐ Not current
2 ☐ Current
3 ☐ Unknown

Prior tobacco use
1 ☐ Never
2 ☐ Former
3 ☐ Unknown

BIOMETRICS/VITAL SIGNS

Height ____ ft ____ in
OR
____ cm

Weight ____ lb ____ oz
OR
____ kg ____ gm

Temperature ____
1 ☐ °C
2 ☐ °F

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

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

Is this visit related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment?
1 ☐ Yes, injury/trauma
2 ☐ Yes, overdose/poisoning
3 ☐ Yes, adverse effect of medical or surgical treatment or adverse effect of medicinal drug
4 ☐ No
5 ☐ Unknown
SKIP to Continuity of Care

Did the injury/trauma, overdose/poisoning or adverse effect occur within 72 hours prior to the date and time of this visit?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown
4 ☐ Not applicable
For adverse effect SKIP to Cause

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

What was the intent of the injury/trauma or overdose/poisoning?
1 ☐ Suicide attempt with intent to die
2 ☐ Intentional self-harm without intent to die
3 ☐ Unclear if suicide attempt or intentional self-harm without intent to die
4 ☐ Intentional harm inflicted by another person (e.g., assault, poisoning)
5 ☐ Intent unclear

Cause of injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment – *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 provider?
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 ☐ Autism spectrum disorder
6 ☐ Cancer
7 ☐ Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA)
8 ☐ Chronic kidney disease (CKD)
9 ☐ Chronic obstructive pulmonary disease (COPD)
10 ☐ Congestive heart failure (CHF)
11 ☐ Coronary artery disease (CAD), ischemic heart disease (IHD) or history of myocardial infarction (MI)
12 ☐ Depression
13 ☐ Diabetes mellitus (DM), Type 1
14 ☐ Diabetes mellitus (DM), Type 2
15 ☐ Diabetes mellitus (DM), Type unspecified
16 ☐ End-stage renal disease (ESRD)
17 ☐ History of pulmonary embolism (PE), or deep vein thrombosis (DVT), or venous thromboembolism (VTE)
18 ☐ HIV Infection/AIDS
19 ☐ Hyperlipidemia
20 ☐ Hypertension
21 ☐ Obesity
22 ☐ Obstructive sleep apnea (OSA)
23 ☐ Osteoporosis
24 ☐ Substance abuse or dependence
25 ☐ None of the above

Complete if Asthma box is marked.

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

Mark (X) all Examinations/Screenings, Laboratory tests, Imaging, Procedures, Treatments, Health education/Counseling, and Other services 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
11 ☐ Skin
12 ☐ Substance abuse screening (includes NIDA/NM ASSIST, CAGE-AID, DAST-10)

Laboratory tests:

13 ☐ Basic metabolic panel (BMP)
14 ☐ CBC
15 ☐ Chlamydia test
16 ☐ Comprehensive metabolic panel (CMP)
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
EGD provided?
1 ☐ Yes
2 ☐ No

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

List up to 30 medications.

		New	Continued
(1)		1 ☐	2 ☐
(2)		1 ☐	2 ☐
(3)		1 ☐	2 ☐
(4)		1 ☐	2 ☐
(5) ↓		1 ☐	2 ☐
		1 ☐	2 ☐
		1 ☐	2 ☐
(30)		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.