

SAMPLE

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY 2016 OUTPATIENT DEPARTMENT PATIENT RECORD

Form Approved: OMB No. 0920-0278; Expiration date 02/28/2018

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PATIENT INFORMATION

Patient medical record No.	Age 1 <input type="checkbox"/> Years 2 <input type="checkbox"/> Months 3 <input type="checkbox"/> Days	Ethnicity 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino	Expected source(s) of payment for THIS VISIT – Mark (X) all that apply. 1 <input type="checkbox"/> Private insurance 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Medicaid or CHIP or other state-based program 4 <input type="checkbox"/> Workers' compensation 5 <input type="checkbox"/> Self-pay 6 <input type="checkbox"/> No charge/Charity 7 <input type="checkbox"/> Other 8 <input type="checkbox"/> Unknown	Tobacco use 1 <input type="checkbox"/> Not current 2 <input type="checkbox"/> Current 3 <input type="checkbox"/> Unknown Prior tobacco use 1 <input type="checkbox"/> Never 2 <input type="checkbox"/> Former 3 <input type="checkbox"/> Unknown
Date of visit Month: <input type="text"/> Day: <input type="text"/> Year: <input type="text"/> 201	Sex 1 <input type="checkbox"/> Female – Is patient pregnant? 1 <input type="checkbox"/> Yes - Specify gestation week – Gestation week refers to the number of weeks plus 2 that the offspring has spent developing in the uterus → <input type="text"/> 2 <input type="checkbox"/> No 2 <input type="checkbox"/> Male	Race – Mark (X) all that apply. 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black or African American 3 <input type="checkbox"/> Asian 4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 5 <input type="checkbox"/> American Indian or Alaska Native		
ZIP Code – Enter "1" if homeless. <input type="text"/>				
Date of birth Month: <input type="text"/> Day: <input type="text"/> Year: <input type="text"/>				

BIOMETRICS/VITAL SIGNS

Height: <input type="text"/> ft <input type="text"/> in OR <input type="text"/> cm	Weight: <input type="text"/> lb <input type="text"/> oz OR <input type="text"/> kg <input type="text"/> gm	Temperature: <input type="text"/> 1 <input type="checkbox"/> °C 2 <input type="checkbox"/> °F	Blood pressure – If multiple measurements are taken, record the last measurement. Systolic: <input type="text"/> Diastolic: <input type="text"/>
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REASON FOR VISIT

List the first 5 reasons for visit (i.e., complaint(s), symptom(s), problem(s), concern(s) of the patient) in the order in which they appear. Start with the chief complaint and then move to the patient history or history of present illness (HPI) for additional reasons. (1) Most important: <input type="text"/> (2) Other: <input type="text"/> (3) Other: <input type="text"/> (4) Other: <input type="text"/> (5) Other: <input type="text"/>	Major reason for this visit 1 <input type="checkbox"/> New problem (<3 mos. onset) 2 <input type="checkbox"/> Chronic problem, routine 3 <input type="checkbox"/> Chronic problem, flare-up 4 <input type="checkbox"/> Pre-surgery 5 <input type="checkbox"/> Post-surgery 6 <input type="checkbox"/> Preventive care (e.g., routine prenatal, well-baby, screening, insurance, general exams)
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INJURY

Is this visit related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment? 1 <input type="checkbox"/> Yes, injury/trauma 2 <input type="checkbox"/> Yes, overdose/poisoning 3 <input type="checkbox"/> Yes, adverse effect of medical or surgical treatment or adverse effect of medicinal drug 4 <input type="checkbox"/> No 5 <input type="checkbox"/> 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 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown <i>For adverse effect SKIP to Cause</i>	Is this injury/trauma or overdose/poisoning intentional or unintentional? 1 <input type="checkbox"/> Intentional 2 <input type="checkbox"/> Unintentional (e.g., accidental) 3 <input type="checkbox"/> Intent unclear	What was the intent of the injury/trauma or overdose/poisoning? 1 <input type="checkbox"/> Suicide attempt with intent to die 2 <input type="checkbox"/> Intentional self-harm without intent to die 3 <input type="checkbox"/> Unclear if suicide attempt or intentional self-harm without intent to die 4 <input type="checkbox"/> Intentional harm inflicted by another person (e.g., assault, poisoning) 5 <input type="checkbox"/> Intent unclear
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Cause of injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment – Describe the place and circumstances that preceded the event. 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

Is this clinic the patient's primary care provider? 1 <input type="checkbox"/> Yes – SKIP to → 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown } Was patient referred for this visit? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	Has the patient been seen in this clinic before? 1 <input type="checkbox"/> Yes, established patient – How many past visits to this clinic in the last 12 months? (Exclude this visit.) <input type="text"/> Visits 1 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> No, new patient
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DIAGNOSIS

As specifically as possible, list diagnoses related to this visit including chronic conditions. (1) Primary diagnosis: <input type="text"/> (2) Other: <input type="text"/> (3) Other: <input type="text"/> (4) Other: <input type="text"/> (5) Other: <input type="text"/>

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

1 <input type="checkbox"/> Alcohol misuse, abuse or dependence 2 <input type="checkbox"/> Alzheimer's disease/Dementia 3 <input type="checkbox"/> Arthritis 4 <input type="checkbox"/> Asthma 5 <input type="checkbox"/> Attention deficit disorder (ADD)/Attention deficit hyperactivity disorder (ADHD) 6 <input type="checkbox"/> Autism spectrum disorder 7 <input type="checkbox"/> Cancer 8 <input type="checkbox"/> Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA) 9 <input type="checkbox"/> Chronic kidney disease (CKD)	10 <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) 11 <input type="checkbox"/> Congestive heart failure (CHF) 12 <input type="checkbox"/> Coronary artery disease (CAD), ischemic heart disease (IHD) or history of myocardial infarction (MI) 13 <input type="checkbox"/> Depression 14 <input type="checkbox"/> Diabetes mellitus (DM), Type I 15 <input type="checkbox"/> Diabetes mellitus (DM), Type II 16 <input type="checkbox"/> Diabetes mellitus (DM), Type unspecified 17 <input type="checkbox"/> End-stage renal disease (ESRD)	18 <input type="checkbox"/> Hepatitis B 19 <input type="checkbox"/> Hepatitis C 20 <input type="checkbox"/> History of pulmonary embolism (PE), deep vein thrombosis (DVT), or venous thromboembolism (VTE) 21 <input type="checkbox"/> HIV Infection/AIDS 22 <input type="checkbox"/> Hyperlipidemia 23 <input type="checkbox"/> Hypertension 24 <input type="checkbox"/> Obesity 25 <input type="checkbox"/> Obstructive sleep apnea (OSA) 26 <input type="checkbox"/> Osteoporosis 27 <input type="checkbox"/> Substance abuse or dependence 28 <input type="checkbox"/> None of the above
Complete if Asthma box is marked. Asthma severity: 1 <input type="checkbox"/> Intermittent 2 <input type="checkbox"/> Mild persistent 3 <input type="checkbox"/> Moderate persistent 4 <input type="checkbox"/> Severe persistent 5 <input type="checkbox"/> Other – Specify <input type="text"/> 6 <input type="checkbox"/> None recorded		
Asthma control: 1 <input type="checkbox"/> Well controlled 2 <input type="checkbox"/> Not well controlled 3 <input type="checkbox"/> Very poorly controlled 4 <input type="checkbox"/> Other – Specify <input type="text"/> 5 <input type="checkbox"/> None recorded		

DIAGNOSTICS

Diagnostic 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/panel
- 26 HIV test
- 27 HPV DNA test

- 28 Lipid profile/panel
- 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 (UA) or urine dipstick
- 36 Vitamin D test

Imaging:

- 37 Bone mineral density
- 38 CT scan
- 39 Echocardiogram
- 40 Other 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 education
- 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 <input type="checkbox"/>	2 <input type="checkbox"/>
(2)		1 <input type="checkbox"/>	2 <input type="checkbox"/>
(3)		1 <input type="checkbox"/>	2 <input type="checkbox"/>
(4)		1 <input type="checkbox"/>	2 <input type="checkbox"/>
(5)		1 <input type="checkbox"/>	2 <input type="checkbox"/>
		1 <input type="checkbox"/>	2 <input type="checkbox"/>
		1 <input type="checkbox"/>	2 <input type="checkbox"/>
		1 <input type="checkbox"/>	2 <input type="checkbox"/>
(30)		1 <input type="checkbox"/>	2 <input type="checkbox"/>

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

DISPOSITION

Mark (X) all that apply.

- 1 Return to referring physician/provider
- 2 Refer to other physician/provider
- 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 blood draw								
1	Total Cholesterol 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	mg/dL	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25%;">Month</td><td style="width: 25%;">Day</td><td style="width: 25%;">Year</td><td style="width: 25%;"></td></tr> <tr><td> </td><td> </td><td style="text-align: center;">201</td><td> </td></tr> </table>	Month	Day	Year				201	
Month	Day	Year									
		201									
2	High density lipoprotein (HDL) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	mg/dL	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25%;">Month</td><td style="width: 25%;">Day</td><td style="width: 25%;">Year</td><td style="width: 25%;"></td></tr> <tr><td> </td><td> </td><td style="text-align: center;">201</td><td> </td></tr> </table>	Month	Day	Year				201	
Month	Day	Year									
		201									
3	Low density lipoprotein (LDL) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	mg/dL	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25%;">Month</td><td style="width: 25%;">Day</td><td style="width: 25%;">Year</td><td style="width: 25%;"></td></tr> <tr><td> </td><td> </td><td style="text-align: center;">201</td><td> </td></tr> </table>	Month	Day	Year				201	
Month	Day	Year									
		201									
4	Triglycerides (TGs) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	mg/dL	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25%;">Month</td><td style="width: 25%;">Day</td><td style="width: 25%;">Year</td><td style="width: 25%;"></td></tr> <tr><td> </td><td> </td><td style="text-align: center;">201</td><td> </td></tr> </table>	Month	Day	Year				201	
Month	Day	Year									
		201									
5	HbA1c (Glycohemoglobin) (A1C) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	%	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25%;">Month</td><td style="width: 25%;">Day</td><td style="width: 25%;">Year</td><td style="width: 25%;"></td></tr> <tr><td> </td><td> </td><td style="text-align: center;">201</td><td> </td></tr> </table>	Month	Day	Year				201	
Month	Day	Year									
		201									
6	Blood glucose (BG) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	mg/dL	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25%;">Month</td><td style="width: 25%;">Day</td><td style="width: 25%;">Year</td><td style="width: 25%;"></td></tr> <tr><td> </td><td> </td><td style="text-align: center;">201</td><td> </td></tr> </table>	Month	Day	Year				201	
Month	Day	Year									
		201									
7	Serum creatinine 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	1 <input type="checkbox"/> mg/dL 2 <input type="checkbox"/> μmol/L	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 25%;">Month</td><td style="width: 25%;">Day</td><td style="width: 25%;">Year</td><td style="width: 25%;"></td></tr> <tr><td> </td><td> </td><td style="text-align: center;">201</td><td> </td></tr> </table>	Month	Day	Year				201	
Month	Day	Year									
		201									

CPT CODES

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

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