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FORM **NHAMCS-100(OPD)**
(9-2-2009)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS DATA COLLECTION AGENT FOR THE
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Health Statistics

# NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
## 2010 OUTPATIENT DEPARTMENT PATIENT RECORD

**PATIENT RECORD NO.:**

**PATIENT'S NAME:**



*(Provider: Detach and keep upper portion)*

*Please keep (X) marks inside of boxes* ➜ ☒ Correct ☒ Incorrect

## 1. PATIENT INFORMATION

**a. Date of visit**

| Month | | Day | | Year | |
|---|---|---|---|---|---|
| | | | | | |

**b. ZIP Code**

**c. Date of birth**

| Month | | Day | | Year | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

**d. Sex**
1 ☐ Female 2 ☐ Male

**e. Ethnicity**
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

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

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

**h. Tobacco use**
1 ☐ Not current 3 ☐ Unknown
2 ☐ Current

## 2. INJURY/POISONING/ ADVERSE EFFECT

**Is this visit related to any of the following?**
1 ☐ Unintentional injury/poisoning
2 ☐ Intentional injury/poisoning
3 ☐ Injury/poisoning – unknown intent
4 ☐ Adverse effect of medical/ surgical care or adverse effect of medicinal drug
5 ☐ None of the above

## 3. REASON FOR VISIT

**Patient's complaint(s), symptom(s), or other reason(s) for this visit –** *Use patient's own words.*

**(1)** Most important:

**(2)** Other:

**(3)** Other:

## 4. CONTINUITY OF CARE

**a. Is this clinic the patient's primary care provider?**
1 ☐ Yes –*SKIP to item 4b.*
2 ☐ No
3 ☐ Unknown

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

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

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

## 5. PROVIDER'S DIAGNOSIS FOR THIS VISIT

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

**(1)** Primary diagnosis:

**(2)** Other:

**(3)** Other:

**b. Regardless of the diagnoses written in 5a, does the patient now have –** *Mark (X) all that apply.*
1 ☐ Arthritis
2 ☐ Asthma
3 ☐ Cancer
0 ☐ In situ
1 ☐ Stage I
2 ☐ Stage II
3 ☐ Stage III
4 ☐ Stage IV
5 ☐ Unknown stage
4 ☐ Cerebrovascular disease
5 ☐ Chronic renal failure
6 ☐ Congestive heart failure
7 ☐ COPD
8 ☐ Depression
9 ☐ Diabetes
10 ☐ Hyperlipidemia
11 ☐ Hypertension
12 ☐ Ischemic heart disease
13 ☐ Obesity
14 ☐ Osteoporosis
15 ☐ None of the above

## 6. VITAL SIGNS

**(1)** Height
☐☐ ft ☐☐ in **OR** ☐☐☐ cm

**(2)** Weight
☐☐☐ lb ☐☐ oz
**OR**
☐☐☐ kg ☐☐☐ gm

**(3)** Temperature
☐☐ ˚C
☐☐ ˚F

**(4)** Blood pressure
Systolic ☐☐☐ / Diastolic ☐☐☐

## 7. DIAGNOSTIC/SCREENING SERVICES

*Mark (X) all* ***ordered*** *or* ***provided*** *at this visit.*
1 ☐ NONE

**Examinations:**
2 ☐ Breast
3 ☐ Foot
4 ☐ Pelvic
5 ☐ Rectal
6 ☐ Retinal
7 ☐ Skin
8 ☐ Depression screening

**Imaging:**
9 ☐ X-ray
10 ☐ Bone mineral density
11 ☐ CT scan
12 ☐ Echocardiogram
13 ☐ Other ultrasound
14 ☐ Mammography
15 ☐ MRI
16 ☐ Other imaging

**Blood tests:**
17 ☐ CBC (complete blood count)
18 ☐ Glucose
19 ☐ HgbA1c (glycohemoglobin)
20 ☐ Lipids/Cholesterol
21 ☐ PSA (prostate specific antigen)
22 ☐ Other blood test

**Scope:**
23 ☐ Scope procedure (e.g., colonoscopy) - *Specify*

**Other tests:**
24 ☐ Biopsy – *Specify site*
25 ☐ Chlamydia test
26 ☐ EKG/ECG
27 ☐ HIV test
28 ☐ HPV DNA test
29 ☐ Pap test - conventional
30 ☐ Pap test - liquid-based
31 ☐ Pap test - unspecified
32 ☐ Pregnancy/HCG test
33 ☐ Urinalysis (UA)
34 ☐ Other exam/test/service - *Specify*

## 8. HEALTH EDUCATION

*Mark (X) all* ***ordered*** *or* ***provided*** *at this visit.*
1 ☐ NONE
2 ☐ Asthma education
3 ☐ Diet/Nutrition
4 ☐ Exercise
5 ☐ Family planning/ Contraception
6 ☐ Growth/Development
7 ☐ Injury prevention
8 ☐ Stress management
9 ☐ Tobacco use/ Exposure
10 ☐ Weight reduction
11 ☐ Other

## 9. NON-MEDICATION TREATMENT

*Mark (X) all* ***ordered*** *or* ***provided*** *at this visit.*
1 ☐ NONE
2 ☐ Complementary alternative medicine (CAM)
3 ☐ Durable medical equipment
4 ☐ Home health care
5 ☐ Physical therapy
6 ☐ Radiation therapy
7 ☐ Speech/Occupational therapy
8 ☐ Psychotherapy
9 ☐ Other mental health counseling
10 ☐ Excision of tissue
11 ☐ Wound care
12 ☐ Cast
13 ☐ Splint or wrap

**Procedures:**
14 ☐ Other non-surgical procedures – *Specify*
15 ☐ Other surgical procedures – *Specify*

## 10. MEDICATIONS & IMMUNIZATIONS

☐ NONE **Include Rx and OTC drugs, immunizations, allergy shots, oxygen, anesthetics, chemotherapy, and dietary supplements that were ordered, supplied, administered or continued during this visit.**

| | | New | Continued |
|---|---|---|---|
| **(1)** | | 1 ☐ | 2 ☐ |
| **(2)** | | 1 ☐ | 2 ☐ |
| **(3)** | | 1 ☐ | 2 ☐ |
| **(4)** | | 1 ☐ | 2 ☐ |
| **(5)** | | 1 ☐ | 2 ☐ |
| **(6)** | | 1 ☐ | 2 ☐ |
| **(7)** | | 1 ☐ | 2 ☐ |
| **(8)** | | 1 ☐ | 2 ☐ |

## 11. 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

## 12. VISIT DISPOSITION

*Mark (X) all that apply.*
1 ☐ Refer to other physician
2 ☐ Return at specified time
3 ☐ Refer to ER/Admit to hospital
4 ☐ Other