

FORM **NHAMCS-100(OPD)**
(9-18-2002)

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

PATIENT RECORD NO.:

PATIENT'S NAME:

**NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2003/2004 OUTPATIENT DEPARTMENT PATIENT RECORD**

Assurance of confidentiality - All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purpose of the survey and will not be disclosed or released to other persons or used for any other purpose without consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

1. PATIENT INFORMATION		2. REASON FOR VISIT	
<p>a. Date of visit</p> <p>Month: <input type="text"/> Day: <input type="text"/> Year: <input type="text"/></p> <p>b. ZIP code</p> <p><input type="text"/></p> <p>c. Date of birth</p> <p>Month: <input type="text"/> Day: <input type="text"/> Year: <input type="text"/></p> <p>d. Sex</p> <p>1 <input type="checkbox"/> Female 2 <input type="checkbox"/> Male</p>	<p>e. Ethnicity</p> <p>1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino</p> <p>f. Race - Mark (X) one or more.</p> <p>1 <input type="checkbox"/> White 4 <input type="checkbox"/> Native Hawaiian/ Other Pacific Islander 2 <input type="checkbox"/> Black/African 5 <input type="checkbox"/> American Indian/ American Alaska Native 3 <input type="checkbox"/> Asian</p> <p>g. Does patient use tobacco?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p> <p>h. Primary expected source of payment for this visit - Mark (X) one.</p> <p>1 <input type="checkbox"/> Private insurance 5 <input type="checkbox"/> Self-pay 2 <input type="checkbox"/> Medicare 6 <input type="checkbox"/> No charge/Charity 3 <input type="checkbox"/> Medicaid/SCHIP 7 <input type="checkbox"/> Other 4 <input type="checkbox"/> Worker's 8 <input type="checkbox"/> Unknown Compensation</p>	<p>Patient's complaint(s), symptom(s), or other reason(s) for this visit - Use patient's own words.</p> <p>(1) Most important:</p> <p>_____</p> <p>(2) Other:</p> <p>_____</p> <p>(3) Other:</p> <p>_____</p>	
3. CONTINUITY OF CARE			
<p>a. Are you the patient's primary care physician?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p> <p>Was patient referred for this visit?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p>	<p>b. Has the patient been seen in this clinic before?</p> <p>1 <input type="checkbox"/> Yes, established patient - How many past visits in the last 12 months? Exclude this visit.</p> <p>1 <input type="checkbox"/> None 2 <input type="checkbox"/> 1-2 3 <input type="checkbox"/> 3-5 4 <input type="checkbox"/> 6+ 5 <input type="checkbox"/> Unknown</p> <p>2 <input type="checkbox"/> No, new patient</p>	<p>c. Major reason for this visit</p> <p>1 <input type="checkbox"/> Acute problem (<3 mos. onset) 2 <input type="checkbox"/> Chronic problem, routine 3 <input type="checkbox"/> Chronic problem, flare-up 4 <input type="checkbox"/> Pre-/Post-surgery</p> <p>5 <input type="checkbox"/> Preventive care (e.g., routine prenatal, general exam, well-baby, screening, insurance exam)</p>	<p>Episode of care</p> <p>1 <input type="checkbox"/> Initial visit for problem 2 <input type="checkbox"/> Follow-up visit for problem 3 <input type="checkbox"/> Unknown</p> <p>d. Do other physicians share patient's care for this problem or diagnosis?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p>
4. INJURY/POISONING/ADVERSE EFFECT		5. PHYSICIAN'S DIAGNOSIS FOR THIS VISIT	
<p>a. Is this visit related to an injury, or poisoning, or adverse effect of medical treatment?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No - SKIP to item 5.</p>	<p>b. Cause of injury, poisoning, or adverse effect - Describe the place, intentionality, and events that preceded the injury, poisoning, or adverse event (e.g., allergy to penicillin, bee sting, pedestrian hit by car driven by drunk driver, wife beaten with fists by husband, heroin overdose, infected shunt, etc.).</p> <p>_____</p>	<p>As specifically as possible, list diagnoses related to this visit including chronic conditions.</p> <p>(1) Primary diagnosis:</p> <p>_____</p> <p>(2) Other:</p> <p>_____</p> <p>(3) Other:</p> <p>_____</p>	
6. DIAGNOSTIC/SCREENING SERVICES			
<p>Mark (X) all ordered or provided at this visit.</p>			
<p>1 <input type="checkbox"/> NONE</p> <p>2 <input type="checkbox"/> General medical exam</p> <p>3 <input type="checkbox"/> Other exam - Specify site (e.g., breast, rectal) <input type="checkbox"/></p> <p>4 <input type="checkbox"/> Temperature Specify <input type="text"/></p>	<p>5 <input type="checkbox"/> Blood pressure - Specify <input type="text"/></p> <p>6 <input type="checkbox"/> Urinalysis (UA)</p> <p>7 <input type="checkbox"/> Urine culture</p> <p>8 <input type="checkbox"/> PAP test</p> <p>9 <input type="checkbox"/> Cervical/Urethral culture</p> <p>10 <input type="checkbox"/> PSA (prostate specific antigen)</p> <p>11 <input type="checkbox"/> Hematocrit/Hemoglobin</p>	<p>12 <input type="checkbox"/> CBC (complete blood count)</p> <p>13 <input type="checkbox"/> Lipids/Cholesterol</p> <p>14 <input type="checkbox"/> Glucose</p> <p>15 <input type="checkbox"/> HgbA1C (glycohemoglobin)</p> <p>16 <input type="checkbox"/> Electrolytes</p> <p>17 <input type="checkbox"/> Other blood test</p> <p>18 <input type="checkbox"/> EKG/ECG (electrocardiogram)</p> <p>19 <input type="checkbox"/> Throat culture/Rapid strep test</p> <p>20 <input type="checkbox"/> Stool culture</p> <p>21 <input type="checkbox"/> X-ray</p>	<p>22 <input type="checkbox"/> Mammography</p> <p>23 <input type="checkbox"/> Other imaging</p> <p>24 <input type="checkbox"/> Scope procedure (e.g., colonoscopy) - Specify <input type="checkbox"/></p> <p>25 <input type="checkbox"/> Other service - Specify <input type="text"/></p>
7. COUNSELING/EDUCATION/THERAPY		8. SURGICAL PROCEDURES	
<p>Mark (X) all ordered or provided at this visit. Exclude medications.</p> <p>1 <input type="checkbox"/> NONE</p> <p>2 <input type="checkbox"/> Asthma education</p> <p>3 <input type="checkbox"/> Diet/Nutrition</p> <p>4 <input type="checkbox"/> Exercise</p> <p>5 <input type="checkbox"/> Growth/Development</p> <p>6 <input type="checkbox"/> Mental health/Stress management</p> <p>7 <input type="checkbox"/> Physiotherapy</p> <p>8 <input type="checkbox"/> Psychotherapy</p> <p>9 <input type="checkbox"/> Tobacco use/exposure</p> <p>10 <input type="checkbox"/> Weight reduction</p> <p>11 <input type="checkbox"/> Other</p>		<p>List up to 2 surgical procedures ordered, scheduled, or performed at this visit.</p> <p><input type="checkbox"/> NONE (1)</p> <p>(2) _____</p> <p>(3) _____</p>	
9. MEDICATIONS & INJECTIONS		10. VISIT DISPOSITION	11. PROVIDERS SEEN
<p>a. What is the total number of drugs prescribed or provided at this visit? _____ Number of drugs</p> <p>Include Rx and OTC medications, immunizations, allergy shots, anesthetics, and dietary supplements that were ordered, supplied, administered or continued during this visit.</p> <p>b. List up to 8 medication/injection names below.</p> <p>(1) _____ (5) _____</p> <p>(2) _____ (6) _____</p> <p>(3) _____ (7) _____</p> <p>(4) _____ (8) _____</p>		<p>Mark (X) all that apply.</p> <p>1 <input type="checkbox"/> No follow-up planned</p> <p>2 <input type="checkbox"/> Return if needed, PRN</p> <p>3 <input type="checkbox"/> Refer to other physician</p> <p>4 <input type="checkbox"/> Return at specified time</p> <p>5 <input type="checkbox"/> Telephone follow-up planned</p> <p>6 <input type="checkbox"/> Admit to hospital</p> <p>7 <input type="checkbox"/> Other</p>	<p>Mark (X) all that apply.</p> <p>1 <input type="checkbox"/> Staff physician 7 <input type="checkbox"/> Nurse practitioner/Midwife</p> <p>2 <input type="checkbox"/> Resident/Intern 8 <input type="checkbox"/> Physician assistant</p> <p>3 <input type="checkbox"/> Other physician 9 <input type="checkbox"/> Medical technician/technologist</p> <p>4 <input type="checkbox"/> RN</p> <p>5 <input type="checkbox"/> LPN</p> <p>6 <input type="checkbox"/> Medical/Nursing assistant</p> <p>10 <input type="checkbox"/> Other</p>