Form Approved OMB No. 0920-0234 Exp. Date 04/30/2005 CDC 64.148

FORM **NAMCS-30**
(10-7-2003)

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 AMBULATORY MEDICAL CARE SURVEY
2004 PATIENT RECORD

PATIENT RECORD NO.:

PATIENT'S NAME:

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

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/African American
3 ☐ Asian
4 ☐ Native Hawaiian/ Other Pacific Islander
5 ☐ American Indian/ Alaska Native

g. Does patient use tobacco?
1 ☐ Yes 2 ☐ No 3 ☐ Unknown

h. Primary expected source of payment for this visit – *Mark (X) one.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid/SCHIP
4 ☐ Worker's Compensation
5 ☐ Self-pay
6 ☐ No charge/Charity
7 ☐ Other
8 ☐ Unknown

2. 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:

3. CONTINUITY OF CARE

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

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

b. Have you or anyone in your practice seen this patient before?
1 ☐ Yes, established patient – **How many past visits in the last 12 months?** *Exclude this visit.*
1 ☐ None
2 ☐ 1-2
3 ☐ 3-5
4 ☐ 6+
5 ☐ Unknown
2 ☐ No, new patient

c. Major reason for this visit
1 ☐ Acute problem (<3 mos. onset)
2 ☐ Chronic problem, routine
3 ☐ Chronic problem, flare-up
4 ☐ Pre-/Post-surgery

Episode of care
1 ☐ Initial visit for problem
2 ☐ Follow-up visit for problem
3 ☐ Unknown

5 ☐ Preventive care (e.g., routine prenatal, general exam, well-baby, screening, insurance exam)

d. Do other physicians share patient's care for this problem or diagnosis?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

4. INJURY/POISONING/ADVERSE EFFECT

a. Is this visit related to an injury, or poisoning, or adverse effect of medical treatment?
1 ☐ Yes →
2 ☐ No – *SKIP to item 5.*

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.).*

5. PHYSICIAN'S DIAGNOSIS FOR THIS VISIT

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

(1) Primary diagnosis:

(2) Other:

(3) Other:

6. DIAGNOSTIC/SCREENING SERVICES

Mark (X) all ***ordered*** *or* ***provided*** *at this visit.*

1 ☐ NONE
2 ☐ General medical exam
3 ☐ Other exam – *Specify site (e.g., breast, rectal)*
4 ☐ Temperature *Specify* →
5 ☐ Blood pressure – *Specify* /
6 ☐ Urinalysis (UA)
7 ☐ Urine culture
8 ☐ PAP test
9 ☐ Cervical/Urethral culture
10 ☐ PSA (prostate specific antigen)
11 ☐ Hematocrit/Hemoglobin
12 ☐ CBC (complete blood count)
13 ☐ Lipids/Cholesterol
14 ☐ Glucose
15 ☐ HgbA1C (glycohemoglobin)
16 ☐ Electrolytes
17 ☐ Other blood test
18 ☐ EKG/ECG (electrocardiogram)
19 ☐ Throat culture/Rapid strep test
20 ☐ Stool culture
21 ☐ X-ray
22 ☐ Mammography
23 ☐ Other imaging
24 ☐ Scope procedure (e.g., colonoscopy) – *Specify*
25 ☐ Other type of test or service – *Specify*

7. COUNSELING/EDUCATION/THERAPY

Mark (X) all ***ordered*** *or* ***provided*** *at this visit. Exclude medications.*

1 ☐ NONE
2 ☐ Asthma education
3 ☐ Diet/Nutrition
4 ☐ Exercise
5 ☐ Growth/Development
6 ☐ Mental health/Stress management
7 ☐ Physiotherapy
8 ☐ Psychotherapy
9 ☐ Tobacco use/ exposure
10 ☐ Weight reduction
11 ☐ Other

8. SURGICAL PROCEDURES

List up to 2 surgical procedures ***ordered, scheduled,*** *or* ***performed*** *at this visit.*

☐ NONE – *SKIP to item 9.*

(1) 1 ☐ Ordered/ Scheduled 2 ☐ Performed

(2) 1 ☐ Ordered/ Scheduled 2 ☐ Performed

9. MEDICATIONS & INJECTIONS

a. What is the total number of drugs prescribed or provided at this visit? → Number of drugs

Include Rx and OTC medications, immunizations, allergy shots, anesthetics, and dietary supplements that were ordered, supplied, administered or continued during this visit.

b. List up to 8 medication/injection names below.

(1)		**(5)**	
(2)		**(6)**	
(3)		**(7)**	
(4)		**(8)**	

10. VISIT DISPOSITION

Mark (X) all that apply.

1 ☐ No follow-up planned
2 ☐ Return if needed, PRN
3 ☐ Refer to other physician
4 ☐ Return at specified time
5 ☐ Telephone follow-up planned
6 ☐ Admit to hospital
7 ☐ Other

11. PROVIDERS SEEN

Mark (X) all that apply.

1 ☐ Physician
2 ☐ RN
3 ☐ LPN
4 ☐ Medical/Nursing assistant
5 ☐ Nurse practitioner/Midwife
6 ☐ Physician assistant
7 ☐ Medical technician/ technologist
8 ☐ Other

12. TIME SPENT WITH PHYSICIAN

Minutes	*Enter zero if no physician seen*