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).

Department of Health and Human Services
Public Health Service
Centers for Disease Control and Prevention
National Center for Health Statistics

OMB No. 0920-0278
Expires: 07/31/99
CDC 64.132

402273

PATIENT'S RECORD NO.:

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
1997–98 OUTPATIENT DEPARTMENT RECORD

PATIENT'S NAME:

1. DATE OF VISIT
____ / ____ / ____
Month Day Year

2. DATE OF BIRTH
____ / ____ / ____
Month Day Year

3. SEX
1 ☐ Female 2 ☐ Male
↓
Is patient pregnant?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

4. RACE
1 ☐ White
2 ☐ Black
3 ☐ Asian/Pacific Islander
4 ☐ American Indian/ Eskimo/Aleut

5. ETHNICITY
1 ☐ Hispanic origin
2 ☐ Not Hispanic

6. WAS PATIENT REFERRED BY ANOTHER PHYSICIAN OR BY A HEALTH PLAN FOR THIS VISIT?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

7. WAS AUTHORIZATION REQUIRED FOR CARE?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

8. ARE YOU THE PATIENT'S PRIMARY CARE PHYSICIAN?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

9. PRIMARY EXPECTED SOURCE OF PAYMENT FOR THIS VISIT *Check one.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid
4 ☐ Worker's Compensation
5 ☐ Self-pay
6 ☐ No charge
7 ☐ Other
8 ☐ Unknown

10. DOES PATIENT BELONG TO AN HMO?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

11. IS THIS A CAPITATED VISIT?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

12. HAS PATIENT BEEN SEEN IN THIS CLINIC BEFORE?
1 ☐ Yes, established patient
2 ☐ No, new patient

13. 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: _____

14. MAJOR REASON FOR THIS VISIT
Check one
1 ☐ Acute problem
2 ☐ Chronic problem, routine
3 ☐ Chronic problem, flareup
4 ☐ Pre- or post-surgery/ injury followup
5 ☐ Non-illness care (e.g., routine prenatal, general exam., well baby)

15. IS THIS VISIT RELATED TO INJURY OR POISONING? *Refers to all types of injury or poisoning, including adverse drug experiences, medical misadventures, etc.*
1 ☐ Yes *(Answer a, b, c, and d.)* 2 ☐ No *(Skip to item 16.)*

a. Place of occurrence *Check one*
1 ☐ Residence
2 ☐ Recreation/sports area
3 ☐ Street or highway
4 ☐ School
5 ☐ Other public building
6 ☐ Industrial places
7 ☐ Other
8 ☐ Unknown

b. Is this injury intentional?
1 ☐ Yes (self-inflicted)
2 ☐ Yes (assault)
3 ☐ No, unintentional
4 ☐ Unknown

c. Is this injury work related?
1 ☐ Yes 2 ☐ No 3 ☐ Unknown

d. Cause of injury *Describe events that preceded injury (e.g. reaction to penicillin, wasp sting, driver in motor vehicle traffic accident involving collision with parked vehicle, shot with a handgun during a brawl, etc.)*

_____
_____

16. PHYSICIAN'S DIAGNOSES FOR THIS VISIT *As specifically as possible, list diagnoses related to this visit including chronic conditions (e.g. depression, obesity, asthma, etc.)*

1. Primary diagnosis: _____
2. Other: _____
3. Other: _____

17. DIAGNOSTIC/SCREENING SERVICES *Check all* ***ordered*** *or* ***provided*** *at this visit.*

1 ☐ None

EXAMINATIONS:
2 ☐ Breast
3 ☐ Pelvic
4 ☐ Rectal
5 ☐ Skin
6 ☐ Visual acuity
7 ☐ Glaucoma
8 ☐ Hearing

TESTS AND MEASUREMENTS:
9 ☐ Blood pressure
10 ☐ Strep test
11 ☐ Pap test
12 ☐ Urinalysis
13 ☐ Pregnancy test
14 ☐ PSA
15 ☐ Blood lead level
16 ☐ Cholesterol measure
17 ☐ HIV serology
18 ☐ Other STD test
19 ☐ Hematocrit/hemoglobin
20 ☐ Other blood test
21 ☐ EKG

IMAGING:
22 ☐ X-Ray
23 ☐ CAT scan/MRI
24 ☐ Mammography
25 ☐ Ultrasound

ALL OTHER: *Specify*
26 ☐ _____

18. THERAPEUTIC AND PREVENTIVE SERVICES *Check all* ***ordered*** *or* ***provided*** *at this visit. Exclude medications.*

1 ☐ None

COUNSELING/EDUCATION:
2 ☐ Diet/nutrition
3 ☐ Exercise
4 ☐ HIV/STD transmission
5 ☐ Family planning/ contraception
6 ☐ Prenatal instructions
7 ☐ Breast self-exam
8 ☐ Tobacco use/exposure
9 ☐ Growth/development
10 ☐ Mental health
11 ☐ Stress management
12 ☐ Skin cancer prevention
13 ☐ Injury prevention

OTHER THERAPY:
14 ☐ Psychotherapy
15 ☐ Psycho-pharmacotherapy
16 ☐ Physiotherapy

ALL OTHER: *Specify*
17 ☐ _____

19. AMBULATORY SURGICAL PROCEDURES

☐ None

List up to 2 surgical procedures actually ***performed*** *at this visit. Include biopsy.*

1. _____
2. _____

20. MEDICATIONS/INJECTIONS *List names of up to 6 medications that were* ***ordered, supplied, administered*** *or* ***continued*** *during this visit. Include R_x and OTC medications, immunizations, allergy shots, and anesthetics.*

☐ None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

21. PROVIDERS SEEN THIS VISIT *Check all that apply.*
1 ☐ Staff physician
2 ☐ Resident/intern
3 ☐ Other physician
4 ☐ Physician assistant
5 ☐ Nurse practitioner
6 ☐ Nurse midwife
7 ☐ R.N.
8 ☐ L.P.N.
9 ☐ Medical/nursing assistant
10 ☐ Other

402273

22. TIME SPENT WITH PHYSICIAN
If not seen by physician, enter zero

_____
Minutes