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.

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

A

NATIONAL AMBULATORY MEDICAL CARE SURVEY
1995-96 PATIENT RECORD

OMB NO. 0920-0234
Expires: 06-30-97
CDC 64.109A

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

2. ZIP CODE _____ Patient's

3. DATE OF BIRTH ___/___/___ Month Day Year

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

5. SEX
1 ☐ Female 2 ☐ Male

6. ETHNICITY
1 ☐ Hispanic origin
2 ☐ Not Hispanic

7. DOES PATIENT SMOKE CIGARETTES ?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

8. EXPECTED SOURCE(S) OF PAYMENT FOR THIS VISIT

a. Type of payment *Check one.*
1 ☐ Preferred provider option
2 ☐ Insured, fee-for-service
3 ☐ HMO / Other prepaid
If checked, answer **b.**
4 ☐ Self-pay
5 ☐ No charge
6 ☐ Other
If checked, skip **b.**

b. Expected sources of insurance *Check all that apply.*
1 ☐ Blue Cross / Blue Shield
2 ☐ Other private insurance
3 ☐ Medicare
4 ☐ Medicaid
5 ☐ Worker's Compensation
6 ☐ Other
7 ☐ Unknown

9. PATIENT'S COMPLAINT(S), SYMPTOM(S), OR OTHER REASON(S) FOR THIS VISIT *Use patient's own words.*
Most
a. Important: _____
b. Other: _____
c. Other: _____

10. IS THIS VISIT INJURY RELATED ?
1 ☐ Yes *(Answer a, b, and c.)*
2 ☐ No *(Skip to Item 11.)*

a. Place of occurrence
1 ☐ Home
2 ☐ School
3 ☐ Sports or athletics area
4 ☐ Street or highway
5 ☐ Other: _____
6 ☐ Unknown

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

c. 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, etc.).*

11. PHYSICIAN'S DIAGNOSES *As specifically as possible, list up to 3 current diagnoses including those unrelated to this visit.*
a. Principal diagnosis or problem associated with Item 9a.: _____
b. Other: _____
c. Other: _____

12. DOES PATIENT HAVE: *Check all that apply regardless of entry in Item 11.*
1 ☐ Arthritis
2 ☐ Artherosclerosis
3 ☐ COPD
4 ☐ Chronic renal failure
5 ☐ Depression
6 ☐ Diabetes
7 ☐ HIV / AIDS
8 ☐ Hyperactivity / ADD
9 ☐ Hypertension
10 ☐ Obesity
11 ☐ None of the above

13. AMBULATORY SURGICAL PROCEDURES
☐ NONE
List up to 2 surgical procedures performed at this visit.
1. _____
2. _____

14. DIAGNOSTIC / SCREENING SERVICES *Check all ordered or provided at this visit.*
1 ☐ NONE

EXAMINATIONS:
2 ☐ Breast
3 ☐ Pelvic
4 ☐ Rectal
5 ☐ Visual acuity
6 ☐ Mental status
7 ☐ Other: _____

TESTS:
8 ☐ Blood pressure
9 ☐ Urinalysis
10 ☐ TB skin test
11 ☐ Blood lead level
12 ☐ Cholesterol measure
13 ☐ PSA
14 ☐ HIV serology
15 ☐ Other blood test
16 ☐ Other: _____

IMAGING:
17 ☐ X-Ray
18 ☐ CAT scan
19 ☐ MRI
20 ☐ Ultrasound
21 ☐ Other: _____

ALL OTHER: *(specify)*
22 ☐ _____

15. THERAPEUTIC AND PREVENTIVE SERVICES
Check all ordered or provided at this visit. Exclude medications.
1 ☐ NONE

COUNSELING / EDUCATION:
2 ☐ Diet
3 ☐ Exercise
4 ☐ Weight reduction
5 ☐ Cholesterol reduction
6 ☐ HIV transmission
7 ☐ Injury prevention
8 ☐ Tobacco use / exposure
9 ☐ Growth / development
10 ☐ Mental health
11 ☐ Other: _____

OTHER THERAPY:
12 ☐ Psychotherapy
13 ☐ Corrective lenses
14 ☐ Physiotherapy
15 ☐ Other: _____

16. MEDICATIONS / INJECTIONS *List names of up to 6 medications that were ordered, supplied, or administered during this visit. Include new medications, continuing medications (with or without new orders), R_X and OTC medications, immunizations, allergy shots, and anesthetics.*
☐ NONE
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

17. PROVIDERS SEEN THIS VISIT *Check all that apply.*
1 ☐ Physician
2 ☐ Physician assistant
3 ☐ Nurse practitioner
4 ☐ R.N.
5 ☐ L.P.N.
6 ☐ Medical assistant
7 ☐ Other: _____

18. HAVE YOU OR ANYONE IN YOUR PRACTICE SEEN PATIENT BEFORE ?
1 ☐ Yes 2 ☐ No
If Yes, for condition in Item 11a.?
1 ☐ Yes 2 ☐ No

19. WAS PATIENT REFERRED FOR THIS VISIT BY ANOTHER PHYSICIAN ?
1 ☐ Yes
2 ☐ No

20. VISIT DISPOSITION *Check all that apply.*
1 ☐ No followup planned
2 ☐ Return if needed, P.R.N.
3 ☐ Return at specified time
4 ☐ Admit to hospital
5 ☐ Other: _____

21. VISIT DURATION
_____ Minutes

Figure 1. Patient Record form