FORM NHAMCS-100A(OPD) (10-12-2000)

U.S. DEPARTMENT OF COMMERCE | PATIENT RECORD NO.: U.S. DEPARTIMENT IOT CUMMIRENT.
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 Contor for Health Statistics

PATIENT'S NAME:

A

## NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY 2001/2002 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. P	ATIENT INFORMATION	7	2.	REASON FOR V	SIT	
a. Date of visit	e. Ethnicity		Patient's complaint(s), symptom(s), or other			
Month Day Year	- 1 ☐ Hispanic or Latino 2 ☐ Not H	lispanic or Latino	reason(s) for this v	r <b>isit –</b> Use patient's d	own words.	
	f. Race - Mark (X) one or more.		(1) Most important:			
	1 ☐ White 4 ☐ Native Hawaiian/ 2 ☐ Black/African ☐ Other Pacific Islander					
b.ZIP code	American 5 American Indian/					
	3 ☐ Asian Alaska Native		(2) Other:			
c. Date of birth	g. Does patient use tobacco?		(L) Guion.			
c. Date of Dirth	1 Yes 2 No 3 Unkn					
Month Day Year	h. Primary expected source of paym visit – Mark (X) one.	ent for this				
	1 ☐ Private insurance 5 ☐ Self-	(3) Other:	· · · · · · · · · · · · · · · · · · ·			
d. Sex	2 ☐ Medicare 6 ☐ No charge/Charity 3 ☐ Medicaid/SCHIP 7 ☐ Unknown					
1 ☐ Female	3					
2 ☐ Male	Compensation					
	34 CONTEN	JUITY OF CARE				
a. Are you the patient's b primary care physician?	. Has the patient been seen in this clinic before?	c. Major reason		1	d. Do other physicians	
1 Yes	1 ☐ Yes, established patient – <b>How</b>	1 ∐ Acute Prob (<3 mos. o		isode of care ☐ Initial visit for	share patient's	
2 □ No	many past visits in the last	2 🔲 Chronic pro	oblem, routine }	problem	care for this problem or	
3 ☐ Unknown 🕽 💮	12 months? Exclude this visit.  1 □ None			Follow-up visit for problem	diagnosis?	
Was patient referred	2 🗆 1-2	4 ☐ Pre-/Post-s		Unknown	1 ☐ Yes	
for this visit?	з 🔲 3-5	₅ □ Proventive	care le a routine n	renatal general	2 🔲 No	
1 ☐ Yes 2 ☐ No	4 □ 6+ 5 □ Unknown	exam, well	tive care (e.g., routine prenatal, general well-baby, screening, insurance exam)			
3 ☐ Unknown	2 No, new patient					
	NING/ADVERSE EFFECT		Б. PHYSICIAN'S	<b>DIAGNOSIS FO</b>	R THIS VISIT	
a. Is this visit b. Cause of Inj	ury, polsoning, or adverse effect – Do onality, and events that preceded the inji adverse event (e.g., allergy to penicillin, t by car driven by drunk driver, wife beat	escribe the As s	pecifically as possible, visit including chronic	list diagnoses relate	d to	
an injury, or poisoning, or	adverse event (e.g., allergy to penicillin,	bee sting,	Primary diagnosis:	conditions.		
poisoning, pedestrian his or adverse by husband,	t by car driven by drunk driver, wife beat heroin overdose, infected shunt, etc.).	en with fists	Tilliary diagnosis.			
effect of						
medical treatment?		(2)	Other:			
1 ☐ Yes						
2 □ No – SKIP   to item 5.		_				
		(3)	Other:			
				at the end of the first of the end of the en	NAN SUBBLIGHT OF THE COURT OF SECTION AS	
	6. DIAGNOSTIC/	SCREENING SE	RVICES			
Mark (X) all ordered or provide		40 □ EVG/ECC	(alastropardiagram)	47 Coope proc	oduro (o a	
1 NONE	5 ☐ Urinalysis (UA) 6 ☐ PAP test		(electrocardiogram) .g., throat) – <i>Specify</i>	17 ☐ Scope proc endoscopy	) – Specify 🙀	
2 ☐ General medical exam 3 ☐ Other exam – Specify site	7 PSA (prostate specific					
(e.g., breast, rectal) 🗾	antigen) s ☐ Hematocrit/Hemoglobin					
	9 CBC (complete blood count	14 🗆 X-ray		18 🗌 Other servi	ce – Specify 📈	
	10 ☐ Cholesterol 11 ☐ Other blood test	15 🔲 Mammog				
4 ∐ Blood pressure	11 🖂 Other blood test	16 🗌 Other ima	ging			
7. COUNSELING	EDUCATION/THERAPY		8. SURGICA	L PROCEDURES		
		ist up to 2 surgical	procedures ordered,			
1 ☐ NONE		1)			1 Ordered/	
2 Asthma education	7 ☐ Physiotherapy				_ Scheduled	
3 ☐ Diet/Nutrition	8 Psychotherapy	- · · · · · · · · · · · · · · · · · · ·			2 Performed	
4  Exercise 5  Growth/Development	9 ☐ Tobacco use/exposure (10 ☐ Weight reduction	2)			1 ☐ Ordered/ Scheduled	
6 Mental health/Stress manager					2 Performed	
Far (All III) and the same of	. MEDICATIONS	10	o. VISIT	11.2:0	OVIDERS	
	& INJECTIONS		DISPOSITION	SEE	N	
a. What is the total number of d		1 _	ark (X) all that apply.	Mark (X) all that a		
prescribed or provided at this		Number 1 [	☐ No follow-up planned	1  Staff physicial 2  Resident/Inter		
Include Rx and OTC medicatio	ns, immunizations, allergy shots, anes ordered, supplied, administered or co	thetics, and 2	Return if	3 Other physicia	midwife I	
dietary supplements that were during this visit.	ordered, supplied, administered or co	ntinued	needed, PRN ☑ Refer to other	4 □ RN	8 ☐ Physician assistant	
b. List up to six medication/injection	ction names below.	_	physician	5 □ LPN 6 □ Medical/	9  Medical technician/	
		4 [	Return at specified time	Nursing	technologist	
(1)	(4)	5[	☐ Telephone	assistant	10 🗌 Other	
			follow-up planned			
(2)	(5)	6 [	☐ Admit to	l _		
(2)	(5)	_		Α	J	