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FORM **NHAMCS-100(OPD)**
(8-1-2005)

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 HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2006 OUTPATIENT DEPARTMENT 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: 2006

b. ZIP code

c. Date of birth
Month | Day | Year

d. Sex
1 ☐ Female – Is patient pregnant?
  1 ☐ Yes - *Specify gestation week* →
  OR
  LMP Month | Day | Year: 200
  2 ☐ No
  3 ☐ Unknown
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. Tobacco use
1 ☐ Not current
  1 ☐ Never
  2 ☐ Former
2 ☐ Current
3 ☐ Unknown

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

2. INJURY/POISONING/ ADVERSE EFFECT

Is this visit related to any of the following?
1 ☐ Unintentional injury/ poisoning
2 ☐ Intentional injury/poisoning
3 ☐ Adverse effect of medical/surgical care or adverse effect of medicinal drug
4 ☐ None of the above
5 ☐ Unknown

3. 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:

4. CONTINUITY OF CARE

a. Are you the patient's primary care physician/provider?
1 ☐ Yes –*SKIP to item 4b.*
2 ☐ No
3 ☐ Unknown

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

b. Has the patient been seen in this clinic 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 ☐ New problem (<3 mos. onset)
2 ☐ Chronic problem, routine
3 ☐ Chronic problem, flare-up
4 ☐ Pre-/Post-surgery
5 ☐ Preventive care (e.g., routine prenatal, well-baby, screening, insurance, general exams)

5. PHYSICIAN'S DIAGNOSIS FOR THIS VISIT

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

(1) Primary diagnosis:

(2) Other:

(3) Other:

b. Regardless of the diagnoses written in 5a, does the patient now have – *Mark (X) all that apply.*
1 ☐ Arthritis
2 ☐ Asthma
3 ☐ Cancer
  0 ☐ In situ
  1 ☐ Local
  2 ☐ Regional
  3 ☐ Distant
  4 ☐ Unknown
4 ☐ Cerebrovascular disease
5 ☐ CHF
6 ☐ Chronic renal failure
7 ☐ COPD
8 ☐ Depression
9 ☐ Diabetes
10 ☐ Hyperlipidemia
11 ☐ Hypertension
12 ☐ Ischemic heart disease
13 ☐ Obesity
14 ☐ Osteoporosis
15 ☐ None of the above

c. Status of patient enrollment in a disease management program for any of the conditions marked in 5b.
1 ☐ Currently enrolled
2 ☐ Ordered/advised to enroll at this visit
3 ☐ Not enrolled
4 ☐ Unknown

6. VITAL SIGNS

(1) Height . . . . . ☐ ft/in ☐ cm

(2) Weight . . . . . ☐ lbs ☐ kg

(3) Temperature ☐ °C ☐ °F

(4) Blood pressure ____ / ____

7. DIAGNOSTIC/SCREENING SERVICES

*Mark (X) all **ordered** or **provided** at this visit.*
1 ☐ NONE

Examinations:
2 ☐ Breast
3 ☐ Pelvic
4 ☐ Rectal
5 ☐ Skin
6 ☐ Depression screening

Imaging:
7 ☐ Bone mineral density
8 ☐ Mammography
9 ☐ MRI/CT/PET
10 ☐ Ultrasound
11 ☐ X-ray
12 ☐ Other imaging

Blood tests:
13 ☐ CBC (complete blood count)
14 ☐ Electrolytes
15 ☐ Glucose
16 ☐ HgbA1C (glycohemoglobin)
17 ☐ Lipids/Cholesterol
18 ☐ PSA (prostate specific antigen)
19 ☐ Other blood test

Scope:
20 ☐ Scope procedure (e.g., colonoscopy) - *Specify*

Other tests:
21 ☐ Biopsy
22 ☐ Chlamydia test
23 ☐ Pap test - conventional
24 ☐ Pap test - liquid-based
25 ☐ Pap test - unspecified
26 ☐ HPV DNA test
27 ☐ EKG/ECG
28 ☐ Spirometry/Pulmonary function test
29 ☐ Urinalysis (UA)
30 ☐ Other test/service - *Specify*

8. HEALTH EDUCATION

*Mark (X) all **ordered** or **provided** at this visit.*
1 ☐ NONE
2 ☐ Asthma education
3 ☐ Diet/Nutrition
4 ☐ Exercise
5 ☐ Growth/Development
6 ☐ Injury prevention
7 ☐ Stress management
8 ☐ Tobacco use/ Exposure
9 ☐ Weight reduction
10 ☐ Other

9. NON-MEDICATION TREATMENT

*Mark (X) or list all **ordered** or **provided** at this visit.*
1 ☐ NONE
2 ☐ Complementary alternative medicine (CAM)
3 ☐ Durable medical equipment
4 ☐ Home health care
5 ☐ Hospice care
6 ☐ Physical therapy
7 ☐ Radiation therapy
8 ☐ Speech/Occupational therapy
9 ☐ Psychotherapy
10 ☐ Other mental health counseling
11 ☐ Excision of tissue
12 ☐ Orthopedic care
13 ☐ Wound care

Procedures:
14 ☐ Other non-surgical procedures – *Specify*
15 ☐ Other surgical procedures – *Specify*

10. MEDICATIONS & IMMUNIZATIONS

☐ NONE

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

		New	Continued
(1)		1 ☐	2 ☐
(2)		1 ☐	2 ☐
(3)		1 ☐	2 ☐
(4)		1 ☐	2 ☐
(5)		1 ☐	2 ☐
(6)		1 ☐	2 ☐
(7)		1 ☐	2 ☐
(8)		1 ☐	2 ☐

11. PROVIDERS

Mark (X) all providers seen at this visit.
1 ☐ Physician
2 ☐ Physician assistant
3 ☐ Nurse practitioner/ Midwife
4 ☐ RN/LPN
5 ☐ Other

12. 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 ☐ Refer to emergency department
7 ☐ Admit to hospital
8 ☐ Other

National Hospital Ambulatory Medical Care Survey

2006 Outpatient Department Patient Record Folio

Hospital ID	REPORTING PERIOD	Month Day TO Month Day	
Ambulatory Unit Number	Start with the _____ Patient. Do every _____ Patient.		

Please return the whole Folio with both the completed and blank forms at the completion of the survey period. Thank you!

		Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	Total
WEEK 1	Dates								
	No. of patient visits								
	No. of records filled								
WEEK 2	Dates								
	No. of patient visits								
	No. of records filled								

		Mon.	Tues.	Wed.	Thur.	Fri.	Sat.	Sun.	Total
WEEK 3	Dates								
	No. of patient visits								
	No. of records filled								
WEEK 4	Dates								
	No. of patient visits								
	No. of records filled								