

FORM **NAMCS-30A**
(9-28-2001)

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

PATIENT RECORD NO.:

A 500156

PATIENT'S NAME:

**NATIONAL AMBULATORY MEDICAL CARE SURVEY
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. PATIENT INFORMATION		2. REASON FOR VISIT
a. Date of visit Month: [] Day: [] Year: [] b. ZIP code [] [] [] [] [] [] c. Date of birth Month: [] Day: [] Year: [] d. Sex 1 <input type="checkbox"/> Female 2 <input type="checkbox"/> Male	e. Ethnicity 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino f. Race – Mark (X) one or more. 1 <input type="checkbox"/> White 4 <input type="checkbox"/> Native Hawaiian/ Other Pacific Islander 2 <input type="checkbox"/> Black/African 5 <input type="checkbox"/> American Indian/ Alaska Native 3 <input type="checkbox"/> Asian g. Does patient use tobacco? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown h. Primary expected source of payment for this visit – Mark (X) one. 1 <input type="checkbox"/> Private insurance 5 <input type="checkbox"/> Self-pay 2 <input type="checkbox"/> Medicare 6 <input type="checkbox"/> No charge/Charity 3 <input type="checkbox"/> Medicaid/SCHIP 7 <input type="checkbox"/> Other 4 <input type="checkbox"/> Worker's 8 <input type="checkbox"/> Unknown Compensation	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 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown Was patient referred for this visit? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	b. Have you or anyone in your practice seen this patient before? 1 <input type="checkbox"/> Yes, established patient – How many past visits in the last 12 months? Exclude this visit. 1 <input type="checkbox"/> None 2 <input type="checkbox"/> 1-2 3 <input type="checkbox"/> 3-5 4 <input type="checkbox"/> 6+ 5 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> No, new patient	c. Major reason for this visit 1 <input type="checkbox"/> Acute problem (<3 mos. onset) 2 <input type="checkbox"/> Chronic problem, routine 3 <input type="checkbox"/> Chronic problem, flare-up 4 <input type="checkbox"/> Pre-/Post-surgery 5 <input type="checkbox"/> 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 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown

4. INJURY/POISONING/ADVERSE EFFECT	5. PHYSICIAN'S DIAGNOSIS FOR THIS VISIT
a. Is this visit related to an injury, or poisoning, or adverse effect of medical treatment? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> 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.). _____ _____

6. DIAGNOSTIC/SCREENING SERVICES		
Mark (X) all ordered or provided at this visit.		
1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> General medical exam 3 <input type="checkbox"/> Other exam – Specify site (e.g., breast, rectal)	5 <input type="checkbox"/> Urinalysis (UA) 6 <input type="checkbox"/> PAP test 7 <input type="checkbox"/> PSA (prostate specific antigen) 8 <input type="checkbox"/> Hematocrit/Hemoglobin 9 <input type="checkbox"/> CBC (complete blood count) 10 <input type="checkbox"/> Cholesterol 11 <input type="checkbox"/> Other blood test	12 <input type="checkbox"/> EKG/ECG (electrocardiogram) 13 <input type="checkbox"/> Culture (e.g., throat) – Specify 14 <input type="checkbox"/> X-ray 15 <input type="checkbox"/> Mammography 16 <input type="checkbox"/> Other imaging 17 <input type="checkbox"/> Scope procedure (e.g., endoscopy) – Specify 18 <input type="checkbox"/> Other service – Specify

7. COUNSELING/EDUCATION/THERAPY	8. SURGICAL PROCEDURES
Mark (X) all ordered or provided at this visit. Exclude medications. 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> Asthma education 3 <input type="checkbox"/> Diet/Nutrition 4 <input type="checkbox"/> Exercise 5 <input type="checkbox"/> Growth/Development 6 <input type="checkbox"/> Mental health/Stress management 7 <input type="checkbox"/> Physiotherapy 8 <input type="checkbox"/> Psychotherapy 9 <input type="checkbox"/> Tobacco use/exposure 10 <input type="checkbox"/> Weight reduction 11 <input type="checkbox"/> Other	List up to 2 surgical procedures ordered, scheduled, or performed at this visit. <input type="checkbox"/> NONE (1) _____ (2) _____ _____

9. MEDICATIONS & INJECTIONS	10. VISIT DISPOSITION	11. PROVIDERS SEEN
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 six medication/injection names below. (1) _____ (4) _____ (2) _____ (5) _____ (3) _____ (6) _____	Mark (X) all that apply. 1 <input type="checkbox"/> No follow-up planned 2 <input type="checkbox"/> Return if needed, PRN 3 <input type="checkbox"/> Refer to other physician 4 <input type="checkbox"/> Return at specified time 5 <input type="checkbox"/> Telephone follow-up planned 6 <input type="checkbox"/> Admit to hospital 7 <input type="checkbox"/> Other	Mark (X) all that apply. 1 <input type="checkbox"/> Physician 2 <input type="checkbox"/> RN 3 <input type="checkbox"/> LPN 4 <input type="checkbox"/> Medical/Nursing assistant 5 <input type="checkbox"/> Nurse practitioner/Midwife 6 <input type="checkbox"/> Physician assistant 7 <input type="checkbox"/> Medical technician/technologist 8 <input type="checkbox"/> Other

12. TIME SPENT WITH PHYSICIAN
Minutes: _____ Enter zero if no physician seen <p style="text-align: right;">A 500156</p>