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).

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Health Statistics

B 830807

NATIONAL AMBULATORY MEDICAL CARE SURVEY
1999–2000 PATIENT RECORD

OMB No. 0920-0234
Expires: 05/31/2001
CDC 64.134B

1. PATIENT'S ZIP CODE

2. DATE OF VISIT
Month | Day | Year

3. DATE OF BIRTH
Month | Day | Year

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

5. ETHNICITY
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

6. 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

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

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

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

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

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

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

13. HAVE YOU OR ANYONE IN YOUR PRACTICE/ DEPARTMENT SEEN PATIENT BEFORE?
1 ☐ Yes, established patient
2 ☐ No, new patient

14. 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: _____

15. MAJOR REASON FOR THIS VISIT – *Mark (X) 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)

16. 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 17.)*

a. Place of occurrence – *Mark (X) 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, heroin overdose, etc.).*

17. 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: _____

18. DIAGNOSTIC/SCREENING SERVICES – *Mark (X) 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 ☐ _____

19. THERAPEUTIC AND PREVENTIVE SERVICES –
Mark (X) 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
17 ☐ Complementary or alternative medicine (CAM)

ALL OTHER – *Specify*
18 ☐ _____

20. AMBULATORY SURGICAL PROCEDURES
☐ None
List up to 2 surgical procedures actually ***performed*** *at this visit. Include biopsy.*
1. _____
2. _____

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

☐ None – *No Medications/Injections*

Mark (X) next to drug name if it is from the patient's insurance formulary list.

☐ *Mark (X) here if NO drugs are from a formulary list.*

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

22. PROVIDERS SEEN THIS VISIT – *Mark (X) all that apply.*
1 ☐ Physician
2 ☐ Physician assistant
3 ☐ Nurse practitioner
4 ☐ Nurse midwife
5 ☐ R.N.
6 ☐ L.P.N.
7 ☐ Medical/ nursing assistant
8 ☐ Other

23. VISIT DISPOSITION – *Mark (X) all that apply.*
1 ☐ No follow-up planned
2 ☐ Return if needed, P.R.N.
3 ☐ Return at specified time
4 ☐ Telephone follow-up planned
5 ☐ Referred to other physician
6 ☐ Returned to referring physician
7 ☐ Admitted to hospital
8 ☐ Other – *Specify*

24. TIME SPENT WITH PHYSICAN
If not seen by physician, enter zero.
_____ Minutes