

FORM **NHAMCS-100(OPD)**
(9-28-2006)

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.: _____

PATIENT'S NAME: _____

**NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2007 OUTPATIENT DEPARTMENT 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).

(Provider: Detach and keep upper portion)

Please keep (X) marks inside of boxes → Correct Incorrect

1. PATIENT INFORMATION				2. INJURY/POISONING/ADVERSE EFFECT	
a. Date of visit Month Day Year 2 0 0 7		d. Sex 1 <input type="checkbox"/> Female 2 <input checked="" type="checkbox"/> Male		g. Expected source(s) of payment for this visit – Mark (X) all that apply. 1 <input type="checkbox"/> Private insurance 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Medicaid/SCHIP 4 <input type="checkbox"/> Worker's compensation 5 <input type="checkbox"/> Self-pay 6 <input type="checkbox"/> No charge/Charity 7 <input type="checkbox"/> Other 8 <input type="checkbox"/> Unknown	
b. ZIP Code _____		e. Ethnicity 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino		Is this visit related to any of the following? 1 <input type="checkbox"/> Unintentional injury/poisoning 2 <input type="checkbox"/> Intentional injury/poisoning 3 <input type="checkbox"/> Injury/poisoning – unknown intent 4 <input type="checkbox"/> Adverse effect of medical/surgical care or adverse effect of medicinal drug 5 <input type="checkbox"/> None of the above	
c. Date of birth Month Day Year _____		f. Race – Mark (X) one or more. 1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black/African American 3 <input type="checkbox"/> Asian 4 <input type="checkbox"/> Native Hawaiian/Other Pacific Islander 5 <input type="checkbox"/> American Indian/Alaska Native		h. Tobacco use 1 <input type="checkbox"/> Not current 3 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> Current	
3. REASON FOR VISIT			4. CONTINUITY OF CARE		
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: _____			a. Is this clinic the patient's primary care provider? 1 <input type="checkbox"/> Yes –SKIP to item 4b. 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. Has the patient been seen in this clinic before? How many past visits in the last 12 months? Exclude this visit. _____ Visits 1 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> No, new patient
			c. Major reason for this visit 1 <input type="checkbox"/> New 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, well-baby, screening, insurance, general exams)		
5. PROVIDER'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 <input type="checkbox"/> Arthritis 4 <input type="checkbox"/> Cerebrovascular disease 10 <input type="checkbox"/> Hyperlipidemia 2 <input type="checkbox"/> Asthma 5 <input type="checkbox"/> CHF 11 <input type="checkbox"/> Hypertension 3 <input type="checkbox"/> Cancer 6 <input type="checkbox"/> Chronic renal failure 12 <input type="checkbox"/> Ischemic heart disease 0 <input type="checkbox"/> In situ 7 <input type="checkbox"/> COPD 13 <input type="checkbox"/> Obesity 1 <input type="checkbox"/> Local 8 <input type="checkbox"/> Depression 14 <input type="checkbox"/> Osteoporosis 2 <input type="checkbox"/> Regional 9 <input type="checkbox"/> Diabetes 15 <input type="checkbox"/> None of the above – SKIP to item 6 3 <input type="checkbox"/> Distant 4 <input type="checkbox"/> Unknown		c. Status of patient enrollment in a disease management program for any of the conditions marked in 5b. 1 <input type="checkbox"/> Currently enrolled 2 <input type="checkbox"/> Ordered/Advised to enroll at this visit 3 <input type="checkbox"/> Not enrolled 4 <input type="checkbox"/> Unknown	
6. VITAL SIGNS		7. DIAGNOSTIC/SCREENING SERVICES			
(1) Height _____ ft _____ in OR _____ cm (2) Weight _____ lb _____ oz OR _____ kg _____ gm (3) Temperature (4) Blood pressure _____ °C Systolic Diastolic °F _____ / _____		Mark (X) all ordered or provided at this visit. Examinations: 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> Breast 3 <input type="checkbox"/> Pelvic 4 <input type="checkbox"/> Rectal 5 <input type="checkbox"/> Skin 6 <input type="checkbox"/> Depression screening Imaging: 7 <input type="checkbox"/> X-ray 8 <input type="checkbox"/> Bone mineral density 9 <input type="checkbox"/> CT scan 10 <input type="checkbox"/> Echocardiogram 11 <input type="checkbox"/> Other ultrasound 12 <input type="checkbox"/> Mammography 13 <input type="checkbox"/> MRI 14 <input type="checkbox"/> PET scan 15 <input type="checkbox"/> Other imaging Blood tests: 16 <input type="checkbox"/> CBC (complete blood count) 17 <input type="checkbox"/> Electrolytes 18 <input type="checkbox"/> Glucose 19 <input type="checkbox"/> HgbA1C (glycohemoglobin) 20 <input type="checkbox"/> Lipids/Cholesterol 21 <input type="checkbox"/> PSA (prostate specific antigen) 22 <input type="checkbox"/> Other blood test Scope: 23 <input type="checkbox"/> Scope procedure (e.g., colonoscopy) - Specify _____ Other tests: 24 <input type="checkbox"/> Biopsy – Specify site _____ 25 <input type="checkbox"/> Chlamydia test 26 <input type="checkbox"/> EKG/ECG 27 <input type="checkbox"/> HPV DNA test 28 <input type="checkbox"/> Pap test - conventional 29 <input type="checkbox"/> Pap test - liquid-based 30 <input type="checkbox"/> Pap test - unspecified 31 <input type="checkbox"/> Pregnancy test 32 <input type="checkbox"/> Spirometry/Pulmonary function test 33 <input type="checkbox"/> Urinalysis (UA) 34 <input type="checkbox"/> Other exam/test/service - Specify _____			
8. HEALTH EDUCATION		9. NON-MEDICATION TREATMENT			
Mark (X) all ordered or provided at this visit. 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"/> Injury prevention 7 <input type="checkbox"/> Stress management 8 <input type="checkbox"/> Tobacco use/Exposure 9 <input type="checkbox"/> Weight reduction 10 <input type="checkbox"/> Other		Mark (X) all ordered or provided at this visit. 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> Complementary alternative medicine (CAM) 3 <input type="checkbox"/> Durable medical equipment 4 <input type="checkbox"/> Home health care 5 <input type="checkbox"/> Hospice care 6 <input type="checkbox"/> Physical therapy 7 <input type="checkbox"/> Radiation therapy 8 <input type="checkbox"/> Speech/Occupational therapy 9 <input type="checkbox"/> Psychotherapy 10 <input type="checkbox"/> Other mental health counseling 11 <input type="checkbox"/> Excision of tissue 12 <input type="checkbox"/> Orthopedic care 13 <input type="checkbox"/> Wound care Procedures: 14 <input type="checkbox"/> Other non-surgical procedures – Specify _____ 15 <input type="checkbox"/> Other surgical procedures – Specify _____			
10. MEDICATIONS & IMMUNIZATIONS		11. PROVIDERS		12. VISIT DISPOSITION	
_____ _____ _____ _____ _____ _____ _____ _____		Mark (X) all providers seen at this visit. 1 <input type="checkbox"/> Physician 2 <input type="checkbox"/> Physician assistant 3 <input type="checkbox"/> Nurse practitioner/Midwife 4 <input type="checkbox"/> RN/LPN 5 <input type="checkbox"/> Mental health provider 6 <input type="checkbox"/> Other		Mark (X) all that apply. 1 <input type="checkbox"/> No show 2 <input type="checkbox"/> Left without being seen 3 <input type="checkbox"/> No follow-up planned 4 <input type="checkbox"/> Return if needed, PRN 5 <input type="checkbox"/> Refer to other physician 6 <input type="checkbox"/> Return at specified time 7 <input type="checkbox"/> Telephone follow-up planned 8 <input type="checkbox"/> Refer to emergency department 9 <input type="checkbox"/> Admit to hospital 10 <input type="checkbox"/> Other	