

SAMPLE

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY 2013 OUTPATIENT DEPARTMENT PATIENT RECORD

Form Approved: OMB No. 0920-0278; Expiration date 12/31/2014

Assurance of confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential; will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls; and will not be disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

PATIENT INFORMATION

Patient medical record No.	Age	Ethnicity	Expected source(s) of payment for this visit – Mark (X) all that apply.	Tobacco use
	Sex	1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino	1 <input type="checkbox"/> Private insurance 2 <input type="checkbox"/> Medicare 3 <input type="checkbox"/> Medicaid or CHIP 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	1 <input type="checkbox"/> Not current 2 <input type="checkbox"/> Current 3 <input type="checkbox"/> Unknown
Date of visit	1 <input type="checkbox"/> Female – Is patient pregnant? 1 <input type="checkbox"/> Yes - Specify gestation week → <input type="text"/> OR LMP Month Day Year <input type="text"/> <input type="text"/> <input type="text"/> 201 <input type="text"/> 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> Male	Race		
Month Day Year <input type="text"/> <input type="text"/> <input type="text"/> 1 <input type="text"/>		1 <input type="checkbox"/> White 2 <input type="checkbox"/> Black or African American 3 <input type="checkbox"/> Asian 4 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 5 <input type="checkbox"/> American Indian or Alaska Native		
ZIP Code				
Month Day Year <input type="text"/> <input type="text"/> <input type="text"/>				
Date of birth				
Month Day Year <input type="text"/> <input type="text"/> <input type="text"/>				

VITAL SIGNS

Height	Weight	Temperature	Blood pressure
<input type="text"/> ft <input type="text"/> in OR <input type="text"/> cm	<input type="text"/> lb <input type="text"/> oz OR <input type="text"/> kg <input type="text"/> gm	<input type="text"/> °C <input type="text"/> °F	Systolic / Diastolic <input type="text"/> / <input type="text"/>

INJURY

Is this visit related to an injury, poisoning, or adverse effect of medical treatment?

1 Yes, injury/trauma
2 Yes, poisoning
3 Yes, adverse effect of medical treatment
4 No
5 Unknown

Is this injury/poisoning unintentional or intentional?

1 Unintentional
2 Intentional
3 Unknown

REASON

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: _____

CONTINUITY OF CARE

Is this clinic the patient's primary care provider?

1 Yes – SKIP to →
2 No
3 Unknown

Was patient referred for this visit?

1 Yes
2 No
3 Unknown

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.
 Visits
1 Unknown
2 No, new patient

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)

DIAGNOSIS

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

(1) Primary diagnosis: _____

(2) Other: _____

(3) Other: _____

Regardless of the diagnoses previously entered, does the patient now have – Mark (X) all that apply.

1 <input type="checkbox"/> Arthritis	3 <input type="checkbox"/> Cancer	6 <input type="checkbox"/> Chronic renal failure	12 <input type="checkbox"/> Ischemic heart disease
2 <input type="checkbox"/> Asthma	4 <input type="checkbox"/> Cerebrovascular disease/History of stroke or transient ischemic attack (TIA)	7 <input type="checkbox"/> Congestive heart failure	13 <input type="checkbox"/> Obesity
Asthma severity:	5 <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD)	8 <input type="checkbox"/> Depression	14 <input type="checkbox"/> Osteoporosis
1 <input type="checkbox"/> Intermittent		9 <input type="checkbox"/> Diabetes	15 <input type="checkbox"/> None of the above
2 <input type="checkbox"/> Mild persistent		10 <input type="checkbox"/> Hyperlipidemia	
3 <input type="checkbox"/> Moderate persistent		11 <input type="checkbox"/> Hypertension	
4 <input type="checkbox"/> Severe persistent			
5 <input type="checkbox"/> Other – Specify			
<input type="text"/>			
6 <input type="checkbox"/> None recorded			
Asthma control:			
1 <input type="checkbox"/> Well controlled			
2 <input type="checkbox"/> Not well controlled			
3 <input type="checkbox"/> Very poorly controlled			
4 <input type="checkbox"/> Other – Specify			
<input type="text"/>			
5 <input type="checkbox"/> None recorded			

SERVICES

Enter all examinations, blood tests, imaging, other tests, non-medication treatment and health education ORDERED OR PROVIDED.

<p>1 <input type="checkbox"/> NONE</p> <p>Examinations:</p> <p>2 <input type="checkbox"/> Breast</p> <p>3 <input type="checkbox"/> Depression screening</p> <p>4 <input type="checkbox"/> Foot</p> <p>5 <input type="checkbox"/> General physical exam</p> <p>6 <input type="checkbox"/> Neurologic</p> <p>7 <input type="checkbox"/> Pelvic</p> <p>8 <input type="checkbox"/> Rectal</p> <p>9 <input type="checkbox"/> Retinal</p> <p>10 <input type="checkbox"/> Skin</p> <p>Blood tests:</p> <p>11 <input type="checkbox"/> CBC</p> <p>12 <input type="checkbox"/> Glucose</p> <p>13 <input type="checkbox"/> HbA1c (Glycohemoglobin)</p> <p>14 <input type="checkbox"/> Lipid profile</p> <p>15 <input type="checkbox"/> PSA (prostate specific antigen)</p> <p>Imaging:</p> <p>16 <input type="checkbox"/> Bone mineral density</p> <p>17 <input type="checkbox"/> CT scan</p>	<p>18 <input type="checkbox"/> Echocardiogram</p> <p>19 <input type="checkbox"/> Other ultrasound</p> <p>20 <input type="checkbox"/> Mammography</p> <p>21 <input type="checkbox"/> MRI</p> <p>22 <input type="checkbox"/> X-ray</p> <p>Other tests and procedures:</p> <p>23 <input type="checkbox"/> Audiometry</p> <p>24 <input type="checkbox"/> Biopsy 1 <input type="checkbox"/> Provided</p> <p>25 <input type="checkbox"/> Cardiac stress test</p> <p>26 <input type="checkbox"/> Colonoscopy 1 <input type="checkbox"/> Provided</p> <p>27 <input type="checkbox"/> Chlamydia test</p> <p>28 <input type="checkbox"/> EKG/ECG</p> <p>29 <input type="checkbox"/> Electroencephalogram (EEG)</p> <p>30 <input type="checkbox"/> Electromyogram (EMG)</p> <p>31 <input type="checkbox"/> Excision of tissue 1 <input type="checkbox"/> Provided</p> <p>32 <input type="checkbox"/> Fetal monitoring</p> <p>33 <input type="checkbox"/> HIV test</p> <p>34 <input type="checkbox"/> HPV DNA test</p>	<p>35 <input type="checkbox"/> PAP test</p> <p>36 <input type="checkbox"/> Peak flow</p> <p>37 <input type="checkbox"/> Pregnancy/HCG test</p> <p>38 <input type="checkbox"/> Sigmoidoscopy 1 <input type="checkbox"/> Provided</p> <p>39 <input type="checkbox"/> Spirometry</p> <p>40 <input type="checkbox"/> Tonometry</p> <p>41 <input type="checkbox"/> Urinalysis</p> <p>Non-medication treatment:</p> <p>42 <input type="checkbox"/> Cast/splint/wrap</p> <p>43 <input type="checkbox"/> Complementary alternative medicine (CAM)</p> <p>44 <input type="checkbox"/> Durable medical equipment</p> <p>45 <input type="checkbox"/> Home health care</p> <p>46 <input type="checkbox"/> Mental health counseling, excluding psychotherapy</p> <p>47 <input type="checkbox"/> Physical therapy</p> <p>48 <input type="checkbox"/> Psychotherapy</p> <p>49 <input type="checkbox"/> Radiation therapy</p> <p>50 <input type="checkbox"/> Wound care</p>	<p>Health education:</p> <p>51 <input type="checkbox"/> Asthma</p> <p>52 <input type="checkbox"/> Asthma action plan given to patient</p> <p>53 <input type="checkbox"/> Diet/Nutrition</p> <p>54 <input type="checkbox"/> Exercise</p> <p>55 <input type="checkbox"/> Family planning/Contraception</p> <p>56 <input type="checkbox"/> Growth/Development</p> <p>57 <input type="checkbox"/> Injury prevention</p> <p>58 <input type="checkbox"/> STD Prevention</p> <p>59 <input type="checkbox"/> Stress management</p> <p>60 <input type="checkbox"/> Tobacco use/Exposure</p> <p>61 <input type="checkbox"/> Weight reduction</p> <p>Other services not listed:</p> <p>62 <input type="checkbox"/> Other service – Specify <input style="width: 50px;" type="text"/></p>
			<p>63 <input type="checkbox"/> Other service – Specify <input style="width: 50px;" type="text"/></p> <p>64 <input type="checkbox"/> Other service – Specify <input style="width: 50px;" type="text"/></p> <p>65 <input type="checkbox"/> Other service – Specify <input style="width: 50px;" type="text"/></p> <p>66 <input type="checkbox"/> Other service – Specify <input style="width: 50px;" type="text"/></p>

MEDICATIONS & IMMUNIZATIONS	PROVIDERS	DISPOSITION																																	
<p><input type="checkbox"/> NONE</p> <p>Were any prescription or non-prescription drugs ORDERED or PROVIDED (by any route of administration) at this visit? Include Rx and OTC drugs, immunizations, allergy shots, oxygen, anesthetics, chemotherapy, and dietary supplements that were ordered, supplied, administered or continued during this visit. Include drugs prescribed at a previous visit if the patient was instructed at THIS VISIT to continue with the medication.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="font-size: small;">New</th> <th style="font-size: small;">Continued</th> </tr> </thead> <tbody> <tr><td>(1)</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td></tr> <tr><td>(2)</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td></tr> <tr><td>(3)</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td></tr> <tr><td>(4)</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td></tr> <tr><td>(5)</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td></tr> <tr><td>(6)</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td></tr> <tr><td>(7)</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td></tr> <tr><td>(8)</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td></tr> <tr><td>(9)</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td></tr> <tr><td>(10)</td><td>1 <input type="checkbox"/></td><td>2 <input type="checkbox"/></td></tr> </tbody> </table>		New	Continued	(1)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(2)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(3)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(4)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(5)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(6)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(7)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(8)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(9)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	(10)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	<p>Mark (X) all providers seen at this visit. Separate with commas.</p> <p>1 <input type="checkbox"/> Physician</p> <p>2 <input type="checkbox"/> Physician assistant</p> <p>3 <input type="checkbox"/> Nurse practitioner/Midwife</p> <p>4 <input type="checkbox"/> RN/LPN</p> <p>5 <input type="checkbox"/> Mental health provider</p> <p>6 <input type="checkbox"/> Other</p> <p>7 <input type="checkbox"/> None</p>	<p>Mark (X) all that apply.</p> <p>1 <input type="checkbox"/> Refer to other physician</p> <p>2 <input type="checkbox"/> Return at specified time</p> <p>3 <input type="checkbox"/> Refer to ER/Admit to hospital</p> <p>4 <input type="checkbox"/> Other</p>
	New	Continued																																	
(1)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																																	
(2)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																																	
(3)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																																	
(4)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																																	
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(9)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																																	
(10)	1 <input type="checkbox"/>	2 <input type="checkbox"/>																																	

TESTS			
#	Was blood for the following laboratory tests drawn on the day of the sampled visit or during the 12 months prior to the visit?	Most recent result	Date of test(mm/dd/yyyy)
1	Total Cholesterol 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<input style="width: 50px;" type="text"/> mg/dL	<input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/>
2	High density lipoprotein (HDL) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<input style="width: 50px;" type="text"/> mg/dL	<input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/>
3	Low density lipoprotein (LDL) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<input style="width: 50px;" type="text"/> mg/dL	<input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/>
4	Triglycerides 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<input style="width: 50px;" type="text"/> mg/dL	<input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/>
5	HbA1c (Glycohemoglobin) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<input style="width: 50px;" type="text"/> %	<input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/>
6	Fasting blood glucose (FBG) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<input style="width: 50px;" type="text"/> mg/dL	<input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/>
7	Serum creatinine 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<input style="width: 50px;" type="text"/> mg/dL	<input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/> / <input style="width: 50px;" type="text"/>