NHAMCS-174
(10-5-2012)

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.

Date of visit
Month | Day | Year: 1

ZIP Code

Date of birth
Month | Day | Year

Age

Sex
1 ☐ Female – Is patient pregnant?
  1 ☐ Yes - *Specify gestation week* →
  OR
  LMP Month | Day | Year: 2 0 1
  2 ☐ No
  3 ☐ Unknown
2 ☐ Male

Ethnicity
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

Race
1 ☐ White
2 ☐ Black or African American
3 ☐ Asian
4 ☐ Native Hawaiian or Other Pacific Islander
5 ☐ American Indian or Alaska Native

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

Tobacco use
1 ☐ Not current
2 ☐ Current
3 ☐ Unknown

VITAL SIGNS

Height: ft | in OR cm

Weight: lb | oz OR kg | gm

Temperature: ☐ °C ☐ °F

Blood pressure: Systolic / Diastolic

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 ☐ Arthritis
2 ☐ Asthma

Asthma severity:
1 ☐ Intermittent
2 ☐ Mild persistent
3 ☐ Moderate persistent
4 ☐ Severe persistent
5 ☐ Other – *Specify*
6 ☐ None recorded

Asthma control:
1 ☐ Well controlled
2 ☐ Not well controlled
3 ☐ Very poorly controlled
4 ☐ Other – *Specify*
5 ☐ None recorded

3 ☐ Cancer
4 ☐ Cerebrovascular disease/History of stroke or transient ischemic attack (TIA)
5 ☐ Chronic obstructive pulmonary disease (COPD)
6 ☐ Chronic renal failure
7 ☐ Congestive heart failure
8 ☐ Depression
9 ☐ Diabetes
10 ☐ Hyperlipidemia
11 ☐ Hypertension
12 ☐ Ischemic heart disease
13 ☐ Obesity
14 ☐ Osteoporosis
15 ☐ None of the above

SERVICES

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

1 ☐ NONE

Examinations:

2 ☐ Breast
3 ☐ Depression screening
4 ☐ Foot
5 ☐ General physical exam
6 ☐ Neurologic
7 ☐ Pelvic
8 ☐ Rectal
9 ☐ Retinal
10 ☐ Skin

Blood tests:

11 ☐ CBC
12 ☐ Glucose
13 ☐ HbA1c (Glycohemoglobin)
14 ☐ Lipid profile
15 ☐ PSA (prostate specific antigen)

Imaging:

16 ☐ Bone mineral density
17 ☐ CT scan
18 ☐ Echocardiogram
19 ☐ Other ultrasound
20 ☐ Mammography
21 ☐ MRI
22 ☐ X-ray

Other tests and procedures:

23 ☐ Audiometry
24 ☐ Biopsy
1 ☐ Provided
25 ☐ Cardiac stress test
26 ☐ Colonoscopy
1 ☐ Provided
27 ☐ Chlamydia test
28 ☐ EKG/ECG
29 ☐ Electroencephalogram (EEG)
30 ☐ Electromyogram (EMG)
31 ☐ Excision of tissue
1 ☐ Provided
32 ☐ Fetal monitoring
33 ☐ HIV test
34 ☐ HPV DNA test
35 ☐ PAP test
36 ☐ Peak flow
37 ☐ Pregnancy/HCG test
38 ☐ Sigmoidoscopy
1 ☐ Provided
39 ☐ Spirometry
40 ☐ Tonometry
41 ☐ Urinalysis

Non-medication treatment:

42 ☐ Cast/splint/wrap
43 ☐ Complementary alternative medicine (CAM)
44 ☐ Durable medical equipment
45 ☐ Home health care
46 ☐ Mental health counseling, excluding psychotherapy
47 ☐ Physical therapy
48 ☐ Psychotherapy
49 ☐ Radiation therapy
50 ☐ Wound care

Health education:

51 ☐ Asthma
52 ☐ Asthma action plan given to patient
53 ☐ Diet/Nutrition
54 ☐ Exercise
55 ☐ Family planning/ Contraception
56 ☐ Growth/Development
57 ☐ Injury prevention
58 ☐ STD Prevention
59 ☐ Stress management
60 ☐ Tobacco use/Exposure
61 ☐ Weight reduction

Other services not listed:

62 ☐ Other service – *Specify*

63 ☐ Other service – *Specify*

64 ☐ Other service – *Specify*

65 ☐ Other service – *Specify*

66 ☐ Other service – *Specify*

MEDICATIONS & IMMUNIZATIONS

☐ NONE

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.*

		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 ☐
(9)		1 ☐	2 ☐
(10)		1 ☐	2 ☐

PROVIDERS

Mark (X) all providers seen at this visit. Separate with commas.

1 ☐ Physician
2 ☐ Physician assistant
3 ☐ Nurse practitioner/ Midwife
4 ☐ RN/LPN
5 ☐ Mental health provider
6 ☐ Other
7 ☐ None

DISPOSITION

Mark (X) all that apply.

1 ☐ Refer to other physician
2 ☐ Return at specified time
3 ☐ Refer to ER/Admit to hospital
4 ☐ Other

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 ☐ Yes → 2 ☐ None found	mg/dL	/ /
2	High density lipoprotein (HDL) 1 ☐ Yes → 2 ☐ None found	mg/dL	/ /
3	Low density lipoprotein (LDL) 1 ☐ Yes → 2 ☐ None found	mg/dL	/ /
4	Triglycerides 1 ☐ Yes → 2 ☐ None found	mg/dL	/ /
5	HbA1c (Glycohemoglobin) 1 ☐ Yes → 2 ☐ None found	%	/ /
6	Fasting blood glucose (FBG) 1 ☐ Yes → 2 ☐ None found	mg/dL	/ /
7	Serum creatinine 1 ☐ Yes → 2 ☐ None found	mg/dL	/ /