

FORM **NHAMCS-100(OPD)**
(9-22-2010)

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
2011 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 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).

(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 <input type="text"/> Day <input type="text"/> Year <input type="text"/>		d. Sex 1 <input type="checkbox"/> Female 2 <input 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 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	
b. ZIP Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		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 <input type="text"/> Day <input type="text"/> Year <input type="text"/>		f. Race – Mark (X) one or more. 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		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? 1 <input type="checkbox"/> Yes, established patient – How many past visits in the last 12 months? Exclude this visit. <input type="text"/> 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 2 <input type="checkbox"/> Asthma 3 <input type="checkbox"/> Cancer 4 <input type="checkbox"/> Cerebrovascular disease/History of stroke or transient ischemic attack (TIA) 5 <input type="checkbox"/> Chronic renal failure 6 <input type="checkbox"/> Congestive heart failure 7 <input type="checkbox"/> COPD 8 <input type="checkbox"/> Depression 9 <input type="checkbox"/> Diabetes 10 <input type="checkbox"/> Hyperlipidemia 11 <input type="checkbox"/> Hypertension 12 <input type="checkbox"/> Ischemic heart disease 13 <input type="checkbox"/> Obesity 14 <input type="checkbox"/> Osteoporosis 15 <input type="checkbox"/> None of the above		
6. VITAL SIGNS			7. DIAGNOSTIC/SCREENING SERVICES		
(1) Height <input type="text"/> ft <input type="text"/> in OR <input type="text"/> cm (2) Weight <input type="text"/> lb <input type="text"/> oz OR <input type="text"/> kg <input type="text"/> gm (3) Temperature <input type="text"/> °C <input type="checkbox"/> °F (4) Blood pressure Systolic <input type="text"/> Diastolic <input type="text"/>			Mark (X) all ordered or provided at this visit. 1 <input type="checkbox"/> NONE Examinations: 2 <input type="checkbox"/> Breast 3 <input type="checkbox"/> Foot 4 <input type="checkbox"/> Pelvic 5 <input type="checkbox"/> Rectal 6 <input type="checkbox"/> Retinal 7 <input type="checkbox"/> Skin 8 <input type="checkbox"/> Depression screening Imaging: 9 <input type="checkbox"/> X-ray 10 <input type="checkbox"/> Bone mineral density 11 <input type="checkbox"/> CT scan 12 <input type="checkbox"/> Echocardiogram 13 <input type="checkbox"/> Other ultrasound 14 <input type="checkbox"/> Mammography 15 <input type="checkbox"/> MRI 16 <input type="checkbox"/> Other imaging Blood tests: 17 <input type="checkbox"/> CBC (complete blood count) 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"/> HIV test 28 <input type="checkbox"/> HPV DNA test 29 <input type="checkbox"/> Pap test 30 <input type="checkbox"/> Pregnancy/HCG test 31 <input type="checkbox"/> Urinalysis (UA) 32 <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"/> Family planning/Contraception 6 <input type="checkbox"/> Growth/Development 7 <input type="checkbox"/> Injury prevention 8 <input type="checkbox"/> Stress management 9 <input type="checkbox"/> Tobacco use/Exposure 10 <input type="checkbox"/> Weight reduction 11 <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"/> Physical therapy 6 <input type="checkbox"/> Radiation therapy 7 <input type="checkbox"/> Speech/Occupational therapy 8 <input type="checkbox"/> Psychotherapy 9 <input type="checkbox"/> Other mental health counseling 10 <input type="checkbox"/> Excision of tissue 11 <input type="checkbox"/> Wound care 12 <input type="checkbox"/> Cast 13 <input type="checkbox"/> Splint or wrap 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
<input type="checkbox"/> NONE Include Rx and OTC drugs, immunizations, allergy shots, oxygen, anesthetics, chemotherapy, and dietary supplements that were ordered, supplied, administered or continued during this visit. (1) _____ (2) _____ (3) _____ (4) _____ (5) _____ (6) _____ (7) _____ (8) _____				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"/> Refer to other physician 2 <input type="checkbox"/> Return at specified time 3 <input type="checkbox"/> Refer to ER/Admit to hospital 4 <input type="checkbox"/> Other Continue on reverse side →
					 2300001

13. LABORATORY TEST RESULTS

Item number (a)	Were the following laboratory tests drawn within 12 months of this visit? (b)	<u>Most recent result</u> (c)	Date of the <u>most recent result</u> (mm/dd/yyyy) (d)
1	Total Cholesterol 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found within 12 months – <i>Skip to next item</i>	_____ mg/dl 1 <input type="checkbox"/> Data not available	/ / 1 <input type="checkbox"/> Data not available
2	High density lipoprotein (HDL) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found within 12 months – <i>Skip to next item</i>	_____ mg/dl 1 <input type="checkbox"/> Data not available	/ / 1 <input type="checkbox"/> Data not available
3	Low density lipoprotein (LDL) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found within 12 months – <i>Skip to next item</i>	_____ mg/dl 1 <input type="checkbox"/> Data not available	/ / 1 <input type="checkbox"/> Data not available
4	Triglycerdes 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found within 12 months – <i>Skip to next item</i>	_____ mg/dl 1 <input type="checkbox"/> Data not available	/ / 1 <input type="checkbox"/> Data not available
5	Glycohemoglobin A1c (HgbA1c) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found within 12 months – <i>Skip to next item</i>	_____ mg/dl 1 <input type="checkbox"/> Data not available	/ / 1 <input type="checkbox"/> Data not available
6	Fasting blood glucose (FBG) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found within 12 months	_____ mg/dl 1 <input type="checkbox"/> Data not available	/ / 1 <input type="checkbox"/> Data not available