

Attachment E: 2012 NAMCS Lookback Module

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OMB No. 0920-0234. Approval expires 03/31/2013.

National Ambulatory Medical Care Survey (NAMCS) - version 1.33

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NewPat_Comp Pat_Appts Asthma CAMs PRF Patient Information Vital Signs Injury or Poisoning Continuity of Care Diagnosis Services Meds Disposition Tests Lookback

♦ Collect the following data for each prior visit in the previous 12 months.

Collect up to 10 prior visits, starting with the oldest. (Exclude telephone calls, emails, and faxes).

Reference Time: 4/20/2010 - 4/20/2011

1. Enter 1 to Continue

Intro

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NewPat_Comp Pat_Appts Asthma CAMs PRF Patient Information Vital Signs Injury or Poisoning Continuity of Care Diagnosis Services Meds Disposition Tests Lookback

Reference Time: 4/20/2010 - 4/20/2011

♦ Date of visit (Format MM/DD/YYYY)

Enter 999 for no other visits

Visit Date	<input type="text"/>	Weight - Lbs	<input type="text"/>	Allergic	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	Weight - Oz	<input type="text"/>	Meds Allergic 1	
Smoke	<input type="checkbox"/>	Weight - Kg	<input type="text"/>	Meds Allergic 2	
Diagnosis	<input type="text"/>	Weight - Gm	<input type="text"/>	Meds Allergic 3	
Family History	<input type="checkbox"/>	BP - Systolic	<input type="text"/>	Meds Allergic 4	
- Male	<input type="checkbox"/>	BP - Diastolic	<input type="text"/>	Meds Allergic 5	
- Female	<input type="checkbox"/>	Services	<input type="text"/>	Meds Allergic 6	
Height - Feet	<input type="text"/>	Health Ed	<input type="text"/>	Meds Allergic 7	
Height - Inches	<input type="text"/>	Plan	<input type="text"/>	Meds Allergic 8	
Height -	<input type="text"/>	Plan - BP			
		Plan - Chol			
		Plan - BG			
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♦ Was the patient pregnant at the time of the visit?

1. Yes
 2. No

Visit Date	<input type="text"/>	Weight - Lbs	<input type="text"/>	Allergic	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	Weight - Oz	<input type="text"/>	Meds Allergic 1	
Smoke	<input type="checkbox"/>	Weight - Kg	<input type="text"/>	Meds Allergic 2	
Diagnosis	<input type="text"/>	Weight - Gm	<input type="text"/>	Meds Allergic 3	
Family History	<input type="checkbox"/>	BP - Systolic	<input type="text"/>	Meds Allergic 4	
- Male	<input type="checkbox"/>	BP - Diastolic	<input type="text"/>	Meds Allergic 5	
- Female	<input type="checkbox"/>	Services	<input type="text"/>	Meds Allergic 6	
Height - Feet	<input type="text"/>	Health Ed	<input type="text"/>	Meds Allergic 7	
Height - Inches	<input type="text"/>	Plan	<input type="text"/>	Meds Allergic 8	
Height -	<input type="text"/>	Plan - BP			
		Plan - Chol			
		Plan - BG			
		Plan - Referral			

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♦ Smoke cigarettes

1. Not current
 2. Current
 3. Unknown

Visit Date	<input type="text"/>	Weight - Lbs	<input type="text"/>	Allergic	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	Weight - Oz	<input type="text"/>	Meds Allergic 1	
Smoke	<input type="checkbox"/>	Weight - Kg	<input type="text"/>	Meds Allergic 2	
Diagnosis	<input type="text"/>	Weight - Gm	<input type="text"/>	Meds Allergic 3	
Family History	<input type="checkbox"/>	BP - Systolic	<input type="text"/>	Meds Allergic 4	
- Male	<input type="checkbox"/>	BP - Diastolic	<input type="text"/>	Meds Allergic 5	
- Female	<input type="checkbox"/>	Services	<input type="text"/>	Meds Allergic 6	
Height - Feet	<input type="text"/>	Health Ed	<input type="text"/>	Meds Allergic 7	
Height - Inches	<input type="text"/>	Plan	<input type="text"/>	Meds Allergic 8	
Height -	<input type="text"/>	Plan - BP			
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♦ Does the patient now have

Enter all that apply, separate with commas

1. NONE 7. Ischemic heart disease

2. Cerebrovascular disease/history of stroke or transient ischemic attack (TIA)

3. Congestive heart failure (CHF)

4. Diabetes

5. Hypertension

6. Hyperlipidemia

Visit Date	<input type="text"/>	Weight - Lbs	<input type="text"/>	Allergic	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	Weight - Oz	<input type="text"/>	Meds Allergic 1	
Smoke	<input type="checkbox"/>	Weight - Kg	<input type="text"/>	Meds Allergic 2	
Diagnosis	<input type="text"/>	Weight - Gm	<input type="text"/>	Meds Allergic 3	
Family History	<input type="checkbox"/>	BP - Systolic	<input type="text"/>	Meds Allergic 4	
- Male	<input type="checkbox"/>	BP - Diastolic	<input type="text"/>	Meds Allergic 5	
- Female	<input type="checkbox"/>	Services	<input type="text"/>	Meds Allergic 6	
Height - Feet	<input type="text"/>	Health Ed	<input type="text"/>	Meds Allergic 7	
Height - Inches	<input type="text"/>	Plan	<input type="text"/>	Meds Allergic 8	
Height -	<input type="text"/>	Plan - BP			
		Plan - Chol			
		Plan - BG			
		Plan - Referral			

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NAMCS FAQ Exit/F10 PRF Patient Information Vital Signs Injury or Poisoning Continuity of Care Diagnosis Services Meds Disposition Tests Lookback

♦ Does the patient have a family history of premature coronary heart disease (CHD), coronary artery disease (CAD), or ischemic heart disease (IHD)...

...in a father, son, or brother less than age 55

1. Yes 3. Unknown

2. No

Visit Date	<input type="text"/>	Weight - Lbs	<input type="text"/>	Allergic	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	Weight - Oz	<input type="text"/>	Meds Allergic 1	
Smoke	<input type="checkbox"/>	Weight - Kg	<input type="text"/>	Meds Allergic 2	
Diagnosis	<input type="text"/>	Weight - Gm	<input type="text"/>	Meds Allergic 3	
Family History	<input type="checkbox"/>	BP - Systolic	<input type="text"/>	Meds Allergic 4	
- Male	<input type="checkbox"/>	BP - Diastolic	<input type="text"/>	Meds Allergic 5	
- Female	<input type="checkbox"/>	Services	<input type="text"/>	Meds Allergic 6	
Height - Feet	<input type="text"/>	Health Ed	<input type="text"/>	Meds Allergic 7	
Height - Inches	<input type="text"/>	Plan	<input type="text"/>	Meds Allergic 8	
Height -	<input type="text"/>	Plan - BP			
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♦ Does the patient have a family history of premature coronary heart disease (CHD), coronary artery disease (CAD), or ischemic heart disease (IHD)...

...in a mother, daughter, or sister less than age 55?

1. Yes
 3. Unknown

2. No

Visit Date	<input type="text"/>	Weight - Lbs	<input type="text"/>	Allergic	<input type="text"/>
Pregnant	<input type="text"/>	Weight - Oz	<input type="text"/>	Meds Allergic 1	
Smoke	<input type="text"/>	Weight - Kg	<input type="text"/>	Meds Allergic 2	
Diagnosis	<input type="text"/>	Weight - Gm	<input type="text"/>	Meds Allergic 3	
Family History	<input type="text"/>	BP - Systolic	<input type="text"/>	Meds Allergic 4	
- Male	<input type="text"/>	BP - Diastolic	<input type="text"/>	Meds Allergic 5	
- Female	<input type="text"/>	Services	<input type="text"/>	Meds Allergic 6	
Height - Feet	<input type="text"/>	Health Ed	<input type="text"/>	Meds Allergic 7	
Height - Inches	<input type="text"/>	Plan	<input type="text"/>	Meds Allergic 8	
Height -	<input type="text"/>	Plan - BP			
		Plan - Chol			
		Plan - BG			
		Plan - Referral			

Skipping height through BP systolic screens- simply asks to fill in the number for: Height (Feet), Height (Inches), Height (Centimeters), Weight (Pounds), Weight (Ounces), Weight (Kilograms), Weight (Grams).

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♦ Blood Pressure - Systolic refers to the top number of the blood pressure measurement

Visit Date	<input type="text"/>	Weight - Lbs	<input type="text"/>	Allergic	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	Weight - Oz	<input type="text"/>	Meds Allergic 1	
Smoke	<input type="checkbox"/>	Weight - Kg	<input type="text"/>	Meds Allergic 2	
Diagnosis	<input type="text"/>	Weight - Gm	<input type="text"/>	Meds Allergic 3	
		BP - Systolic	<input type="text"/>	Meds Allergic 4	
Family History	<input type="checkbox"/>	BP - Diastolic	<input type="text"/>	Meds Allergic 5	
- Male	<input type="checkbox"/>	Services	<input type="text"/>	Meds Allergic 6	
- Female	<input type="checkbox"/>	Health Ed	<input type="text"/>	Meds Allergic 7	
Height - Feet	<input type="text"/>	Plan	<input type="text"/>	Meds Allergic 8	
Height - Inches	<input type="text"/>	Plan - BP			
Height -	<input type="text"/>	Plan - Chol			
		Plan - BG			
		Plan - Referral			

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♦ Blood pressure - Diastolic refers to the bottom number of the blood pressure measurement

Enter 998 for P, PAL, DOPP, or DOPPLER

Visit Date	<input type="text"/>	Weight - Lbs	<input type="text"/>	Allergic	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	Weight - Oz	<input type="text"/>	Meds Allergic 1	
Smoke	<input type="checkbox"/>	Weight - Kg	<input type="text"/>	Meds Allergic 2	
Diagnosis	<input type="text"/>	Weight - Gm	<input type="text"/>	Meds Allergic 3	
		BP - Systolic	<input type="text"/>	Meds Allergic 4	
Family History	<input type="checkbox"/>	BP - Diastolic	<input type="text"/>	Meds Allergic 5	
- Male	<input type="checkbox"/>	Services	<input type="text"/>	Meds Allergic 6	
- Female	<input type="checkbox"/>	Health Ed	<input type="text"/>	Meds Allergic 7	
Height - Feet	<input type="text"/>	Plan	<input type="text"/>	Meds Allergic 8	
Height - Inches	<input type="text"/>	Plan - BP			
Height -	<input type="text"/>	Plan - Chol			
		Plan - BG			
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Services

Enter all that apply, separate with commas

1. NONE
 2. Lipids/cholesterol
 3. HbA1c (Glycohemoglobin A1c)
 4. Fasting blood glucose (FBG)
 5. Creatinine
 6. Potassium
 7. Sodium
 8. AST/ALT
 9. Basic metabolic panel
 10. Comprehensive metabolic panel (CMP)

Visit Date	<input type="text"/>	Weight - Lbs	<input type="text"/>	Allergic	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	Weight - Oz	<input type="text"/>	Meds Allergic 1	
Smoke	<input type="checkbox"/>	Weight - Kg	<input type="text"/>	Meds Allergic 2	
Diagnosis	<input type="text"/>	Weight - Gm	<input type="text"/>	Meds Allergic 3	
Family History	<input type="checkbox"/>	BP - Systolic	<input type="text"/>	Meds Allergic 4	
- Male	<input type="checkbox"/>	BP - Diastolic	<input type="text"/>	Meds Allergic 5	
- Female	<input type="checkbox"/>	Services	<input type="text"/>	Meds Allergic 6	
Height - Feet	<input type="text"/>	Health Ed	<input type="text"/>	Meds Allergic 7	
Height - Inches	<input type="text"/>	Plan	<input type="text"/>	Meds Allergic 8	
Height -	<input type="text"/>	Plan - BP			
		Plan - Chol			
		Plan - BG			
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Health education/counseling

Enter all that apply, separate with commas

1. NONE
 2. Diet/Nutrition-Reduce fat/cholesterol
 3. Diet/Nutrition-Reduce salt/sodium
 4. Weight or caloric reduction
 5. Exercise
 6. Smoking cessation

Visit Date	<input type="text"/>	Weight - Lbs	<input type="text"/>	Allergic	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	Weight - Oz	<input type="text"/>	Meds Allergic 1	
Smoke	<input type="checkbox"/>	Weight - Kg	<input type="text"/>	Meds Allergic 2	
Diagnosis	<input type="text"/>	Weight - Gm	<input type="text"/>	Meds Allergic 3	
Family History	<input type="checkbox"/>	BP - Systolic	<input type="text"/>	Meds Allergic 4	
- Male	<input type="checkbox"/>	BP - Diastolic	<input type="text"/>	Meds Allergic 5	
- Female	<input type="checkbox"/>	Services	<input type="text"/>	Meds Allergic 6	
Height - Feet	<input type="text"/>	Health Ed	<input type="text"/>	Meds Allergic 7	
Height - Inches	<input type="text"/>	Plan	<input type="text"/>	Meds Allergic 8	
Height -	<input type="text"/>	Plan - BP			
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		Plan - Referral			

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♦ Assessment and plan

Enter all that apply, separate with commas

1. NONE
 2. Blood pressure assessment and plan
 3. Cholesterol assessment and plan
 4. Blood glucose assessment and plan
 5. Referral

Visit Date	<input type="text"/>	Weight - Lbs	<input type="text"/>	Allergic	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	Weight - Oz	<input type="text"/>	Meds Allergic 1	
Smoke	<input type="checkbox"/>	Weight - Kg	<input type="text"/>	Meds Allergic 2	
Diagnosis	<input type="text"/>	Weight - Gm	<input type="text"/>	Meds Allergic 3	
Family History	<input type="checkbox"/>	BP - Systolic	<input type="text"/>	Meds Allergic 4	
- Male	<input type="checkbox"/>	BP - Diastolic	<input type="text"/>	Meds Allergic 5	
- Female	<input type="checkbox"/>	Services	<input type="text"/>	Meds Allergic 6	
Height - Feet	<input type="text"/>	Health Ed	<input type="text"/>	Meds Allergic 7	
Height - Inches	<input type="text"/>	Plan	<input type="text"/>	Meds Allergic 8	
Height -	<input type="text"/>	Plan - BP	<input type="text"/>		
		Plan - Chol	<input type="text"/>		
		Plan - BG	<input type="text"/>		
		Plan - Referral	<input type="text"/>		

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♦ Assessment and plan - blood pressure

Enter all that apply, separate with commas

1. Controlled
 2. Elevated or uncontrolled
 3. Medication being titrated
 4. Ambulatory/home blood pressure monitoring normal
 5. Patient nonadherence

Visit Date	<input type="text"/>	Weight - Lbs	<input type="text"/>	Allergic	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	Weight - Oz	<input type="text"/>	Meds Allergic 1	
Smoke	<input type="checkbox"/>	Weight - Kg	<input type="text"/>	Meds Allergic 2	
Diagnosis	<input type="text"/>	Weight - Gm	<input type="text"/>	Meds Allergic 3	
Family History	<input type="checkbox"/>	BP - Systolic	<input type="text"/>	Meds Allergic 4	
- Male	<input type="checkbox"/>	BP - Diastolic	<input type="text"/>	Meds Allergic 5	
- Female	<input type="checkbox"/>	Services	<input type="text"/>	Meds Allergic 6	
Height - Feet	<input type="text"/>	Health Ed	<input type="text"/>	Meds Allergic 7	
Height - Inches	<input type="text"/>	Plan	2,3,4,5	Meds Allergic 8	
Height -	<input type="text"/>	Plan - BP	<input type="text"/>		
		Plan - Chol	<input type="text"/>		
		Plan - BG	<input type="text"/>		
		Plan - Referral	<input type="text"/>		

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♦ **Assessment and plan - cholesterol**

Enter all that apply, separate with commas

1. Controlled 3. Medication being titrated

2. Elevated or uncontrolled 4. Patient nonadherence

Visit Date	<input type="text"/>	Weight - Lbs	<input type="text"/>	Allergic	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	Weight - Oz	<input type="text"/>	Meds Allergic 1	
Smoke	<input type="checkbox"/>	Weight - Kg	<input type="text"/>	Meds Allergic 2	
Diagnosis	<input type="text"/>	Weight - Gm	<input type="text"/>	Meds Allergic 3	
		BP - Systolic	<input type="text"/>	Meds Allergic 4	
Family History	<input type="checkbox"/>	BP - Diastolic	<input type="text"/>	Meds Allergic 5	
- Male	<input type="checkbox"/>	Services	<input type="text"/>	Meds Allergic 6	
- Female	<input type="checkbox"/>	Health Ed	<input type="text"/>	Meds Allergic 7	
		Plan	2,3,4,5	Meds Allergic 8	
Height - Feet	<input type="text"/>	Plan - BP	<input type="text"/>		
Height - Inches	<input type="text"/>	Plan - Chol	<input type="text"/>		
Height -	<input type="text"/>	Plan - BG	<input type="text"/>		
		Plan - Referral	<input type="text"/>		

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♦ **Assessment and plan - blood glucose**

Enter all that apply, separate with commas

1. Controlled 3. Medication being titrated

2. Elevated or uncontrolled 4. Patient nonadherence

Visit Date	<input type="text"/>	Weight - Lbs	<input type="text"/>	Allergic	<input type="checkbox"/>
Pregnant	<input type="checkbox"/>	Weight - Oz	<input type="text"/>	Meds Allergic 1	
Smoke	<input type="checkbox"/>	Weight - Kg	<input type="text"/>	Meds Allergic 2	
Diagnosis	<input type="text"/>	Weight - Gm	<input type="text"/>	Meds Allergic 3	
		BP - Systolic	<input type="text"/>	Meds Allergic 4	
Family History	<input type="checkbox"/>	BP - Diastolic	<input type="text"/>	Meds Allergic 5	
- Male	<input type="checkbox"/>	Services	<input type="text"/>	Meds Allergic 6	
- Female	<input type="checkbox"/>	Health Ed	<input type="text"/>	Meds Allergic 7	
		Plan	2,3,4,5	Meds Allergic 8	
Height - Feet	<input type="text"/>	Plan - BP	<input type="text"/>		
Height - Inches	<input type="text"/>	Plan - Chol	<input type="text"/>		
Height -	<input type="text"/>	Plan - BG	<input type="text"/>		
		Plan - Referral	<input type="text"/>		

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♦ **Assessment and plan - referral**

Enter all that apply, separate with commas

1. Nurse management

2. Nutritionist

3. Smoking-cessation program

4. Weight loss program

5. Other physician, including primary care provider

Visit Date <input style="width: 80%;" type="text"/> Pregnant <input type="checkbox"/> Smoke <input type="checkbox"/> Diagnosis <input style="width: 80%;" type="text"/> Family History <input type="checkbox"/> - Male <input type="checkbox"/> - Female <input type="checkbox"/> Height - Feet <input type="checkbox"/> Height - Inches <input type="checkbox"/> Height - <input type="checkbox"/>	Weight - Lbs <input style="width: 80%;" type="text"/> Weight - Oz <input style="width: 80%;" type="text"/> Weight - Kg <input style="width: 80%;" type="text"/> Weight - Gm <input style="width: 80%;" type="text"/> BP - Systolic <input style="width: 80%;" type="text"/> BP - Diastolic <input style="width: 80%;" type="text"/> Services <input style="width: 80%;" type="text"/> Health Ed <input style="width: 80%;" type="text"/> Plan <input type="text" value="2,3,4,5"/> Plan - BP <input style="width: 80%;" type="text"/> Plan - Chol <input style="width: 80%;" type="text"/> Plan - BG <input style="width: 80%;" type="text"/> Plan - Referral <input style="width: 80%;" type="text"/>	Allergic <input type="checkbox"/> Meds Allergic 1 <input type="checkbox"/> Meds Allergic 2 <input type="checkbox"/> Meds Allergic 3 <input type="checkbox"/> Meds Allergic 4 <input type="checkbox"/> Meds Allergic 5 <input type="checkbox"/> Meds Allergic 6 <input type="checkbox"/> Meds Allergic 7 <input type="checkbox"/> Meds Allergic 8 <input type="checkbox"/>
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♦ **Is patient allergic to any medication, e.g., bleeding from aspirin?**

1. Yes 3. Unknown

2. No

Visit Date <input style="width: 80%;" type="text"/> Pregnant <input type="checkbox"/> Smoke <input type="checkbox"/> Diagnosis <input style="width: 80%;" type="text"/> Family History <input type="checkbox"/> - Male <input type="checkbox"/> - Female <input type="checkbox"/> Height - Feet <input type="checkbox"/> Height - Inches <input type="checkbox"/> Height - <input type="checkbox"/>	Weight - Lbs <input style="width: 80%;" type="text"/> Weight - Oz <input style="width: 80%;" type="text"/> Weight - Kg <input style="width: 80%;" type="text"/> Weight - Gm <input style="width: 80%;" type="text"/> BP - Systolic <input style="width: 80%;" type="text"/> BP - Diastolic <input style="width: 80%;" type="text"/> Services <input style="width: 80%;" type="text"/> Health Ed <input style="width: 80%;" type="text"/> Plan <input type="text" value="2,3,4,5"/> Plan - BP <input style="width: 80%;" type="text"/> Plan - Chol <input style="width: 80%;" type="text"/> Plan - BG <input style="width: 80%;" type="text"/> Plan - Referral <input style="width: 80%;" type="text"/>	Allergic <input type="checkbox"/> Meds Allergic 1 <input type="checkbox"/> Meds Allergic 2 <input type="checkbox"/> Meds Allergic 3 <input type="checkbox"/> Meds Allergic 4 <input type="checkbox"/> Meds Allergic 5 <input type="checkbox"/> Meds Allergic 6 <input type="checkbox"/> Meds Allergic 7 <input type="checkbox"/> Meds Allergic 8 <input type="checkbox"/>
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National Ambulatory Medical Care Survey (NAMCS) - version 1.33
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♦ Enter medication(s) patient is allergic or intolerant to

Visit Date	<input type="text"/>	Weight - Lbs	<input type="text"/>	Allergic	<input type="text" value="1"/>
Pregnant	<input type="checkbox"/>	Weight - Oz	<input type="text"/>	Meds Allergic 1	<input type="text"/>
Smoke	<input type="checkbox"/>	Weight - Kg	<input type="text"/>	Meds Allergic 2	<input type="text"/>
Diagnosis	<input type="text"/>	Weight - Gm	<input type="text"/>	Meds Allergic 3	<input type="text"/>
Family History	<input type="checkbox"/>	BP - Systolic	<input type="text"/>	Meds Allergic 4	<input type="text"/>
- Male	<input type="checkbox"/>	BP - Diastolic	<input type="text"/>	Meds Allergic 5	<input type="text"/>
- Female	<input type="checkbox"/>	Services	<input type="text"/>	Meds Allergic 6	<input type="text"/>
Height - Feet	<input type="text"/>	Health Ed	<input type="text"/>	Meds Allergic 7	<input type="text"/>
Height - Inches	<input type="text"/>	Plan	<input type="text" value="2,3,4,5"/>	Meds Allergic 8	<input type="text"/>
Height -	<input type="text"/>	Plan - BP	<input type="text"/>		
		Plan - Chol	<input type="text"/>		
		Plan - BG	<input type="text"/>		
		Plan - Referral	<input type="text"/>		

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Date of visit: 1/1/2011

♦ List all prescription and over-the-counter (OTC) medications and immunizations ordered, administered, or continued during this visit.

Enter 0 for no more

	Meds/Immunizations	New/Continued	Dose
[1]	<input type="text"/>	<input type="text"/>	
[2]			
[3]			
[4]			
[5]			
[6]			
[7]			
[8]			
[9]			
[10]			
[11]			
[12]			
[13]			
[14]			
[15]			

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NewPat_Comp | Pat_Appts | Asthma | CAMs | PRF | Patient Information | Vital Signs | Injury or Poisoning | Continuity of Care | Diagnosis | Services | Meds | Disposition | Tests | Lookback

♦ Now you will be collecting laboratory test results for certain tests performed within the 15 months before the sampled visit (4/20/2011).

Collect up to 15 results for each type of test, starting with the oldest.

Reference Time: 1/15/2010 - 4/20/2011

0 1. Enter 1 to Continue

Intro for Tests

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♦ Was a total cholesterol test performed within the 15 months before 4/19/2011?
 Reference Time: 1/14/2010 - 4/19/2011

1. Yes
 2. None found

Cholesterol

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♦ Total cholesterol result (Start with the oldest test)
 Enter '999' for no more

	Visit Date	Reference Time	Chol Results	Chol Date
[1]	4/19/2011	1/14/2010	<input type="text"/>	<input type="text"/>
[2]				
[3]				
[4]				
[5]				
[6]				
[7]				
[8]				
[9]				
[10]				
[11]				
[12]				
[13]				
[14]				
[15]				

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♦ Was a high density lipoprotein (HDL) test performed within the 15 months before 4/19/2011?

Reference Time: 1/14/2010 - 4/19/2011

1. Yes
 2. None found

HDL

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♦ Total high density lipoprotein (HDL) result (Start with the oldest test)

Enter '999' for no more

	Visit Date	Reference Time	HDL Results	HDL Date
[1]	4/19/2011	1/14/2010	<input type="text"/>	<input type="text"/>
[2]				
[3]				
[4]				
[5]				
[6]				
[7]				
[8]				
[9]				
[10]				
[11]				
[12]				
[13]				
[14]				
[15]				

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♦ Was a low density lipoprotein (LDL) test performed within the 15 months before 4/19/2011?

Reference Time: 1/14/2010 - 4/19/2011

1. Yes
 2. None found

LDL

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NAMCS | FAQ | Exit/F10 | PRF | Patient Information | Vital Signs | Injury or Poisoning | Continuity of Care | Diagnosis | Services | Meds | Disposition | Tests | Lookback

♦ Total low density lipoprotein (LDL) result (Start with the oldest test)

Enter '999' for no more

	Visit Date	Reference Time	LDL Results	LDL Date
[1]	4/19/2011	1/14/2010	<input type="text"/>	<input type="text"/>
[2]				
[3]				
[4]				
[5]				
[6]				
[7]				
[8]				
[9]				
[10]				
[11]				
[12]				
[13]				
[14]				
[15]				

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♦ Was a triglycerides test performed within the 15 months before 4/19/2011?

Reference Time: 1/14/2010 - 4/19/2011

1. Yes
 2. None found

TGS

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NAMCS | FAQ | Exit/F10 | PRF | Patient Information | Vital Signs | Injury or Poisoning | Continuity of Care | Diagnosis | Services | Meds | Disposition | Tests | Lookback

♦ Total triglycerides result (Start with the oldest test)

Enter '999' for no more

	Visit Date	Reference Time	TGS Results	TGS Date
[1]	4/19/2011	1/14/2010	<input type="text"/>	<input type="text"/>
[2]				
[3]				
[4]				
[5]				
[6]				
[7]				
[8]				
[9]				
[10]				
[11]				
[12]				
[13]				
[14]				
[15]				

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♦ Was a glycohemoglobin A1c (HbA1c) test performed within the 15 months before 4/19/2011?

Reference Time: 1/14/2010 - 4/19/2011

1. Yes
 2. None found

A1C

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1 First 2 Prev 3 Next 4 Last 5 Add 6 Delete Z Exit

NAMCS FAQ Exit/F10 PRF Patient Information Vital Signs Injury or Poisoning Continuity of Care Diagnosis Services Meds Disposition Tests Lookback

♦ Total Glycohemoglobin A1c(HbA1c) result (Start with the oldest test)

Enter '99' for no more

	Visit Date	Reference Time	A1C Results	A1C Date
[1]	4/19/2011	1/14/2010	<input type="text"/>	<input type="text"/>
[2]				
[3]				
[4]				
[5]				
[6]				
[7]				
[8]				
[9]				
[10]				
[11]				
[12]				
[13]				
[14]				
[15]				

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NAMCS FAQ Exit/F10 PRF Patient Information Vital Signs Injury or Poisoning Continuity of Care Diagnosis Services Meds Disposition Tests Lookback

♦ Was a fasting blood glucose (FBG) test performed within the 15 months before 4/19/2011?

Reference Time: 1/14/2010 - 4/19/2011

1. Yes
 2. None found

FBG

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NAMCS FAQ Exit/F10 PRF Patient Information Vital Signs Injury or Poisoning Continuity of Care Diagnosis Services Meds Disposition Tests Lookback

♦ Total fasting blood glucose result (Start with the oldest test)

Enter '999' for no more

	Visit Date	Reference Time	FBG Results	FBG Date
[1]	4/19/2011	1/14/2010	<input type="text"/>	<input type="text"/>
[2]				
[3]				
[4]				
[5]				
[6]				
[7]				
[8]				
[9]				
[10]				
[11]				
[12]				
[13]				
[14]				
[15]				