

**NHAMCS-910**  
(4-27-2011)



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

**PRETEST**

**2011**  
**National Hospital**  
**Ambulatory Medical**  
**Care Survey**

**LOOK**  
**BACK**  
**MODULE**

For each prior visit in the previous 12 months, starting with the oldest visit, up to 10 prior visits, collect the following additional data (exclude telephone calls, emails, and faxes):

<b>a. Date of visit</b>			<b>b. If female age 18-50: Pregnant</b>			<b>c. Vital signs</b>		
Month	Day	Year	1 <input type="checkbox"/> Yes - If yes, do not abstract any information for this visit. Continue to the next visit, and check pregnancy status then. 2 <input type="checkbox"/> No - If no, continue to abstract the rest of the data for this visit.			<b>(1) Blood pressure</b> Systolic: <input type="text"/> / <input type="text"/> Diastolic: <input type="text"/> <b>(2) Height</b> <input type="text"/> ft <input type="text"/> in OR <input type="text"/> cm <b>(3) Weight</b> <input type="text"/> lb <input type="text"/> oz OR <input type="text"/> kg <input type="text"/> gm		
<input type="text"/>	<input type="text"/>	<input type="text"/>						

<b>d. Risk factors - Mark (X) all that apply.</b> 1 <input type="checkbox"/> None 2 <input type="checkbox"/> Family history of coronary heart disease (CHD) in first degree relative — a. In father, son, brother < age 55 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown b. In mother, daughter, sister < age 65 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Cerebrovascular disease/history of stroke or transient ischemic attack (TIA) 4 <input type="checkbox"/> Congestive heart failure (CHF) 5 <input type="checkbox"/> Diabetes 6 <input type="checkbox"/> Hyperlipidemia 7 <input type="checkbox"/> Hypertension 8 <input type="checkbox"/> Ischemic heart disease 9 <input type="checkbox"/> Smoking status 1 <input type="checkbox"/> Not current 2 <input type="checkbox"/> Current 3 <input type="checkbox"/> Unknown	<b>e. Documentation of health education/counseling - Mark (X) all ordered or provided at this visit.</b> 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> Diet/Nutrition-Reduce fat/Cholesterol 3 <input type="checkbox"/> Diet/Nutrition-Reduce salt/sodium 4 <input type="checkbox"/> Exercise 5 <input type="checkbox"/> Smoking cessation 6 <input type="checkbox"/> Weight or caloric reduction	<b>f. Contraindications to appropriate med.</b> <b>Is patient allergic or intolerant to any medication, e.g., bleeding from aspirin?</b> 1 <input type="checkbox"/> Yes - If yes, which medication(s): <input style="width:100%; height:20px;" type="text"/> <input style="width:100%; height:20px;" type="text"/> <input style="width:100%; height:20px;" type="text"/> 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown
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<b>g. Laboratory tests ordered</b> 1 <input type="checkbox"/> Lipids/cholesterol 2 <input type="checkbox"/> HgbA1C (Glycohemoglobin A1C) 3 <input type="checkbox"/> Fasting blood glucose (FBG) 4 <input type="checkbox"/> Creatinine 5 <input type="checkbox"/> Potassium 6 <input type="checkbox"/> Sodium 7 <input type="checkbox"/> AST/ALT 8 <input type="checkbox"/> Basic metabolic panel 9 <input type="checkbox"/> Comprehensive metabolic panel (CMP)	<b>h. Assessment and Plan Mark (X) all that apply.</b> 1 <input type="checkbox"/> None 2 <input type="checkbox"/> Blood pressure a <input type="checkbox"/> Controlled b <input type="checkbox"/> Elevated or uncontrolled c <input type="checkbox"/> Medication being titrated d <input type="checkbox"/> Ambulatory/home blood pressure monitoring normal e <input type="checkbox"/> Patient nonadherence 3 <input type="checkbox"/> Cholesterol a <input type="checkbox"/> Controlled b <input type="checkbox"/> Elevated or uncontrolled c <input type="checkbox"/> Medication being titrated d <input type="checkbox"/> Patient nonadherence 4 <input type="checkbox"/> Blood glucose a <input type="checkbox"/> Controlled b <input type="checkbox"/> Elevated or uncontrolled c <input type="checkbox"/> Medication being titrated d <input type="checkbox"/> Patient nonadherence 5 <input type="checkbox"/> Blood glucose a <input type="checkbox"/> Nurse management b <input type="checkbox"/> Nutritionist c <input type="checkbox"/> Smoking-cessation program d <input type="checkbox"/> Weight loss Program e <input type="checkbox"/> Other physician, including primary care provider
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**i. Medications and immunizations prescribed - List all prescription and over-the-counter (OTC) medications and immunizations ordered, and administered, or continued during this visit if continued mark a, b, c, d, Discontinued or e. Not mentioned:**

	1 <input type="checkbox"/> NONE				1 <input type="checkbox"/> NONE		
	New	Continued	If continued then mark a, b, c, d, or e		New	Continued	If continued then mark a, b, c, d, or e
(1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	(1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
(2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	(2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
(3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	(3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
(4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	(4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
(5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	(5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
(6)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	(6)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
(7)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	(7)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
(8)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	(8)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
(9)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	(9)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
(10)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	(10)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
(11)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	(11)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
(12)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	(12)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
(13)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	(13)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
(14)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	(14)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
(15)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	(15)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

**LABORATORY TEST RESULTS** – Enter up to six separate lab tests.

Date of 1 <sup>st</sup> Lab test in the previous 15 months: (mm/dd/yyyy) <div style="text-align: center; border: 1px solid black; width: 100px; height: 30px; margin: 5px auto;">/ /</div> <input type="checkbox"/> Data not available			Date of 2 <sup>nd</sup> Lab test in the previous 15 months: (mm/dd/yyyy) <div style="text-align: center; border: 1px solid black; width: 100px; height: 30px; margin: 5px auto;">/ /</div> <input type="checkbox"/> Data not available			Date of 3 <sup>rd</sup> Lab test in the previous 15 months: (mm/dd/yyyy) <div style="text-align: center; border: 1px solid black; width: 100px; height: 30px; margin: 5px auto;">/ /</div> <input type="checkbox"/> Data not available		
Item number	LAB TEST	Mg/dl	Item number	LAB TEST	Mg/dl	Item number	LAB TEST	Mg/dl
1	Total cholesterol	<input style="width: 80%;" type="text"/> mg/dl	1	Total cholesterol	<input style="width: 80%;" type="text"/> mg/dl	1	Total cholesterol	<input style="width: 80%;" type="text"/> mg/dl
2	High density lipoprotein (HDL)	<input style="width: 80%;" type="text"/> mg/dl	2	High density lipoprotein (HDL)	<input style="width: 80%;" type="text"/> mg/dl	2	High density lipoprotein (HDL)	<input style="width: 80%;" type="text"/> mg/dl
3	Low density lipoprotein (LDL)	<input style="width: 80%;" type="text"/> mg/dl	3	Low density lipoprotein (LDL)	<input style="width: 80%;" type="text"/> mg/dl	3	Low density lipoprotein (LDL)	<input style="width: 80%;" type="text"/> mg/dl
4	Triglycerides	<input style="width: 80%;" type="text"/> mg/dl	4	Triglycerides	<input style="width: 80%;" type="text"/> mg/dl	4	Triglycerides	<input style="width: 80%;" type="text"/> mg/dl
5	Glycohemoglobin A1c (HgbA1c)	<input style="width: 80%;" type="text"/> mg/dl	5	Glycohemoglobin A1c (HgbA1c)	<input style="width: 80%;" type="text"/> mg/dl	5	Glycohemoglobin A1c (HgbA1c)	<input style="width: 80%;" type="text"/> mg/dl
6	Fasting blood glucose (FBG)	<input style="width: 80%;" type="text"/> mg/dl	6	Fasting blood glucose (FBG)	<input style="width: 80%;" type="text"/> mg/dl	6	Fasting blood glucose (FBG)	<input style="width: 80%;" type="text"/> mg/dl
Date of 4 <sup>th</sup> Lab test in the previous 15 months: (mm/dd/yyyy) <div style="text-align: center; border: 1px solid black; width: 100px; height: 30px; margin: 5px auto;">/ /</div> <input type="checkbox"/> Data not available			Date of 5 <sup>th</sup> Lab test in the previous 15 months: (mm/dd/yyyy) <div style="text-align: center; border: 1px solid black; width: 100px; height: 30px; margin: 5px auto;">/ /</div> <input type="checkbox"/> Data not available			Date of 6 <sup>th</sup> Lab test in the previous 15 months: (mm/dd/yyyy) <div style="text-align: center; border: 1px solid black; width: 100px; height: 30px; margin: 5px auto;">/ /</div> <input type="checkbox"/> Data not available		
Item number	LAB TEST	Mg/dl	Item number	LAB TEST	Mg/dl	Item number	LAB TEST	Mg/dl
1	Total cholesterol	<input style="width: 80%;" type="text"/> mg/dl	1	Total cholesterol	<input style="width: 80%;" type="text"/> mg/dl	1	Total cholesterol	<input style="width: 80%;" type="text"/> mg/dl
2	High density lipoprotein (HDL)	<input style="width: 80%;" type="text"/> mg/dl	2	High density lipoprotein (HDL)	<input style="width: 80%;" type="text"/> mg/dl	2	High density lipoprotein (HDL)	<input style="width: 80%;" type="text"/> mg/dl
3	Low density lipoprotein (LDL)	<input style="width: 80%;" type="text"/> mg/dl	3	Low density lipoprotein (LDL)	<input style="width: 80%;" type="text"/> mg/dl	3	Low density lipoprotein (LDL)	<input style="width: 80%;" type="text"/> mg/dl
4	Triglycerides	<input style="width: 80%;" type="text"/> mg/dl	4	Triglycerides	<input style="width: 80%;" type="text"/> mg/dl	4	Triglycerides	<input style="width: 80%;" type="text"/> mg/dl
5	Glycohemoglobin A1c (HgbA1c)	<input style="width: 80%;" type="text"/> mg/dl	5	Glycohemoglobin A1c (HgbA1c)	<input style="width: 80%;" type="text"/> mg/dl	5	Glycohemoglobin A1c (HgbA1c)	<input style="width: 80%;" type="text"/> mg/dl
6	Fasting blood glucose (FBG)	<input style="width: 80%;" type="text"/> mg/dl	6	Fasting blood glucose (FBG)	<input style="width: 80%;" type="text"/> mg/dl	6	Fasting blood glucose (FBG)	<input style="width: 80%;" type="text"/> mg/dl
Notes								