SAMPLE  
NATIONAL AMBULATORY MEDICAL CARE SURVEY

**Attachment D2: 2015 Patient Record form (NAMCS-30), sample card**

PATIENT RECORD

2015

OMB No. 0920-0234; Expiration date XX/XX/20XX

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **NOTICE-**Public reporting burden for this collection of information is estimated to average 14 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.  An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a current valid OMB control number.  Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden to:  CDC/ATSDR Information Collection Review Office, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN:  PRA (0920-0234).  **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’s medical record #** | | | | | | | | | | | | | | | | **PTMEDRECNUM / ENTER\_PTMEDRECNUM** | | | | | | | | | **Zip Code** | | | | | | | | | | | **PATZIP** | | |
| **Date of Visit VDATE** | | | | | | | | | | | | | | | | | | | | **Sex SEX**  1  Female – **Is patient pregnant?**  **PREG**  1  Yes – **Specify gestation**   |  | | --- | | **GESTWK** |   **week**  2  No  2  Male  **Ethnicity ETHNIC**  1  Hispanic or Latino  2  Not Hispanic or Latino | | | | | | | **Race –** *Mark (X) all that apply*. | | | | | | **Expected source(s) of payment for this visit –** *Mark (X) all that apply*.  **PAY\_SOURCE1-8**  1  Private insurance  2  Medicare  3  Medicaid or CHIP or other state-based program  4  Workers’ compensation  5  Self-pay  6  No charge/Charity  7  Other  8  Unknown | | | | | **Tobacco use**  **USETOBAC**  1  Not current  2  Current  3  Unknown  **EVERTOBAC**  1  Never  2  Former  3  unknown |
| Month | | | | Day | | | | | | Year | | | | | | | | | | 1  White  2  Black or African  American  3  Asian  4  Native Hawaiian or  Other Pacific Islander  5  American Indian or Alaska Native | | | | | |
|  | |  | |  | | | |  | | **2** | | **0** | | | **1** | | | |  |
| **Date of Birth BDATE** | | | | | | | | | | | | | | | | | | | |
| Month | | | | | Day | | | | | | Year | | | | | | | | |
|  |  | | | |  | | |  | | |  | |  | |  | | |  | |
| **Age AGE/AGET**   |  | | --- | |  |   1  Years  2  Months  3  Days | | | | | | | | | | | | | | | | | | | |
| BIOMETRICS/VITAL SIGNS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Height**   |  |  |  |  | | --- | --- | --- | --- | | **HTFT** | ft | **HTINCG** | in |   **OR**   |  |  |  | | --- | --- | --- | |  | **HTCM** | cm | | | | | | | | | | | | | | | | | | | | | | | **Weight**   |  |  |  |  | | --- | --- | --- | --- | | **WTLBCG** | lb | **WTOZ** | oz |   **OR**   |  |  |  |  | | --- | --- | --- | --- | | **WTKG** | kg | **WTGM** | gm | | | | | | | **Temperature**   |  |  |  | | --- | --- | --- | | **TEMP** |  |  | |  |  |  | | | | | | | | **Blood pressure**   |  |  |  | | --- | --- | --- | | Systolic |  | Diastolic | | **BPSYS** | / | **BPDIAS** |   Enter 998 for P, Palp, Dopp, or Doppler | | | |
| REASON FOR VISIT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **List the first 5 reasons for visit (i.e., complaint(s), symptom(s), problem(s), concern(s) of the patient in the order in which they appear. Start with the chief complaint and then move to the patient history for additional reasons.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Major reason for this visit MAJOR**  1  New problem (<3 mos. onset)  2  Chronic problem, routine  3  Chronic problem, flare-up  4  Pre-surgery  5  Post-surgery  6  Preventive care (e.g., routine, prenatal, well-baby, screening, insurance, general exams) | | | | | | | |
| First: | | | | | | 1. **VRFV1 / VRFV1\_LKUP** | | | | | | | | | | | | | | | | | | | | | | | |  |
| Other: | | | | | | 2. **VRFV2 / VRFV2\_LKUP** | | | | | | | | | | | | | | | | | | | | | | | |  |
| Other: | | | | | | 3. **VRFV3 / VRFV3\_LKUP** | | | | | | | | | | | | | | | | | | | | | | | |  |
| Other: | | | | | | 4. **VRFV4 / VRFV4\_LKUP** | | | | | | | | | | | | | | | | | | | | | | | |  |
| Other: | | | | | | 5. **VRFV5 / VRFV5\_LKUP** | | | | | | | | | | | | | | | | | | | | | | | |  |
| INJURY/TRAUMA/OVERDOSE/POISONING/ADVERSE EFFECT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Is this visit related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment?**  1  Yes, injury/trauma **INJURY**  2  Yes,overdose/poisoning  3  Yes, adverse effect of medical or surgical   treatment or adverse effect of medicinal drug  4  No  5  Unknown | | | | | | | | | | | | | | | | | | | | | | | **Did the injury/trauma, overdose/poisoning, or adverse effect occur within 72 hours prior to the date and time of this visit?**  **INJURY72**  1  Yes  2  No  3  Unknown  4  Not applicable | | | | | | | | | | | **Is this injury/trauma or overdose/poisoning intentional or unintentional?**  **INTENTO**  1  Intentional  2  Unintentional (e.g., accidental)  3  Intent unclear | | | | |
| **What was the intent of the injury/trauma or overdose/poisoning?**  **INTENTYP**  1  Suicide attempt with intent to die  2  Intentional self-harm without intent to die  3  Unclear if suicide attempt or intentional self-harm without intent to die  4  Intentional harm inflicted by another person (e.g., assault, poisoning)  5  Intent unclear | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Cause of injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment—** Describe the place and circumstances that preceded the injury/trauma, overdose/poisoning, or adverse effect.  Examples:   1. Injury/Trauma (e.g., patient fell while walking down stairs at home and sprained her ankle; patient was bitten by a spider) 2. Overdose/Poisoning (e.g., child was given adult cold/cough medicine and became lethargic; child swallowed large amount of liquid cleanser and began vomiting) 3. Adverse effect (e.g., patient developed a rash on his arm 2 days after taking penicillin for an ear infection) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | **VCAUSE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| CONTINUITY OF CARE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Are you the patient’s primary care provider? PRIMCARE**  1  Yes  2  No  3  Unknown  **Was patient referred for this visit? REFER**  1  Yes  2  No  3  Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | **Has the patient been seen in this practice before? SENBEFOR**  1  Yes, established patient  **How many past visits in the last 12 months?**  **(**Exclude this visit.)   |  |  | | --- | --- | | **PASTVIS** | Visits |   Enter F5 if unknown  2  No, new patient | | | | | | | | | | | | |
| PROVIDER’S DIAGNOSIS FOR THIS VISIT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **As specifically as possible, list all diagnoses related to this visit, including chronic conditions.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary: | | | | | | | **1.** | | **VDIAG1 / VDIAG1\_LKUP** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other: | | | | | | | **2.** | | **VDIAG2 / VDIAG2\_LKUP** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other: | | | | | | | **3.** | | **VDIAG3 / VDIAG3\_LKUP** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other: | | | | | | | **4.** | | **VDIAG4 / VDIAG4\_LKUP** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other: | | | | | | | **5.** | | **VDIAG5 / VDIAG5\_LKUP** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONDITIONS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Regardless of the diagnoses previously entered, does the patient now have –** *Mark (X) all that apply*. **PAT\_HAV** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1  Alcohol misuse, abuse, or dependence  2  Alzheimer’s disease/Dementia  3  Arthritis  4  Asthma | | | | | | | | | | | | | | | | | | | | | | | | 5  Autism spectrum disorder  6  Cancer  7  Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA)  8  Chronic kidney disease (CKD)  9  Chronic obstructive pulmonary disease (COPD)  10  Congestive heart failure (CHF)  11  Coronary artery disease (CAD), ischemic heart disease (IHD), or history of myocardial infarction (MI)  12  Depression  13  Diabetes mellitus (DM) – Type I  14  Diabetes mellitus (DM) – Type II | | | | | | | | 15  Diabetes mellitus (DM) – Type unspecified  16  End-stage renal disease (ESRD)  17  History of pulmonary embolism (PE), deep vein thrombosis (DVT), or venous thromboembolism (VTE)  18  HIV infection/AIDS  19  Hyperlipidemia  20  Hypertension  21  Obesity  22  Obstructive sleep apnea (OSA)  23  Osteoporosis  24  Substance abuse, misuse, or dependence  25  None of the above | | | | | | |
| **Asthma severity:**  **ASTH\_SEV**  1  Intermittent  2  Mild persistent  3  Moderate persistent  4  Severe persistent  5  Other – Specify   |  | | --- | | **ASTH\_SEV\_SP** |   6  None recorded | | | | | | | | | | | | | | | | | **Asthma control:**  **ASTH\_CON**  1  Well controlled  2  Not well controlled  3  Very poorly controlled  4  Other – Specify   |  | | --- | | **ASTH\_CON\_SP** |   5  None recorded | | | | | | |
| SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Enter all examinations/screenings, laboratory tests, imaging, procedures,treatment,health education/counseling,and other services not listed ORDERED OR PROVIDED*. **DIAG\_SERVICE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1  NO SERVICES  **Examinations/**  **Screenings**  2  Alcohol misuse screening (includes AUDIT, MAST, CAGE,   T-ACE)  3  Breast  4  Depression  screening  5  Domestic violence   screening  6  Foot  7  Neurologic  8  Pelvic  9  Rectal  10  Retinal/Eye  11  Skin  12  Substance abuse screening   (includes   NIDA/NM ASSIST, CAGE-AID,   DAST-10)  **Laboratory Tests**  13  BMP (Basic metabolic panel)  14  CBC  15  Chlamydia test | | | | | | | | | | | | | | **Laboratory Tests (cont.)**  16  CMP (Comprehensive metabolic panel)  17  Creatinine/Renal function panel  18  Culture, blood  19  Culture, throat  20  Culture, urine  21  Culture, other  22  Glucose, serum  23  Gonorrhea test  24  HbA1C (Glycohemoglobin)  25  Hepatitis panel  26  HIV test  27  HPV DNA test  28  Lipid profile/panel  29  Liver enzymes/ Hepatic function panel  30  PAP test  31  Pregnancy/HCG test  32  PSA (prostate specific antigen)  33  Rapid strep test | | | | | | | **Laboratory Tests (cont.)**  34  TSH/Thyroid panel  35  Urinalysis  36  Vitamin D test  **Imaging**  37  Bone mineral density  38  CT scan  39  Echocardiogram  40  Ultrasound  41  Mammography  42  MRI  43  X-ray  **Procedures**  44  Audiometry  45  Biopsy  46  Cardiac stress test  47  Colonoscopy  48  Cryosurgery (cryotherapy)/ Destruction of tissue  49  EKG/ECG  50  Electroencephalogram (EEG)  51  Electromyogram (EMG)  52  Excision of tissue  53  Fetal monitoring | | | | | **Procedures (cont.)**  54  Peak flow  55  Sigmoidoscopy  56  Spirometry  57  Tonometry  58  Tuberculosis skin testing/ PPD  59  Upper gastrointestinal endoscopy (EGD)  **Treatments**  60  Cast/splint/wrap  61  Complementary and alternative medicine (CAM)  62  Durable medical equipment  63  Home health care  64  Mental health counseling, excluding psychotherapy  65  Occupational therapy  66  Physical therapy  67  Psychotherapy | | | **Treatments (cont.)**  68  Radiation therapy  69  Wound care  **Health Education/ Counseling**  70  Alcohol misuse counseling  71  Asthma education  72  Asthma action plan given to patient  73  Diabetes education  74  Diet/Nutrition  75  Exercise  76  Family planning/ Contraception  77  Genetic counseling  78  Growth/ Development  79  Injury prevention  80  STD prevention  81  Stress management  82  Substance abuse counseling  83  Tobacco use/ Exposure  84  Weight reduction | | | | | | | | **Other services not listed**  85  Other service – Specify   |  | | --- | | **OTHER\_SP** |   Other service – Specify   |  | | --- | | **OTHER\_SP2** |   Other service – Specify   |  | | --- | | **OTHER\_SP3** |   Other service – Specify   |  | | --- | | **OTHER\_SP4** |   Other service – Specify   |  | | --- | | **OTHER\_SP5** | | |
|  | | | | | | | | | | | | | |  | | | | | | |  | | | | |  | | |  | | | | | | | |  | |

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| --- | --- | --- | --- | --- | --- |
| **MEDICATION(S) & IMMUNIZATIONS** | | | | | |
| **NOMED=Were any prescription or non-prescription drugs ORDERED or PROVIDED (by any route of administration) at this visit?** 1  Yes 2  No  **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 medications prescribed at a previous visit if the patient was instructed at THIS VISIT to continue with the medication. Enter XXX if medication cannot be found. Enter 0 for No more.** | | | **NCMED** | |  |
| **New** | **Continued** |  |
| (1) | **VMED1 / VMEDOTH1** |  | 1 | 2 |  |
| (2) | **VMED2 / VMEDOTH2** |  | 1 | 2 |
| (3) | **VMED3 / VMEDOTH3** |  | 1 | 2 |
| (4) | **VMED4 / VMEDOTH4** |  | 1 | 2 |
| (5) | **VMED5 / VMEDOTH5** |  | 1 | 2 |
| (6) | **VMED6 / VMEDOTH6** |  | 1 | 2 |
| (7) | **VMED7 / VMEDOTH7** |  | 1 | 2 |
| (8) | **VMED8 / VMEDOTH8** |  |  |  |
| (9) | **VMED9 / VMEDOTH9** |  | 1 | 2 |
| (10-30) | **VMED10-30 / VMEDOTH10-30 (Up to 30 drugs can be listed.)** |  | 1 | 2 |
|  |  |  |  |  |
| PROVIDERS | | | | | |
| **Mark (X) all providers seen at this visit PROV\_SEEN1-7** | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | Physician | 5 | Mental health provider |
| 2 | Physician assistant (PA) | 6 | Other |
| 3 | Nurse practitioner (NP)/Midwife (CNM) | 7 | NONE |
| 4 | RN/LPN |  | |

|  |
| --- |
| TIME SPENT WITH PROVIDER |
| **Enter estimated time spent with sampled provider. Enter 0 if no provider seen. DURATION** |

|  |  |
| --- | --- |
| |  | | --- | |  |   Minutes |

|  |
| --- |
| VISIT DISPOSITION |
| ***Mark (X) all that apply.*** **VISIT\_DISP** |

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | Return to referring physician | 6 | Return at unspecified time |
| 2 | Refer to other physician | 7 | Return as needed (p.r.n.) |
| 3 | Return in less than 1 week | 8 | Refer to ER/Admit to hospital |
| 4 | Return in 1 week to less than 2 months | 9 | Other |
| 5 | Return in 2 months or greater |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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? **LAB\_TEST** | | | Most recent result | | | Date of test | | |
| Total Cholesterol **CHOL**  1  Yes  2  None found | | | |  |  | | --- | --- | | **CHOLRES** | mg/dL | | | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | |  |  |  |  |  | | **CHOLDATE** | | | | 201 | 0 | **1** |  | | mm | | dd | | yyyy | | | | | | |
| High density lipoprotein (HDL) **HDL**  1  Yes  2  None found | | |  |  | | --- | --- | | **HDLRES** | mg/dL | | | | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | |  |  |  |  |  | | **HDLDATE** | | | | 201 | 0 | **1** |  | | mm | | dd | | yyyy | | | | | | |
| Low density lipoprotein (LDL) **LDL**  1  Yes  2  None found | | |  |  | | --- | --- | | **LDLRES** | mg/dL | | | | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | |  |  |  |  |  | | **LDLDATE** | | | | 201 | 0 | **1** |  | | mm | | dd | | yyyy | | | | | | |
| Triglycerides **TGS**  1  Yes  2  None found | | |  |  | | --- | --- | | **TGSRES** | mg/dL | | | | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | |  |  |  |  |  | | **TGSDATE** | | | | 201 | 0 | **1** |  | | mm | | dd | | yyyy | | | | | | |
| HbA1c (Glycohemoglobin) **A1C**  1  Yes  2  None found | | |  |  | | --- | --- | | **A1CRES** | % | | | | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | |  |  |  |  |  | | **A1CDATE** | | | | 201 | 0 | **1** |  | | mm | | dd | | yyyy | | | | | | |
| Blood glucose (BG) **FBG**  1  Yes  2  None found | | |  |  | | --- | --- | | **FBGRES** | mg/dL | | | | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | |  |  |  |  |  | | **FBGDATE** | | | | 201 | 0 | **1** |  | | mm | | dd | | yyyy | | | | | | |
| Serum creatinine **SERUM**  1  Yes  2  None found | | |  |  | | --- | --- | | **SERUMRES** | mg/dL | | | | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | |  |  |  |  |  | | **SERUMDATE** | | | | 201 | 0 | **1** |  | | mm | | dd | | yyyy | | | | | | |
| CPT CODES | | | | | | | | |
| **Enter Current Procedure Terminology (CPT) or Healthcare Common Procedure Codinbg System (HCPCS) code.** Up to 18 CPT codes can be listed. | | | | | | | | |
| |  | | --- | | **CPTCODE1** | | **CPTCODE2** | | **CPTCODE3** | | |  | | --- | | **CPTCODE4** | | **CPTCODE5** | | **CPTCODE6** | | | | |  | | --- | | **CPTCODE7** | | **CPTCODE8** | | **CPTCODE9** | | |  | | --- | | **CPTCODE10** | | **CPTCODE11** | | **CPTCODE12** | | | |  | | --- | | **CPTCODE13** | | **CPTCODE14** | | **CPTCODE15** | | |  | | --- | | **CPTCODE16** | | **CPTCODE17** | | **CPTCODE18** | |
|  |  | | |  |  | |  |  |