

Attachment D1: 2014 Patient Record form (NAMCS-30)

NAMCS-73
(3-6-2014)

SAMPLE

NATIONAL AMBULATORY MEDICAL CARE SURVEY 2014 PATIENT RECORD

Form Approved: OMB No. 0920-0234; Expiration date 12/31/2014

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PATIENT INFORMATION

Patient medical record No.	Age <input type="text"/> 1 <input type="checkbox"/> Years 2 <input type="checkbox"/> Months 3 <input type="checkbox"/> Days	Ethnicity 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino	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 or other state-based program 4 <input type="checkbox"/> Workers' compensation 5 <input type="checkbox"/> Self-pay 6 <input type="checkbox"/> No charge/Charity 7 <input type="checkbox"/> Other 8 <input type="checkbox"/> Unknown	Tobacco use 1 <input type="checkbox"/> Never smoker 2 <input type="checkbox"/> Former smoker 3 <input type="checkbox"/> Current smoker 4 <input type="checkbox"/> Unknown
Date of visit Month Day Year <input type="text"/> <input type="text"/> <input type="text"/> 201	Sex 1 <input type="checkbox"/> Female – Is patient pregnant? 1 <input type="checkbox"/> Yes - Specify gestation week – Gestation week refers to the number of weeks plus 2 that the offspring has spent developing in the uterus → <input type="text"/> OR LMP Month Day Year <input type="text"/> <input type="text"/> <input type="text"/> 201 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> Male	Race – Mark (X) all that apply. 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		
ZIP Code Enter "1" if homeless <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
Date of birth Month Day Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				

BIOMETRICS/VITAL SIGNS

Height <input type="text"/> ft <input type="text"/> in OR <input type="text"/> cm	Weight <input type="text"/> lb <input type="text"/> oz OR <input type="text"/> kg <input type="text"/> gm	Temperature <input type="text"/> °C <input type="checkbox"/> °F	Blood pressure Systolic Diastolic <input type="text"/> / <input type="text"/> If multiple measurements are taken, record the last measurement.
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REASON FOR VISIT

List the first 5 reasons for visit (i.e., symptoms, problems, issues, concerns 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. (1) Most important <input type="text"/> (2) Other <input type="text"/> (3) Other <input type="text"/> (4) Other <input type="text"/> (5) Other <input type="text"/>	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 surgery 5 <input type="checkbox"/> Post surgery 6 <input type="checkbox"/> Preventive care (e.g., routine prenatal, well-baby, screening, insurance, general exams)
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INJURY/POISONING/ADVERSE EFFECT

Is this visit related to an injury, poisoning, or adverse effect of medical treatment? 1 <input type="checkbox"/> Yes, injury 2 <input type="checkbox"/> Yes, poisoning 3 <input type="checkbox"/> Yes, adverse effect of medical/surgical care or adverse effect of medicinal drug <i>SKIP to Cause of injury, poisoning, or adverse effect</i> 4 <input type="checkbox"/> No 5 <input type="checkbox"/> Unknown	Did the injury or poisoning occur within 72 hours prior to the date and time of this visit? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown 4 <input type="checkbox"/> Not applicable	Is this injury or poisoning intentional or unintentional? 1 <input type="checkbox"/> Intentional 2 <input type="checkbox"/> Unintentional (e.g., accidental) 3 <input type="checkbox"/> Intent unclear	Cause of injury, poisoning, or adverse effect – Describe the place and circumstances that preceded the injury, poisoning, or adverse effect. Examples: 1 – Injury (e.g., patient fell while walking down stairs at home and sprained her ankle; patient was bitten by a spider); 2 – Poisoning (e.g., 4 year old child was given adult cold/cough medication 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). <input type="text"/>
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CONTINUITY OF CARE

Are you the patient's primary care physician? 1 <input type="checkbox"/> Yes – SKIP to → 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	Has the patient been seen in this practice before? 1 <input type="checkbox"/> Yes, established patient – How many past visits to this practice in the last 12 months? Exclude this visit. <input type="text"/> Visits 2 <input type="checkbox"/> No, new patient	DIAGNOSIS As specifically as possible, list diagnoses related to this visit including chronic conditions. (1) Primary diagnosis <input type="text"/> (2) Other <input type="text"/> (3) Other <input type="text"/> (4) Other <input type="text"/> (5) Other <input type="text"/>
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Regardless of the diagnoses previously entered, does the patient now have – Mark (X) all that apply.

1 <input type="checkbox"/> Alcohol misuse, abuse or dependence	7 <input type="checkbox"/> Chronic kidney disease (CKD)	11 <input type="checkbox"/> Depression	17 <input type="checkbox"/> HIV Infection/AIDS
2 <input type="checkbox"/> Alzheimer's disease/Dementia	8 <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD)	12 <input type="checkbox"/> Diabetes mellitus (DM), Type 1	18 <input type="checkbox"/> Hyperlipidemia
3 <input type="checkbox"/> Arthritis	9 <input type="checkbox"/> Congestive heart failure (CHF)	13 <input type="checkbox"/> Diabetes mellitus (DM), Type 2	19 <input type="checkbox"/> Hypertension
4 <input type="checkbox"/> Asthma	10 <input type="checkbox"/> Coronary artery disease (CAD), ischemic heart disease (IHD) or history of myocardial infarction (MI)	14 <input type="checkbox"/> Diabetes mellitus (DM), Type unspecified	20 <input type="checkbox"/> Obesity
5 <input type="checkbox"/> Cancer		15 <input type="checkbox"/> End-stage renal disease (ESRD)	21 <input type="checkbox"/> Obstructive sleep apnea (OSA)
6 <input type="checkbox"/> Cerebrovascular disease/stroke (CVA) or transient ischemic attack (TIA)		16 <input type="checkbox"/> History of pulmonary embolism (PE) or deep vein thrombosis (DVT)	22 <input type="checkbox"/> Osteoporosis
Asthma severity: 1 <input type="checkbox"/> Intermittent 2 <input type="checkbox"/> Mild persistent 3 <input type="checkbox"/> Moderate persistent 4 <input type="checkbox"/> Severe persistent	5 <input type="checkbox"/> Other – Specify <input type="text"/> 6 <input type="checkbox"/> None recorded	Asthma control: 1 <input type="checkbox"/> Well controlled 2 <input type="checkbox"/> Not well controlled 3 <input type="checkbox"/> Very poorly controlled	4 <input type="checkbox"/> Other – Specify <input type="text"/> 5 <input type="checkbox"/> None recorded

SERVICES

Enter all Examinations/Screenings, Laboratory tests, Imaging, Procedures, Treatments, Health education/Counseling, and Other services not listed ORDERED OR PROVIDED.

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 Exam
- 11 Skin
- 12 Substance abuse screening (includes NIDA/NM ASSIST, CAGE-AID, DAST-10)

Laboratory tests:

- 13 Basic metabolic panel
- 14 CBC
- 15 Chlamydia test
- 16 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 testing/Hepatitis panel
- 26 HIV test
- 27 HPV DNA test

- 28 Lipid profile
- 29 Liver enzymes/Hepatic function panel
- 30 Pap test
- 31 Pregnancy/HCG test
- 32 PSA (prostate specific antigen)
- 33 Rapid strep test
- 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
Biopsy provided?
1 Yes
2 No
- 46 Cardiac stress test
- 47 Colonoscopy
Colonoscopy provided?
1 Yes
2 No
- 48 Cryosurgery (cryotherapy)/
Destruction of tissue
- 49 EKG/ECG

- 50 Electroencephalogram (EEG)
- 51 Electromyogram (EMG)
- 52 Excision of tissue
Excision of tissue provided?
1 Yes
2 No
- 53 Fetal monitoring
- 54 Peak flow
- 55 Sigmoidoscopy
Sigmoidoscopy provided?
1 Yes
2 No
- 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
- 68 Radiation therapy
- 69 Wound care

Health education/Counseling:

- 70 Alcohol abuse counseling
- 71 Asthma
- 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 ↗

Up to 5 other services can be listed.

MEDICATIONS & IMMUNIZATIONS

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.

- 1 Yes
- 2 No

		New	Continued
(1)		1 <input type="checkbox"/>	2 <input type="checkbox"/>
(2)		1 <input type="checkbox"/>	2 <input type="checkbox"/>
(3)		1 <input type="checkbox"/>	2 <input type="checkbox"/>
(4)		1 <input type="checkbox"/>	2 <input type="checkbox"/>
(5)		1 <input type="checkbox"/>	2 <input type="checkbox"/>
↓		1 <input type="checkbox"/>	2 <input type="checkbox"/>
↓		1 <input type="checkbox"/>	2 <input type="checkbox"/>
(30)	Up to 30 medications can be listed.	1 <input type="checkbox"/>	2 <input type="checkbox"/>

PROVIDERS

Mark (X) all providers seen at this visit.

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

TIME SPENT WITH PROVIDER

Minutes Enter estimated time spent with sampled provider – Enter 0 if no provider seen

VISIT DISPOSITION

Mark (X) all that apply.

- 1 Return to referring physician
- 2 Refer to other physician
- 3 Return in less than 1 week
- 4 Return in 1 week to less than 2 months
- 5 Return in 2 months or greater
- 6 Return at unspecified time
- 7 Return as needed (p.r.n.)
- 8 Refer to ER/Admit to hospital
- 9 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
1	Total Cholesterol 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<input style="width: 50px;" type="text"/> mg/dL	Month <input style="width: 20px;" type="text"/> Day <input style="width: 20px;" type="text"/> Year <input style="width: 20px;" type="text"/> 20 <input style="width: 20px;" type="text"/> 1
2	High density lipoprotein (HDL) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<input style="width: 50px;" type="text"/> mg/dL	Month <input style="width: 20px;" type="text"/> Day <input style="width: 20px;" type="text"/> Year <input style="width: 20px;" type="text"/> 20 <input style="width: 20px;" type="text"/> 1
3	Low density lipoprotein (LDL) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<input style="width: 50px;" type="text"/> mg/dL	Month <input style="width: 20px;" type="text"/> Day <input style="width: 20px;" type="text"/> Year <input style="width: 20px;" type="text"/> 20 <input style="width: 20px;" type="text"/> 1
4	Triglycerides (TGs) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<input style="width: 50px;" type="text"/> mg/dL	Month <input style="width: 20px;" type="text"/> Day <input style="width: 20px;" type="text"/> Year <input style="width: 20px;" type="text"/> 20 <input style="width: 20px;" type="text"/> 1
5	HbA1c (A1C) (Glycohemoglobin) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<input style="width: 50px;" type="text"/> %	Month <input style="width: 20px;" type="text"/> Day <input style="width: 20px;" type="text"/> Year <input style="width: 20px;" type="text"/> 20 <input style="width: 20px;" type="text"/> 1
6	Blood glucose (BG) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<input style="width: 50px;" type="text"/> mg/dL	Month <input style="width: 20px;" type="text"/> Day <input style="width: 20px;" type="text"/> Year <input style="width: 20px;" type="text"/> 20 <input style="width: 20px;" type="text"/> 1
7	Serum creatinine 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	<input style="width: 50px;" type="text"/> mg/dL	Month <input style="width: 20px;" type="text"/> Day <input style="width: 20px;" type="text"/> Year <input style="width: 20px;" type="text"/> 20 <input style="width: 20px;" type="text"/> 1

CPT CODES

Enter Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code. Up to 18 CPT codes can be listed.
