NAMCS-73
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SAMPLE

National Ambulatory Medical Care Survey
2021 PATIENT RECORD

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PATIENT INFORMATION

Patient medical record No.

Date of visit
Month | Day | Year 2 0 2

ZIP Code *Enter "1" if homeless.*

Date of birth
Month | Day | Year

Age ☐ 1 Years ☐ 2 Months ☐ 3 Days

Sex
☐ 1 Female – Is patient pregnant?
- ☐ 1 Yes – *Specify gestation – Gestation week refers to the number of weeks plus 2 that the offspring has spent developing in the uterus* →
- ☐ 2 No

☐ 2 Male

Ethnicity
☐ 1 Hispanic or Latino
☐ 2 Not Hispanic or Latino

Race – *Mark (X) all that apply.*
☐ 1 White
☐ 2 Black or African American
☐ 3 Asian
☐ 4 Native Hawaiian or Other Pacific Islander
☐ 5 American Indian or Alaska Native

Expected source(s) of payment for THIS VISIT – *Mark (X) all that apply.*
☐ 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
☐ 1 Not current →
☐ 2 Current

Prior tobacco use
☐ 1 Never
☐ 2 Former
☐ 3 Unknown

BIOMETRICS/VITAL SIGNS

Height ____ ft ____ in
OR
____ cm

Weight ____ lb ____ oz
OR
____ kg ____ gm

Temperature ____ ☐ 1 °C ☐ 2 °F

Blood pressure – *If multiple measurements are taken, record the last measurement.*
Systolic ____ / Diastolic ____

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
(2) Other
(3) Other
(4) Other
(5) Other

Major reason for this visit
☐ 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)

INJURY

Is this visit related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment?
☐ 1 Yes, injury/trauma
☐ 2 Yes, overdose/poisoning
☐ 3 Yes, adverse effect of medical or surgical treatment or adverse effect of medicinal drug
☐ 4 No
☐ 5 Unknown
} *SKIP to Continuity of Care*

Did the injury/trauma, overdose/poisoning or adverse effect occur within 72 hours prior to the date and time of this visit?
☐ 1 Yes
☐ 2 No
☐ 3 Don't Know

For adverse effect SKIP to Cause ↓

Is this injury/trauma or overdose/poisoning intentional or unintentional?
☐ 1 Intentional →
☐ 2 Unintentional (e.g., accidental)
☐ 3 Intent unclear
} ↓

What was the intent of the injury/trauma or overdose/poisoning?
☐ 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, poisoning, or adverse effect. Examples:* **1 –** *Injury/Trauma (for example, patient fell while walking down stairs at home and sprained her ankle; patient was bitten by a spider);* **2 –** *Overdose/Poisoning (for example, 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 (for example, patient developed a rash on his arm 2 days after taking penicillin for an ear infection)*

CONTINUITY OF CARE

Is the sampled provider the patient's primary care provider?
☐ 1 Yes – *SKIP to* →
☐ 2 No
☐ 3 Don't Know
} ↓

Was patient referred for this visit?
☐ 1 Yes ☐ 3 Don't Know
☐ 2 No

Has the patient been seen in this practice before?
☐ 1 Yes, established patient –
How many past visits to this practice in the last 12 months? *(Exclude this visit.)*
____ Visits
☐ 2 No, new patient

DIAGNOSIS

As specifically as possible, list diagnoses related to this visit including chronic conditions.

(1) Primary diagnosis
(2) Other
(3) Other
(4) Other
(5) Other

Regardless of the diagnoses previously entered, does the patient now have –
Mark (X) all that apply.

☐ 11 Alcohol misuse, abuse or dependence
☐ 12 Alzheimer's disease/Dementia
☐ 13 Arthritis
☐ 14 Asthma
☐ 15 Attention deficit disorder (ADD)/Attention deficit hyperactivity disorder (ADHD)
☐ 16 Autism spectrum disorder
☐ 17 Cancer
☐ 18 Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA)
☐ 19 Chronic kidney disease (CKD)
☐ 20 Chronic obstructive pulmonary disease (COPD)
☐ 21 Congestive heart failure (CHF)
☐ 22 Coronary artery disease (CAD), ischemic heart disease (IHD) or history of myocardial infarction (MI)
☐ 23 Depression
☐ 24 Diabetes mellitus (DM), Type 1
☐ 25 Diabetes mellitus (DM), Type 2
☐ 26 Diabetes mellitus (DM), Type unspecified
☐ 27 End-stage renal disease (ESRD)
☐ 28 Hepatitis B
☐ 29 Hepatitis C
☐ 30 History of pulmonary embolism (PE) or deep vein thrombosis (DVT), or venous thromboembolism (VTE)
☐ 31 HIV Infection/AIDS
☐ 32 Hyperlipidemia
☐ 33 Hypertension
☐ 34 Obesity
☐ 35 Obstructive sleep apnea (OSA)
☐ 36 Osteoporosis
☐ 37 Substance abuse or dependence
☐ 38 None of the above

Complete if Asthma box is marked.

Asthma severity:
☐ 1 Intermittent
☐ 2 Mild persistent
☐ 3 Moderate persistent
☐ 4 Severe persistent
☐ 5 Other – *Specify* ↓
____
☐ 6 None recorded

Asthma control:
☐ 1 Well controlled
☐ 2 Not well controlled
☐ 3 Very poorly controlled
☐ 4 Other – *Specify* ↓
____
☐ 5 None recorded

SERVICES

Mark (X) all Examinations/Screenings, Laboratory tests, Diagnostic Imaging, Procedures, Treatments, and Health education/Counseling ORDERED OR PROVIDED.

11 ☐ NO SERVICES

Examinations/Screenings:

12 ☐ Alcohol misuse screening (includes AUDIT, MAST, CAGE, T-ACE)
13 ☐ Breast
14 ☐ Depression screening
15 ☐ Domestic violence screening
16 ☐ Foot
17 ☐ Neurologic
18 ☐ Pelvic
19 ☐ Rectal
20 ☐ Retinal/Eye
21 ☐ Skin
22 ☐ Substance abuse screening (includes NIDA/NM ASSIST, CAGE-AID, DAST-10)

Laboratory tests:

23 ☐ Basic metabolic panel (BMP)
24 ☐ CBC
25 ☐ Chlamydia test
26 ☐ Comprehensive metabolic panel (CMP)
27 ☐ Creatinine/Renal function panel
28 ☐ Culture, blood
29 ☐ Culture, throat
30 ☐ Culture, urine
31 ☐ Culture, other
32 ☐ Glucose, serum
33 ☐ Gonorrhea test
34 ☐ HbA1c (Glycohemoglobin)
35 ☐ Hepatitis testing/panel
36 ☐ HIV test
37 ☐ HPV DNA test
38 ☐ Lipid profile/panel
39 ☐ Liver enzymes/Hepatic function panel
40 ☐ PAP test
41 ☐ Pregnancy/HCG test
42 ☐ PSA (prostate specific antigen)
43 ☐ Rapid strep test
44 ☐ TSH/Thyroid panel
45 ☐ Urinalysis (UA) or urine dipstick
46 ☐ Vitamin D test

Diagnostic Imaging:

47 ☐ Bone mineral density
48 ☐ CT scan
49 ☐ Echocardiogram
50 ☐ Other Ultrasound
51 ☐ Mammography
52 ☐ MRI
53 ☐ X-ray

Procedures:

54 ☐ Audiometry
55 ☐ Biopsy
Biopsy provided? 1 ☐ Yes 2 ☐ No
56 ☐ Cardiac stress test
57 ☐ Colonoscopy
Colonoscopy provided? 1 ☐ Yes 2 ☐ No
58 ☐ Cryosurgery (cryotherapy)/ Destruction of tissue
59 ☐ EKG/ECG
60 ☐ Electroencephalogram (EEG)
61 ☐ Electromyogram (EMG)
62 ☐ Excision of tissue
Excision of tissue provided? 1 ☐ Yes 2 ☐ No
63 ☐ Fetal monitoring
64 ☐ Peak flow
65 ☐ Sigmoidoscopy
Sigmoidoscopy provided? 1 ☐ Yes 2 ☐ No
66 ☐ Spirometry
67 ☐ Tonometry
68 ☐ Tuberculosis skin testing/PPD
69 ☐ Upper gastrointestinal endoscopy/EGD
Upper gastrointestinal endoscopy/EGD provided? 1 ☐ Yes 2 ☐ No

Treatments:

70 ☐ Cast/splint/wrap
71 ☐ Complementary and alternative medicine (CAM)
72 ☐ Durable medical equipment
73 ☐ Home health care
74 ☐ Mental health counseling, excluding psychotherapy
75 ☐ Occupational therapy
76 ☐ Physical therapy
77 ☐ Psychotherapy
78 ☐ Radiation therapy
79 ☐ Wound care

Health education/Counseling:

80 ☐ Alcohol abuse counseling
81 ☐ Asthma education
82 ☐ Asthma action plan given to patient
83 ☐ Diabetes education
84 ☐ Diet/Nutrition
85 ☐ Exercise
86 ☐ Family planning/Contraception
87 ☐ Genetic counseling
88 ☐ Growth/Development
89 ☐ Injury prevention
90 ☐ STD prevention
91 ☐ Stress management
92 ☐ Substance abuse counseling
93 ☐ Tobacco use/Exposure
94 ☐ Weight reduction

Other services not listed:

95 ☐ 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

List up to 30 drugs.

		New	Continued
(1)		1 ☐	2 ☐
(2)		1 ☐	2 ☐
(3)		1 ☐	2 ☐
(4)		1 ☐	2 ☐
(5)		1 ☐	2 ☐
		1 ☐	2 ☐
		1 ☐	2 ☐
(30)		1 ☐	2 ☐

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 sampled provider not seen. Leave blank if time spent with sampled provider is unknown.

VISIT DISPOSITION

Mark (X) all that apply.

1 ☐ Return to referring physician/provider
2 ☐ Refer to other physician/provider
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 blood draw
1	Total Cholesterol — 1 ☐ Yes → 2 ☐ None found	____ mg/dL	Month Day Year 20__
2	High density lipoprotein (HDL) — 1 ☐ Yes → 2 ☐ None found	____ mg/dL	Month Day Year 20__
3	Low density lipoprotein (LDL) — 1 ☐ Yes → 2 ☐ None found	____ mg/dL	Month Day Year 20__
4	Triglycerides (TGs) — 1 ☐ Yes → 2 ☐ None found	____ mg/dL	Month Day Year 20__
5	HbA1c Glycohemoglobin — 1 ☐ Yes → 2 ☐ None found	____ %	Month Day Year 20__
6	Blood glucose (BG) — 1 ☐ Yes → 2 ☐ None found	____ mg/dL	Month Day Year 20__
7	Serum creatinine — 1 ☐ Yes → 2 ☐ None found	____ 1 ☐ mg/dL 2 ☐ µmol/L	Month Day Year 20__

CPT CODES

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