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FORM **NAMCS-30**
(11-15-2010)

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

NATIONAL AMBULATORY MEDICAL CARE SURVEY
2011 PATIENT RECORD

PATIENT RECORD NO.:

PATIENT'S NAME:

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 the 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).

(Provider: Detach and keep upper portion)

Please keep (X) marks inside of boxes ➜ ☒ Correct ☒ Incorrect Office Location _____

1. PATIENT INFORMATION

a. Date of visit

Month		Day		Year	
				1	

b. ZIP Code

c. Date of birth

Month		Day		Year			

d. Sex
1 ☐ Female 2 ☐ Male

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

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

g. Expected source(s) of payment for this visit – *Mark (X) all that apply.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid or CHIP
4 ☐ Worker's compensation
5 ☐ Self-pay
6 ☐ No charge/Charity
7 ☐ Other
8 ☐ Unknown

h. Tobacco use
1 ☐ Not current 3 ☐ Unknown
2 ☐ Current

2. INJURY/POISONING/ ADVERSE EFFECT

Is this visit related to any of the following?
1 ☐ Unintentional injury/poisoning
2 ☐ Intentional injury/poisoning
3 ☐ Injury/poisoning – unknown intent
4 ☐ Adverse effect of medical/ surgical care or adverse effect of medicinal drug
5 ☐ None of the above

3. REASON FOR VISIT

Patient's complaint(s), symptom(s), or other reason(s) for this visit – *Use patient's own words.*

(1) Most important:

(2) Other:

(3) Other:

4. CONTINUITY OF CARE

a. Are you the patient's primary care physician/provider?
1 ☐ Yes –*SKIP to item 4b.*
2 ☐ No
3 ☐ Unknown

Was patient referred for this visit?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

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

c. Major reason for this visit
1 ☐ New problem (<3 mos. onset)
2 ☐ Chronic problem, routine
3 ☐ Chronic problem, flare-up
4 ☐ Pre/Post surgery
5 ☐ Preventive care (e.g., routine prenatal, well-baby, screening, insurance, general exams)

5. PROVIDER'S DIAGNOSIS FOR THIS VISIT

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

(1) Primary diagnosis:

(2) Other:

(3) Other:

b. Regardless of the diagnoses written in 5a, does the patient now have – *Mark (X) all that apply.*
1 ☐ Arthritis
2 ☐ Asthma
3 ☐ Cancer
4 ☐ Cerebrovascular disease/History of stroke or transient ischemic attack (TIA)
5 ☐ Chronic renal failure
6 ☐ Congestive heart failure
7 ☐ COPD
8 ☐ Depression
9 ☐ Diabetes
10 ☐ Hyperlipidemia
11 ☐ Hypertension
12 ☐ Ischemic heart disease
13 ☐ Obesity
14 ☐ Osteoporosis
15 ☐ None of the above

6. VITAL SIGNS

(1) Height
☐ ft ☐ in **OR** ☐ cm

(2) Weight
☐ lb ☐ oz
OR
☐ kg ☐ gm

(3) Temperature
☐ ☐ °C ☐ °F

(4) Blood pressure
Systolic ☐ / Diastolic ☐

7. DIAGNOSTIC/SCREENING SERVICES

Mark (X) all ***ordered*** *or* ***provided*** *at this visit.*
1 ☐ NONE

Examinations:
2 ☐ Breast
3 ☐ Foot
4 ☐ Pelvic
5 ☐ Rectal
6 ☐ Retinal
7 ☐ Skin
8 ☐ Depression screening

Imaging:
9 ☐ X-ray
10 ☐ Bone mineral density
11 ☐ CT scan
12 ☐ Echocardiogram
13 ☐ Other ultrasound
14 ☐ Mammography
15 ☐ MRI
16 ☐ Other imaging

Blood tests:
17 ☐ CBC (complete blood count)
18 ☐ Glucose
19 ☐ HgbA1c (glycohemoglobin)
20 ☐ Lipids/Cholesterol
21 ☐ PSA (prostate specific antigen)
22 ☐ Other blood test

Scope:
23 ☐ Scope procedure (e.g., colonoscopy) - *Specify*

Other tests:
24 ☐ Biopsy – *Specify site*
25 ☐ Chlamydia test
26 ☐ EKG/ECG
27 ☐ HIV test
28 ☐ HPV DNA test
29 ☐ Pap test
30 ☐ Pregnancy/HCG test
31 ☐ Urinalysis (UA)
32 ☐ Other exam/test/service - *Specify*

8. HEALTH EDUCATION

Mark (X) all ***ordered*** *or* ***provided*** *at this visit.*
1 ☐ NONE
2 ☐ Asthma education
3 ☐ Diet/Nutrition
4 ☐ Exercise
5 ☐ Family planning/ Contraception
6 ☐ Growth/Development
7 ☐ Injury prevention
8 ☐ Stress management
9 ☐ Tobacco use/ Exposure
10 ☐ Weight reduction
11 ☐ Other

9. NON-MEDICATION TREATMENT

Mark (X) all ***ordered*** *or* ***provided*** *at this visit.*
1 ☐ NONE
2 ☐ Complementary alternative medicine (CAM)
3 ☐ Durable medical equipment
4 ☐ Home health care
5 ☐ Physical therapy
6 ☐ Radiation therapy
7 ☐ Speech/Occupational therapy
8 ☐ Psychotherapy
9 ☐ Other mental health counseling
10 ☐ Excision of tissue
11 ☐ Wound care
12 ☐ Cast
13 ☐ Splint or wrap

Procedures:
14 ☐ Other non-surgical procedures – *Specify*
15 ☐ Other surgical procedures – *Specify*

10. MEDICATIONS & IMMUNIZATIONS

☐ NONE **Include Rx and OTC drugs, immunizations, allergy shots, oxygen, anesthetics, chemotherapy, and dietary supplements that were ordered, supplied, administered or continued during this visit.**

	New	Continued
(1)	1 ☐	2 ☐
(2)	1 ☐	2 ☐
(3)	1 ☐	2 ☐
(4)	1 ☐	2 ☐
(5)	1 ☐	2 ☐
(6)	1 ☐	2 ☐
(7)	1 ☐	2 ☐
(8)	1 ☐	2 ☐

11. 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

12. VISIT DISPOSITION

Mark (X) all that apply.
1 ☐ Refer to other physician
2 ☐ Return at specified time
3 ☐ Refer to ER/Admit to hospital
4 ☐ Other

Continue on reverse side ➥

13. TIME SPENT WITH PROVIDER

Minutes	*Enter zero if no provider seen*

14. LABORATORY TEST RESULTS

If the "Complete Item 14" box is checked YES on the front of this folio, please provide the test results requested below. If neither box is checked, please see Appendix E in the NAMCS-26 Instruction Booklet.

Item number (a)	Were the following laboratory tests drawn within 12 months of this visit? (b)	Most recent result (c)	Date of the most recent result (mm/dd/yyyy) (d)
1	Total Cholesterol 1 ☐ Yes → 2 ☐ None found within 12 months – *Skip to next item*	_____ mg/dl 1 ☐ Data not available	/ / 1 ☐ Data not available
2	High density lipoprotein (HDL) 1 ☐ Yes → 2 ☐ None found within 12 months – *Skip to next item*	_____ mg/dl 1 ☐ Data not available	/ / 1 ☐ Data not available
3	Low density lipoprotein (LDL) 1 ☐ Yes → 2 ☐ None found within 12 months – *Skip to next item*	_____ mg/dl 1 ☐ Data not available	/ / 1 ☐ Data not available
4	Triglycerdes 1 ☐ Yes → 2 ☐ None found within 12 months – *Skip to next item*	_____ mg/dl 1 ☐ Data not available	/ / 1 ☐ Data not available
5	Glycohemoglobin A1c (HgbA1c) 1 ☐ Yes → 2 ☐ None found within 12 months – *Skip to next item*	_____ mg/dl 1 ☐ Data not available	/ / 1 ☐ Data not available
6	Fasting blood glucose (FBG) 1 ☐ Yes → 2 ☐ None found within 12 months	_____ mg/dl 1 ☐ Data not available	/ / 1 ☐ Data not available