NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
LIST OF DATA ITEMS, 1992-2004

The NHAMCS public use data set for each year comprises two separate files--one for outpatient department visits and another for emergency department visits. Each record on the file contains a complete description of the ambulatory care visit, based on information provided on the Patient Record forms. Additionally, each record contains the statistical weight for inflating the sample visit to reflect annual utilization of hospital outpatient departments or emergency departments in the United States. Diagnosis, cause of injury, and procedure data are coded using the International Classification of Diseases, Ninth Revision, Clinical Modification. Patient's reason for visit and medications provided or prescribed are coded using internal systems developed by the National Center for Health Statistics.

Items without dates are available on the public use files for all survey years.

Outpatient department visit file

Date of visit
Patient age
Patient sex
If female, is patient pregnant? (1997-present)
Patient race (revised 1999)
Patient ethnicity
Does patient smoke cigarettes? (1997-1998)
Does patient use tobacco? (2001-present)
Expected source(s) of payment (revised in 1995 and 1997)
Was authorization required for care? (1997-2000)
Patient's reason(s) for visit (up to three)
Are you the patient's primary care physician? (1997-present)
Does patient belong to an HMO? (1997-2000)
Is this a capitated visit? (1997-2000)
Has patient been seen in this clinic before? (1995-present)
If yes, for same condition as this visit? (1995-96)
Episode of care (2001-present)
How many past visits in the last 12 months? (2001-present)
Was patient referred for this visit by another physician?
Major reason for visit (1997-present)
Do other physicians share patient’s care for this problem? (2001-2004)
Is visit injury related? (1995-present)
Cause of injury (up to 3) (1995-2004) (ICD-9-CM E codes)
Place of occurrence (1995-2000)
Is injury work related? (1995-2000)
Is this injury intentional? (1997-2000)
Cause of injury verbatim text (1997-2004)
Physician's diagnoses (up to 3) (ICD-9-CM)
Is diagnosis probable, questionable, or rule out? (1997-present)
Does patient have any of the following conditions:
- arthritis (1995-96)
- atherosclerosis (1995-96)
- COPD (1995-96)
- chronic renal failure (1995-96)

depression (1995-96)
diabetes (1995-96)
HIV/AIDS(1995-96)
hyperactivity/ADD (1995-96)
hypertension (1995-96)
obesity (1995-96)

Ambulatory surgical procedures (up to two) (1992, 1997-present)
(ICD-9-CM) (reported under "Tests, Surgical and Nonsurgical Procedures, and Therapies" in 1993-94)

Scheduled or performed? (1992; for 1995-2000, only performed procedures were to be reported; for 2001-present, procedures could be ordered/scheduled or performed)

Type of anesthesia? (1992 only)

Diagnostic and screening services[1]
(includes patient's temperature and blood pressure readings [2003-present])

Therapeutic and preventive services[1]

Medications provided or prescribed (up to five in 1992-94, up to six in 1995-2002, up to 8 in 2003-present)

Is this a new medication for the patient? (1992)

Additional drug characteristics for each medication coded:
- Generic name code
- Prescription status code
- Controlled substance status code
- Composition status code
- Drug class (based on National Drug Code Directory)
- Ingredient codes (up to five)

Providers seen this visit

Disposition of visit (1992-96, 1999-present)

Time spent with physician (1997-2000)

Patient visit weight (inflation factor assigned to the visit)

Geographic region of visit

Metropolitan statistical area (MSA) or non-MSA location of visit

Hospital ownership

Hospital code (code assigned to all records from a particular hospital)

Clinic type

Patient code (sequential listing of all records from hospital) (1993-present)

Race recode (1993-present)

Age recode (1995-present)

Intentionality of injury recode (based on E code) (1997-2004)

Age in days for patients less than one year (1995-present)

Who completed the Patient Record forms (1999-present)

Setting type (2001-present)

Masked sample design variables (1993-present)

Emergency department visit file

Date of visit

Time of visit (1995-present)

Patient age

Patient sex

If female, is patient pregnant? (1997-2000)

Patient race (revised 1999)
Patient ethnicity
Waiting time to see physician (1997-2000, 2003-present)
Arrival time (2001-present)
Length of visit (2001-present)
Mode of arrival (1997-2000, 2003-present)
Was patient oriented x 3? (2003-present)
Does patient reside in nursing home or other institution? (2001-present)
Does patient smoke cigarettes? (1995-96)
Expected source(s) of payment (revised in 1995 and 1997)
Does patient belong to an HMO? (1997-2000)
Patient's expressed reason(s) for visit (up to 3)
Is this visit related to alcohol use? (2001-2004)
Problem alcohol or drug related? (1992-96)
Has patient been seen in this ED within the last 72 hours? (2001-present)
Immediacy with which patient should be seen (1997-present)
Urgency of visit (1992-96)
Presenting level of pain (1997-2000, 2003-present)
Episode of care (2001-2004)
Major reason for this visit (illness, injury, other) (1992)
Is visit work related ? (2003-present)
Is visit injury related? (1995-present)
Cause of injury (up to three) (ICD-9-CM E-codes)
Place of occurrence (1993-2000)
Is injury work related? (1995-2002)
Did a firearm produce the injury? (1995-96)
Is injury violence related? (1995-96)
If interpersonal violence/assault, person who caused the injury (1995-96)
Is injury intentional? (1997-present)
Is this visit related to an adverse drug event? (2001-02)
  If yes, list up to 2 drugs (2001-02)
Cause of injury verbatim text (1997-present)
Initial vital signs – temperature (2001-present)
Initial vital signs – pulse (2001-present)
Initial vital signs – systolic and diastolic blood pressure (2001-present)
Physician's diagnoses (up to three) (ICD-9-CM)
Is diagnosis probable, questionable, or rule out? (1997-present)
Does patient have depression or HIV/AIDS? (1995-96)
Medications provided or prescribed (up to five in 1992-94, up to six in 1995-2002, up to 8 in 2003-present)
Additional drug characteristics for each medication coded:
  Generic name code
  Prescription status code
  Controlled substance status code
  Composition status code
  Drug class (based on National Drug Code Directory)
  Ingredient codes (up to five)
Diagnostic and screening services[1]
Procedures[1]
Disposition of visit
Providers seen
Patient visit weight (an inflation factor assigned to the visit)
Geographic region

Metropolitan statistical area (MSA) or non-MSA location of visit
Hospital ownership
Hospital code (code assigned to all the records from a particular hospital)
Patient code (sequential listing of all records from a hospital) (1993-present)
Race recode (1993-present)
Age recode (1995-present)
Intentionality of injury recode (based on E code) (1997-present)
Age in days for patients less than one year (1995-present)
Who completed the Patient Record forms? (1999-present)
Setting type (2001-present)
Masked sample design variables (1993-present)

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[1]Updated and/or reformatted periodically to reflect changing health data needs. Most years include a combination of checkbox and open-ended responses, with the latter coded according to the ICD-9-CM procedure classification.

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