NATIONAL AMBULATORY MEDICAL CARE SURVEY
2005 PATIENT RECORD

1. PATIENT INFORMATION
   a. Date of visit
      Month Day Year
   d. Sex
      Female - Is patient pregnant?
      Yes - Specify gestation week
   e. Ethnicity
      1. Hispanic or Latino
      2. Not Hispanic or Latino
   f. Tobacco use
      1. Not current
      2. Current
      3. Former
      4. Never

2. INJURY/POISONING/ADVERSE EFFECT
   Is this visit related to any of the following?
   1. Unintentional injury/poisoning
   2. Intentional injury/poisoning
   3. Adverse effect of medical/surgical care
   4. Adverse effect of medication
   5. None of the above

3. REASON FOR VISIT
   a. Patient's complaint(s), symptoms, or other reason(s) for this visit - Use patient's own words.
      1. Most important:
      2. Other:
      3. Other:
   b. Are you the patient's primary care physician?
      1. Yes - Skip to item 4b
      2. No
      3. Unknown
   c. Status of patient
      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)

4. CONTINUITY OF CARE
   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. Cancer
      2. Asthma
      3. Arthritis
      4. Hyperlipidemia
      5. Hypertension
      6. Depression
      7. Obesity
      8. Diabetes
      9. Chronic renal failure
      10. Ischemic heart disease
      11. COPD
      12. Heart disease
      13. Heart failure
      14. Adverse effect of the conditions
      15. If you enroll at this visit
      16. Preventive care (e.g., routine prenatal, well-baby, screening, insurance, general exams)

5. PHYSICIAN’S DIAGNOSIS FOR THIS VISIT
   a. Mark (X) all ordered or provided at this visit.
   b. Mark (X) or list all ordered or provided at this visit.
   c. Other tests:
      1. Blood tests:
      2. Imaging:
      3. Other diagnostic services:
   d. Other medications:

6. VITAL SIGNS
   a. Height
   b. Weight
   c. Temperature
   d. Blood pressure

7. DIAGNOSTIC/SCREENING SERVICES
   a. Examinations:
   b. Blood tests:
   c. Imaging:
   d. Other diagnostic services:

8. HEALTH EDUCATION
   a. Mark (X) all ordered or provided at this visit.
   b. Mark (X) or list all ordered or provided at this visit.
   c. Other teaching:
   d. Other non-surgical procedures

10. MEDICATIONS & IMMUNIZATIONS
   a. Rx and OTC drugs
   b. Medications
   c. Immunizations
   d. Allergies
   e. Dietary supplements

11. PROVIDERS
   a. Mark (X) all providers seen at this visit.
   b. Mark (X) or list all providers seen at this visit.
   c. Other providers:

12. VISIT DISPOSITION
   a. Mark (X) providers seen at this visit.
   b. Mark (X) all that apply:
   c. Mark (X) or list all that apply:
   d. Other providers:

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1. PATIENT INFORMATION
   a. Date of visit
   d. Sex
   e. Ethnicity
   f. Tobacco use

2. INJURY/POISONING/ADVERSE EFFECT
   Is this visit related to any of the following?

3. REASON FOR VISIT
   a. Patient's complaint(s), symptoms, or other reason(s) for this visit - Use patient's own words.
   b. Are you the patient's primary care physician?
   c. Status of patient

4. CONTINUITY OF CARE
   a. As specifically as possible, list diagnoses related to this visit including chronic conditions.
   b. Regardless of the diagnoses written in 5a, does the patient now have - Mark (X) all that apply.
   c. Status of patient

5. PHYSICIAN’S DIAGNOSIS FOR THIS VISIT
   a. Mark (X) all ordered or provided at this visit.
   b. Mark (X) or list all ordered or provided at this visit.
   c. Other tests:
   d. Other medications:

6. VITAL SIGNS
   a. Height
   b. Weight
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7. DIAGNOSTIC/SCREENING SERVICES
   a. Examinations:
   b. Blood tests:
   c. Imaging:
   d. Other diagnostic services:

8. HEALTH EDUCATION
   a. Mark (X) all ordered or provided at this visit.
   b. Mark (X) or list all ordered or provided at this visit.
   c. Other teaching:
   d. Other non-surgical procedures

10. MEDICATIONS & IMMUNIZATIONS
   a. Rx and OTC drugs
   b. Medications
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11. PROVIDERS
   a. Mark (X) all providers seen at this visit.
   b. Mark (X) or list all providers seen at this visit.
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12. VISIT DISPOSITION
   a. Mark (X) providers seen at this visit.
   b. Mark (X) all that apply:
   c. Mark (X) or list all that apply:
   d. Other providers: