NATIONAL AMBULATORY MEDICAL CARE SURVEY
2006 PATIENT RECORD

1. PATIENT INFORMATION

a. Date of visit
   - Month Day Year
   - 1-2 00

b. Sex
   - Female
   - 1-2 00
   - Male
   - 1-2 00

c. Zip code
   - Month Day Year
   - 1-2 00

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 medicinal drug
5. None of the above
6. Unknown

3. REASON FOR VISIT

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

4. CONTINUITY OF CARE

a. Are you the patient’s primary care physician/provider?
   - 1-2 00

5. PROVIDER’S DIAGNOSIS FOR THIS VISIT

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

6. VITAL SIGNS

Mark (X) all ordered or provided at this visit.

7. DIAGNOSTIC/SCREENING SERVICES

Mark (X) all ordered or provided at this visit.

8. HEALTH EDUCATION

Mark (X) all ordered or provided at this visit.

9. NON-MEDICATION TREATMENT

Mark (X) all ordered or provided at this visit.

10. MEDICATIONS & IMMUNIZATIONS

Include Rx and OTC drugs, immunizations, allergy shots, anesthetics, chemotherapy, and dietary supplements that were ordered, supplied, administered or continued during the visit.

11. PROVIDERS

Mark (X) all providers seen at this visit.

12. VISIT DISPOSITION

13. TIME SPENT WITH PROVIDER

14. Minor reason for this visit

15. Major reason for this visit

16. Other reason for this visit

17. Other

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

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