1. PATIENT INFORMATION

1. Date of visit
   - Month: [Enter Month]
   - Day: [Enter Day]
   - Year: [Enter Year]

2. Ethnicity
   - [ ] Hispanic or Latino
   - [ ] Not Hispanic or Latino

3. Race
   - [ ] White
   - [ ] Black/African American
   - [ ] Native Hawaiian/Other Pacific Islander
   - [ ] American Indian/Alaska Native
   - [ ] Asian
   - [ ] Other

4. Does patient use tobacco?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

5. Primary expected source of payment for this visit
   - [ ] Private insurance
   - [ ] Medicare
   - [ ] Medicaid/SCHIP
   - [ ] Worker's Compensation
   - [ ] Other
   - [ ] Unknown

6. Are you the patient's primary care physician?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

3. CONTINUITY OF CARE

a. Was patient referred for this visit?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

4. INJURY/POISONING/ADVERSE EFFECT

a. Cause of injury, poisoning, or adverse effect
   - Describe the place, immediately, and events that preceded the injury, poisoning, or adverse event (e.g., allergy in penicillin, fall, pedestrian hit by car driven by drunk driver, was bitten by bees by husband, heroin overdose, infected shunt, etc.).

5. PHYSICIAN'S DIAGNOSIS FOR THIS VISIT

6. DIAGNOSTIC/SCREENING SERVICES

7. MEDICATIONS & INJECTIONS

8. MEDICATIONS & INJECTIONS
   - (Number of drugs)
   - Include Rx and OTC medications, immunizations, allergy shots, anesthetics, and dietary supplements that were ordered, supplied, administered or continued during this visit.

   List up to six medication/injection names below:

   (1)
   (2)
   (3)
   (4)
   (5)
   (6)

9. PROVIDERS SEEN

10. VITAL DISPOSITION

11. TIME SPENT WITH PHYSICIAN

   Minutes:
   - Enter zero if no physician seen

   A 500156

   NAMC-30A (05/20-2011)