NAMCS-73
(11-1-2012)

# SAMPLE

## NATIONAL AMBULATORY MEDICAL CARE SURVEY
## 2013 PATIENT RECORD

Form Approved: OMB No. 0920-0234; Expiration date 12/31/2014

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## PATIENT INFORMATION

**Patient medical record No.**

**Date of visit**
Month | Day | Year: 2 0 1

**ZIP Code**

**Date of birth**
Month | Day | Year

**Sex**
1 ☐ Female – Is patient pregnant?
  1 ☐ Yes - *Specify gestation week* →
  **OR**
  *LMP* Month | Day | Year: 2 0 1
  2 ☐ No
  3 ☐ Unknown
2 ☐ Male

**Ethnicity**
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

**Race**
1 ☐ White
2 ☐ Black or African American
3 ☐ Asian
4 ☐ Native Hawaiian or Other Pacific Islander
5 ☐ American Indian or Alaska Native

**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

**Tobacco use**
1 ☐ Not current
2 ☐ Current
3 ☐ Unknown

## VITAL SIGNS

Height: ft ____ in ____ **OR** cm ____

Weight: lb ____ oz ____ **OR** kg ____ gm ____

Temperature: ____ ☐ °C ☐ °F

Blood pressure: Systolic ____ / Diastolic ____

## INJURY/POISONING/ADVERSE EFFECT

**Is this visit related to an injury, poisoning, or adverse effect of medical treatment?**
1 ☐ Yes, injury/trauma
2 ☐ Yes, poisoning
3 ☐ Yes, adverse effect of medical treatment
4 ☐ No
5 ☐ Unknown
*SKIP to Reason For Visit*

**Is this injury/poisoning unintentional or intentional**
1 ☐ Unintentional
2 ☐ Intentional
3 ☐ Unknown

## 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

## CONTINUITY OF CARE

**Are you the patient's primary care physician?**
1 ☐ Yes – *SKIP to* →
2 ☐ No
3 ☐ Unknown

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

**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

**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)

## DIAGNOSIS

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

(1) Primary diagnosis
(2) Other
(3) Other

**Regardless of the diagnoses previously entered, does the patient now have –** *Mark (X) all that apply.*

1 ☐ Arthritis
2 ☐ Asthma ↙

**Asthma severity:**
1 ☐ Intermittent
2 ☐ Mild persistent
3 ☐ Moderate persistent
4 ☐ Severe persistent
5 ☐ Other – *Specify* ↙
6 ☐ None recorded

**Asthma control:**
1 ☐ Well controlled
2 ☐ Not well controlled
3 ☐ Very poorly controlled
4 ☐ Other – *Specify* ↙
5 ☐ None recorded

3 ☐ Cancer
4 ☐ Cerebrovascular disease/History of stroke or transient ischemic attack (TIA)
5 ☐ Chronic obstructive pulmonary disease (COPD)
6 ☐ Chronic renal failure
7 ☐ Congestive heart failure
8 ☐ Depression
9 ☐ Diabetes Includes both Type I diabetes mellitus (insulin dependent or IDDM) and Type II diabetes mellitus (non-insulin dependent or NIDDM). Excludes diabetes insipidus and gestational diabetes.
10 ☐ Hyperlipidemia
11 ☐ Hypertension
12 ☐ Ischemic heart disease
13 ☐ Obesity Provider-diagnosed and documented in record
14 ☐ Osteoporosis
15 ☐ None of the above

## SERVICES

*Enter all examinations, blood tests, imaging, other tests, non-medication treatment and health education ORDERED or PROVIDED.*

1 ☐ NONE

**Examinations:**

2 ☐ Breast
3 ☐ Depression screening
4 ☐ Foot
5 ☐ General physical exam
6 ☐ Neurologic
7 ☐ Pelvic
8 ☐ Rectal
9 ☐ Retinal
10 ☐ Skin

**Blood tests:**

11 ☐ CBC
12 ☐ Glucose
13 ☐ HbA1c (Glycohemoglobin)
14 ☐ Lipid profile
15 ☐ PSA (prostate specific antigen)

**Imaging:**

16 ☐ Bone mineral density
17 ☐ CT scan
18 ☐ Echocardiogram
19 ☐ Other ultrasound
20 ☐ Mammography
21 ☐ MRI
22 ☐ X-ray

**Other tests and procedures:**

23 ☐ Audiometry
24 ☐ Biopsy
1 ☐ Provided
25 ☐ Cardiac stress test
26 ☐ Chlamydia test
27 ☐ Colonoscopy
1 ☐ Provided
28 ☐ EKG/ECG
29 ☐ Electroencephalogram (EEG)
30 ☐ Electromyogram (EMG)
31 ☐ Excision of tissue
1 ☐ Provided
32 ☐ Fetal monitoring
33 ☐ HIV test
34 ☐ HPV DNA test
35 ☐ PAP test
36 ☐ Peak flow
37 ☐ Pregnancy/HCG test
38 ☐ Sigmoidoscopy
1 ☐ Provided
39 ☐ Spirometry
40 ☐ Tonometry
41 ☐ Urinalysis

**Non-medication treatment:**

42 ☐ Cast/splint/wrap
43 ☐ Complementary and alternative medicine (CAM)
44 ☐ Durable medical equipment
45 ☐ Home health care
46 ☐ Mental health counseling, excluding psychotherapy
47 ☐ Physical therapy
48 ☐ Psychotherapy
49 ☐ Radiation therapy
50 ☐ Wound care

**Health education/ Counseling:**

51 ☐ Asthma
52 ☐ Asthma action plan given to patient
53 ☐ Diet/Nutrition
54 ☐ Exercise
55 ☐ Family planning/ Contraception
56 ☐ Growth/Development
57 ☐ Injury prevention
58 ☐ STD prevention
59 ☐ Stress management
60 ☐ Tobacco use/Exposure
61 ☐ Weight reduction

**Other services not listed:**

62 ☐ Other service – *Specify*

63 ☐ Other service – *Specify*

64 ☐ Other service – *Specify*

65 ☐ Other service – *Specify*

66 ☐ Other service – *Specify*

## MEDICATIONS & IMMUNIZATIONS

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

☐ NONE

| | | 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 ☐ |
| (9) | | 1 ☐ | 2 ☐ |
| (10) | | 1 ☐ | 2 ☐ |

## 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
7 ☐ None

## TIME SPENT WITH PROVIDER

Minutes

*Enter zero if no provider seen*

## 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

## CPT CODES

**Please record ALL CPT Codes (Current Procedural Terminology) or HCPCS (Healthcare Common Procedure Coding System) Codes associated with this visit. Include CPT modifier codes if available.**

## TESTS

| | Was blood for the following laboratory tests drawn on the day of the sampled visit or during the 12 months prior to the visit? | Most recent result | Date of test (mm/dd/yyyy) |
|---|---|---|---|
| 1 | Total Cholesterol — 1 ☐ Yes → 2 ☐ None found | mg/dL | / / |
| 2 | High density lipoprotein (HDL) — 1 ☐ Yes → 2 ☐ None found | mg/dL | / / |
| 3 | Low density lipoprotein (LDL) — 1 ☐ Yes → 2 ☐ None found | mg/dL | / / |
| 4 | Triglycerides (TGs) — 1 ☐ Yes → 2 ☐ None found | mg/dL | / / |
| 5 | HbA1c (Glycohemoglobin) — 1 ☐ Yes → 2 ☐ None found | % | / / |
| 6 | Fasting blood glucose (FBG) — 1 ☐ Yes → 2 ☐ None found | mg/dL | / / |
| 7 | Serum creatinine — 1 ☐ Yes → 2 ☐ None found | mg/dL | / / |