ICPSR | INTER-UNIVERSITY CONSORTIUM FOR POLITICAL AND SOCIAL RESEARCH

ICPSR 28442

National Hospital Ambulatory Medical Care Survey, 2007

United States Department of Health and Human Services. Centers for Disease Control and Prevention. National Center for Health Statistics

Outpatient Department Questionnaire

Inter-university Consortium for Political and Social Research
P.O. Box 1248
Ann Arbor, Michigan 48106
www.icpsr.umich.edu

Terms of Use

Information about Copyrighted Content

Form Approved OMB No. 0920-0278 Exp. Date 08/31/2009 CDC 64.135

FORM **NHAMCS-100(OPD)**
(9-28-2006)

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
National Center for Health Statistics

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2007 OUTPATIENT DEPARTMENT PATIENT RECORD

PATIENT RECORD NO.:

PATIENT'S NAME:

Assurance of confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purpose of the survey and will not be disclosed or released to other persons or used for any other purpose without consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

(Provider: Detach and keep upper portion)

Please keep (X) marks inside of boxes ➜ ☒ Correct ☒ Incorrect

1. PATIENT INFORMATION

a. Date of visit

Month		Day		Year			
				2	0	0	7

b. ZIP Code

c. Date of birth

Month		Day		Year			

d. Sex
1 ☐ Female 2 ☐ Male

e. Ethnicity
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

f. Race – *Mark (X) one or more.*
1 ☐ White
2 ☐ Black/African American
3 ☐ Asian
4 ☐ Native Hawaiian/ Other Pacific Islander
5 ☐ American Indian/Alaska Native

g. Expected source(s) of payment for this visit – *Mark (X) all that apply.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid/SCHIP
4 ☐ Worker's compensation
5 ☐ Self-pay
6 ☐ No charge/Charity
7 ☐ Other
8 ☐ Unknown

h. Tobacco use
1 ☐ Not current 3 ☐ Unknown
2 ☐ Current

2. INJURY/POISONING/ ADVERSE EFFECT

Is this visit related to any of the following?
1 ☐ Unintentional injury/poisoning
2 ☐ Intentional injury/poisoning
3 ☐ Injury/poisoning – unknown intent
4 ☐ Adverse effect of medical/ surgical care or adverse effect of medicinal drug
5 ☐ None of the above

3. 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:

4. CONTINUITY OF CARE

a. Is this clinic the patient's primary care provider?
1 ☐ Yes –*SKIP to item 4b.*
2 ☐ No
3 ☐ Unknown

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

b. Has the patient been seen in this clinic before?
1 ☐ Yes, established patient – **How many past visits in the last 12 months?** *Exclude this visit.*
☐ Visits
1 ☐ Unknown
2 ☐ No, new patient

c. 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)

5. PROVIDER'S DIAGNOSIS FOR THIS VISIT

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 ☐ Arthritis
2 ☐ Asthma
3 ☐ Cancer
0 ☐ In situ
1 ☐ Local
2 ☐ Regional
3 ☐ Distant
4 ☐ Unknown
4 ☐ Cerebrovascular disease
5 ☐ CHF
6 ☐ Chronic renal failure
7 ☐ COPD
8 ☐ Depression
9 ☐ Diabetes
10 ☐ Hyperlipidemia
11 ☐ Hypertension
12 ☐ Ischemic heart disease
13 ☐ Obesity
14 ☐ Osteoporosis
15 ☐ None of the above – *SKIP to item 6*

c. Status of patient enrollment in a disease management program for any of the conditions marked in 5b.
1 ☐ Currently enrolled
2 ☐ Ordered/Advised to enroll at this visit
3 ☐ Not enrolled
4 ☐ Unknown

6. VITAL SIGNS

(1) Height
☐ ft ☐ in OR ☐ cm

(2) Weight
☐ lb ☐ oz
OR
☐ kg ☐ gm

(3) Temperature
☐ ˚C
☐ ˚F

(4) Blood pressure
Systolic / Diastolic

7. DIAGNOSTIC/SCREENING SERVICES

Mark (X) all ***ordered*** *or* ***provided*** *at this visit.*
1 ☐ NONE

Examinations:
2 ☐ Breast
3 ☐ Pelvic
4 ☐ Rectal
5 ☐ Skin
6 ☐ Depression screening

Imaging:
7 ☐ X-ray
8 ☐ Bone mineral density
9 ☐ CT scan
10 ☐ Echocardiogram
11 ☐ Other ultrasound
12 ☐ Mammography
13 ☐ MRI
14 ☐ PET scan
15 ☐ Other imaging

Blood tests:
16 ☐ CBC (complete blood count)
17 ☐ Electrolytes
18 ☐ Glucose
19 ☐ HgbA1C (glycohemoglobin)
20 ☐ Lipids/Cholesterol
21 ☐ PSA (prostate specific antigen)
22 ☐ Other blood test

Scope:
23 ☐ Scope procedure (e.g., colonoscopy) - *Specify*

Other tests:
24 ☐ Biopsy – *Specify site*
25 ☐ Chlamydia test
26 ☐ EKG/ECG
27 ☐ HPV DNA test
28 ☐ Pap test - conventional
29 ☐ Pap test - liquid-based
30 ☐ Pap test - unspecified
31 ☐ Pregnancy test
32 ☐ Spirometry/Pulmonary function test
33 ☐ Urinalysis (UA)
34 ☐ Other exam/test/service - *Specify*

8. HEALTH EDUCATION

Mark (X) all ***ordered*** *or* ***provided*** *at this visit.*
1 ☐ NONE
2 ☐ Asthma education
3 ☐ Diet/Nutrition
4 ☐ Exercise
5 ☐ Growth/Development
6 ☐ Injury prevention
7 ☐ Stress management
8 ☐ Tobacco use/ Exposure
9 ☐ Weight reduction
10 ☐ Other

9. NON-MEDICATION TREATMENT

Mark (X) all ***ordered*** *or* ***provided*** *at this visit.*
1 ☐ NONE
2 ☐ Complementary alternative medicine (CAM)
3 ☐ Durable medical equipment
4 ☐ Home health care
5 ☐ Hospice care
6 ☐ Physical therapy
7 ☐ Radiation therapy
8 ☐ Speech/Occupational therapy
9 ☐ Psychotherapy
10 ☐ Other mental health counseling
11 ☐ Excision of tissue
12 ☐ Orthopedic care
13 ☐ Wound care

Procedures:
14 ☐ Other non-surgical procedures – *Specify*
15 ☐ Other surgical procedures – *Specify*

10. MEDICATIONS & IMMUNIZATIONS

☐ NONE

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

	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 ☐

11. 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

12. VISIT DISPOSITION

Mark (X) all that apply.
1 ☐ No show
2 ☐ Left without being seen
3 ☐ No follow-up planned
4 ☐ Return if needed, PRN
5 ☐ Refer to other physician
6 ☐ Return at specified time
7 ☐ Telephone follow-up planned
8 ☐ Refer to emergency department
9 ☐ Admit to hospital
10 ☐ Other