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National Ambulatory Medical Care Survey: 2003 Summary

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Abstract

Objective—This report describes ambulatory care visits made to physician offices in the United States. Statistics are presented on selected characteristics of the physician's practice, the patient, and the visit. Selected trends in office visits from 1993 through 2003 are presented.

Methods—The data presented in this report were collected from the 2003 National Ambulatory Medical Care Survey (NAMCS). NAMCS is part of the ambulatory care component of the National Health Care Survey that measures health care utilization by various types of providers. NAMCS is a national probability sample survey of visits to office-based physicians in the United States. Sample data are weighted to produce annual national estimates using an estimator that uses a revised nonresponse adjustment.

Results—During 2003, an estimated 906.0 million visits were made to physician offices in the United States, an overall rate of 317.3 visits per 100 persons. The visit rate to physician offices in metropolitan statistical areas (MSAs) (334.7 visits per 100 persons) was significantly larger than the rate in non-MSAs (229.3 visits per 100 persons). Females had a higher visit rate compared with males, and white persons had higher rates than black or African-American persons. Overall, 59.4 percent of visits were to physicians in the specialties of general and family practice, internal medicine, pediatrics, and obstetrics and gynecology. Primary care specialists provided 87.8 percent of all preventive care visits. New patients, representing 11.6 percent of visits in 2003, have decreased 26 percent since 1993 (15.6 percent). Utilization rates were highest for Medicare enrollees (585.0 visits per 100 persons) and lowest for patients without insurance (106.8 visits per 100 persons). The percent of visits relying on Medicaid or the State Children's Health Insurance Program increased by 42% between 2001 and 2003. Essential hypertension, acute upper respiratory infection, arthropathies, and diabetes mellitus were the leading illness-related primary diagnoses. The percent of visits made by patients with high blood pressure readings was highest among those 45–64 years of age. On average, 2.6 medications were ordered or provided at each office visit with any mention of a medication. Between 2001 and 2003, the estrogen and progestin drug mention rate for females 45 years and over declined by 45 percent.

Keywords: ambulatory care • physician office care • diagnoses • injury • medications • ICD-9-CM • primary care

Introduction

The National Ambulatory Medical Care Survey (NAMCS), which began in 1973, collects data on the utilization of ambulatory medical care services provided by office-based physicians. It was conducted annually until 1981, again in 1985, and resumed an annual schedule in 1989. The NAMCS is complemented by the National Hospital Ambulatory Medical Care Survey (NHAMCS), which was inaugurated in 1992 to expand the scope of data collection to the medical services provided by hospital outpatient and emergency departments. Together, NAMCS and NHAMCS data provide an important tool for tracking ambulatory health care utilization in the United States. The NAMCS and NHAMCS are part of the National Health Care Survey, which measures health care utilization across various types of providers. More information about the National Health Care Survey can be found at the National Center for Health Statistics' (NCHS) Web site: www.cdc.gov/nchs/nhcs.htm. More information on the 2003 NHAMCS annual summaries (hospital outpatient and emergency departments) is available (1,2). A separate report combining NAMCS and NHAMCS data provides a comprehensive picture of ambulatory health care utilization (3). It shows that 81 percent of ambulatory

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care delivered by non-Federal physicians is provided in office-based practices. Hospital ambulatory patients are known to differ from office patients in certain demographic and medical characteristics.

This report presents national annual estimates of physician office visits for 2003 using an estimator with a revised nonresponse adjustment. For analytic purposes, trend comparisons were analyzed separately for 1993–2001 using the original weight and for 2001–03 using the revised weight because visit estimates using the revised estimator are expected to be higher in magnitude than estimates using the previous estimator when there is greater nonresponse from physicians with greater volume. Physician practice, patient, and visit characteristics are described. Vital signs, including temperature and blood pressure readings, are reported for the first time. The upper limit on the number of medications recorded increased from six to eight and affected drug mention estimates.

Data Highlights

Physician office utilization

- In 2003, 906.0 million visits were made to physician offices, or about 317.3 visits per 100 persons. Of these visits, 58.9 percent were made to primary care specialists, 20.2 percent to surgical specialists, and the remaining 20.9 percent to medical specialists.
- The visit rate for infants under 12 months of age (662.8 per 100 persons) was similar to the visit rate for elderly persons aged 65 years and over (663.7 per 100 persons). From 1993 through 2001, the visit rate increased for all ages by 7%, from 282.0 to 300.4 per 100 persons (using original estimator). Between 2001 and 2003, the visit rates for all ages remained stable (using revised estimator).
- The visit rate for white persons (337.2 visits per 100 persons) was higher than for black or African-American persons (235.9 visits per 100 persons), but was similar to the visit rate for Asians (313.2 visits per 100 persons). The visit rate for Hispanic or Latino persons (260.8 per 100 persons) was not statistically different from the rate for non-Hispanic persons (326.4 per 100 persons).
- Private insurance was the most frequent expected source of payment, accounting for 56.2 percent of all visits, and government sources (Medicare and Medicaid or State Children's Health Insurance Program (SCHIP) combined) accounted for 33.0 percent of visits. Utilization rates were highest for Medicare enrollees (585.0 per 100 persons) and lowest for uninsured patients (106.8 per 100 persons). Between 2001 and 2003, the percentage of visits relying on Medicaid or SCHIP increased by 42%.
- Of visits made to office-based physicians, 14.5 percent were referred for the current visit.
- There were 99.9 million injury visits to office-based physicians in 2003. The visit rate for injuries increased with patient age resulting in a rate of 63.8 per 100 persons for patients 75 years of age and over. White persons had a significantly greater rate of injury visits than did black or African-American persons or persons of other races (38.3, 22.5, and 19.1 visits per 100 persons, respectively).

Services provided

- The rate of preventive care visits was higher for females than for males. There were no race differences observed. Twelve percent of preventive care visits were made to specialists. Diagnostic and screening services were ordered or provided at 85.7 percent of visits; counseling, education, or therapeutic services were ordered or provided at 41.5 percent of visits; and surgical procedures were ordered or provided at 7.0 percent of visits. An estimated 74.8 million ambulatory surgical procedures were ordered, scheduled, or performed during office visits. The patient's blood pressure was measured at 52.4 percent of visits. Among these visits, a higher percentage of those 45–64 years had high blood pressure measurements, defined as either a systolic measurement ≥ 140 mmHg or diastolic measurement ≥ 90 mmHg.
- About 1.6 billion drugs were prescribed or provided at 65.7 percent of office visits. Multiple drugs were prescribed at 39.5 percent of visits. Drug mention rates varied by physician specialty (ranging from 46.4 for general surgery to 398.6 mentions per 100 visits for cardiovascular disease physicians).
- The therapeutic classes of nonsteroidal anti-inflammatory drugs (NSAIDS), antidepressants, and hyperlipidemia increased significantly between 1995 and 2001, but were stable between 2001 and 2003. Estrogen and progestin drug mentions for women 45 years and over declined by 45% between 2001 and 2003.
- A physician was seen during most office visits (95.5 percent). During 21.6 percent of the visits, a medical or nursing assistant was seen.

Methods

The data presented in this report are from the 2003 NAMCS, a national probability sample survey conducted by the Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Health Care Statistics. The survey was conducted from December 30, 2002, through December 28, 2003. The target universe of the NAMCS includes visits made in the United States to the offices of nonfederally employed physicians (excluding those in the specialties of anesthesiology, radiology, and pathology) who were classified by the American Medical Association (AMA) and the American Osteopathic Association (AOA) as ''office-based, patient care.'' Visits to private, nonhospital-based clinics and health maintenance organizations (HMOs) were within the scope of the survey, but those that occurred in federally operated facilities and hospital-based outpatient departments were not. Telephone contacts and visits made outside the physician's office were also excluded.

The NAMCS utilizes a multistage probability sample design involving

samples of 112 geographic primary sampling units (PSUs), physician practices within PSUs, and patient visits within physician practices. The PSUs are counties, groups of counties, county equivalents (such as parishes or independent cities), or towns and townships for some PSUs in New England. A sample of physicians was selected from the master files of the AMA and the AOA; 2,007 were in scope (eligible to participate in the survey). Sample physicians were asked to complete Patient Record forms (see figure I) for a systematic random sample of approximately 30 office visits occurring during a randomly assigned 1-week reporting period. The weighted response rate for in-scope physicians was 66.3 percent, and a total of 25,288 Patient Record forms were completed. The ''Technical Notes'' provide more information on characteristics of nonresponding physicians.

Sample data are weighted to produce annual national estimates. Beginning in the 2003 data year, estimates presented use a weight that includes a revised adjustment for nonresponse. In previous years, the adjustment accounted for nonresponse by physician specialty, geographic region, and metropolitan statistical area status. The revised nonresponse adjustment additionally accounts for nonresponse from physicians by practice size as measured by number of weekly visits and for variability in number of weeks participating physicians saw patients during the year. Previously, these characteristics were assumed to be the same for physicians providing patient encounter information and those who do not. However, research conducted with 2003 data showed that physicians with larger visit volumes were more likely to refuse to participate. In addition, physicians who did not see patients during their assigned week saw patients fewer weeks annually than physicians who did see patients (4). The revised nonresponse adjustment uses information collected from physicians during the induction interview. Information on usual weekly visit volume has been collected since 2001 from sample physicians who refuse to provide encounter information.

For analytic purposes, trend comparisons were analyzed separately for 1993–2001 using the original weight and for 2001–03 using the revised weight because visit estimates using the revised estimator are expected to be higher in magnitude than estimates using the previous estimator when there is greater nonresponse from physicians with greater volume. For comparability in drug mention rate trends, drug mentions for 2003 were limited to the first six drug mentions. Original weights were used to analyze 1995–2001 drug mentions separately from 2001–03 trends using revised weights. Effects of the revised weight relative to the original weight on visit estimates are presented in several charts included in the report. The ''Technical Notes'' at the end of this report include an explanation of the revised estimator.

Because the estimates presented in this report are based on a sample rather than on the entire universe of office visits, they are subject to sampling variability. The ''Technical Notes'' at the end of this report include an explanation of the sampling errors with guidelines for judging the precision of the estimates and information on physician and item nonresponse. The standard errors are calculated using Taylor approximations in SUDAAN, which take into account the complex sample design of the NAMCS (5). Data on physician office utilization rates from 1993 through 2003 and selected trends by patient age and by drugs are also presented. A weighted least-squares regression analysis was used to determine the significance of trends at the 0.05 level.

The U.S. Census Bureau was responsible for data collection. Data processing operations and medical coding were performed by Constella Group, Inc., Durham, North Carolina. As part of the quality assurance procedure, a 10-percent quality control sample of survey records was independently keyed and coded. Coding error rates ranged between 0.1 and 1.1 percent for various survey items.

Several of the tables in this report present rates of physician office visits per population. The population figures used in calculating these rates are based on Census Bureau monthly postcensal estimates of the civilian noninstitutional population of the United States as of July 1, 2003. These population estimates are based on postcensal estimates from Census 2000 and are available from the Census Bureau. For some rates, other denominators were used. See the ''Technical Notes'' for more detail on population figures and rate calculations. Estimates presented in the tables and figure for specific race categories reflect visits at which only a single race was reported. See ''Technical Notes'' for more detail on race estimates.

In April 2003, the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) was implemented to establish minimum Federal standards for safeguarding the privacy of individually identifiable health information. Therefore, the NAMCS implemented additional data collection procedures to help providers assure patient confidentiality. See ''Technical Notes'' for more information.

Results

There were an estimated 906.0 million visits to office-based physicians in 2003, about 317.3 visits per 100 persons. Although the population of the United States has increased by 12 percent since 1993, the number of visits to physician offices increased by 23 percent between 1993 and 2001 (using original estimator) (6). Although the number of visits appeared to decline between 2001 and 2003 (from 951.2 to 906.0 million visits using revised estimator), the difference was not statistically significant. Selected characteristics of the encounter pertaining to the physician's practice, the patient, and the visit are described.

Office practice characteristics—The distribution of office visits according to physician specialty is presented in table 1 and figure 1. About a quarter of all visits were to general and family practice physicians with an additional 34.8 percent of visits to physicians specializing in internal medicine, pediatrics, and obstetrics and gynecology. Of all the office visits made in 2003, about 6 out of every 10 were to

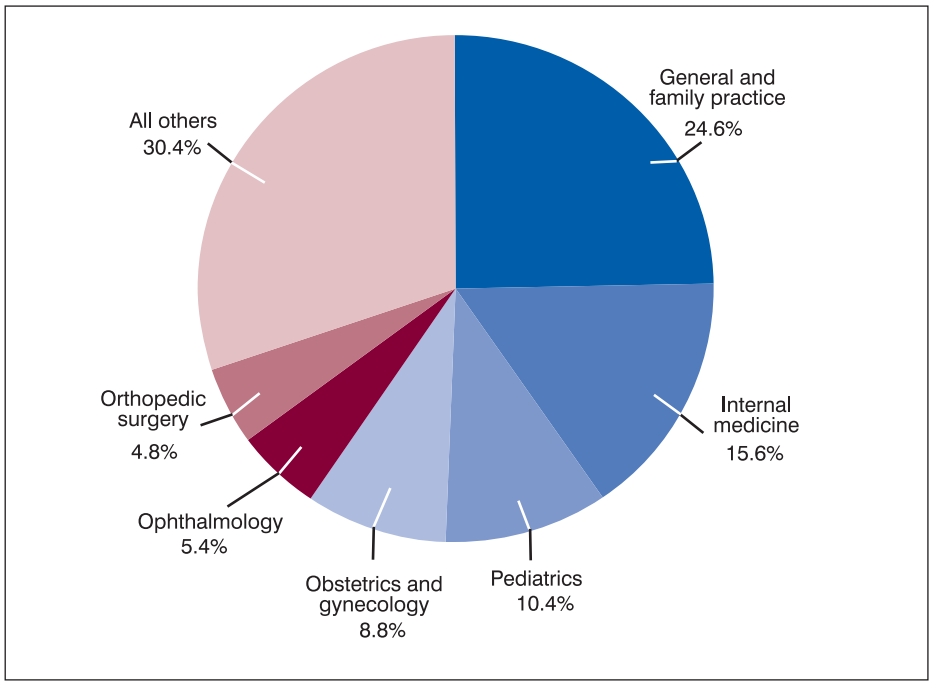


Figure 1. Percent distribution of office visits by physician specialty: United States, 2003

physicians in primary care specialties (58.9 percent). For definitions of those specialties, see the "Technical Notes." Throughout this report, visits to "primary care specialists or specialties" and "primary care visits" will be used interchangeably. Surgical and medical specialties accounted for 20.2 and 20.9 percent of visits, respectively. Table 1 also shows that doctors of osteopathy received 66.7 million visits during 2003, or 7.4 percent of all office visits. Visits to osteopathic physicians occurred at a rate of 23.3 visits per 100 persons. Visits according to geographic region and metropolitan status are also displayed in table 1. The visit rates were similar for each of the geographic regions, except the visit rate for the Northeast region (353.5 visits per 100 persons) was significantly higher than the rate in the Midwest (282.9 visits per 100 persons). The visit rate to physician offices located in MSAs (334.7 visits per 100 persons) was significantly higher than the rate observed in non-MSAs (229.3 visits per 100 persons).

Additional information on the physician's practice has been collected annually in the NAMCS through the Physician Induction Interview (PII) form. The PII is used to obtain basic information on the practice, to establish the visit sampling rate, and to record the final disposition of the interview. In 2003, selected survey items on the physician and physician's practice, including employment status, ownership, practice size, and office type, were weighted and edited to produce national estimates of office visits by these characteristics. These data demonstrate the type of practices to which visits are being made and are displayed in table 2. Overall, 86.9 percent of the visits were to physicians who owned the practice themselves or with a group of other physicians. The majority of office visits (61.3 percent) were made to physicians engaged in group practice (table 2). More than one-half of all visits were to physicians in practices with 2–9 physicians (51.1 percent) compared with 10.2 percent of visits to large practices with 10 or more physicians. Significantly more visits to group practices were characterized as single-specialty practices (44.0 percent) compared with multispecialty practices (17.5 percent).

Patient characteristics—Office visits by patient's age, sex, race, and ethnicity are shown in table 3. As in previous years, females made the majority of office visits during 2003. The percentage of visits was higher for females compared with males in age groups 15 years of age and over. Sex differences were also observed for visit rates between 15 and 64 years of age (figure 2).

Annual rate of visits to office-based physicians and corresponding standard errors (SE) by detailed age groups

- Under 1 year (662.8 per 100 persons, SE=75.6)
- 1–12 years (217.2 per 100 persons, SE=17.0)
- 13–21 years (117.7 per 100 persons, SE=12.0)
- 22–49 years (256.0 per 100 persons, SE=11.6)
- 50–64 years (398.5 per 100 persons, SE=18.3)
- 65 years and over (663.7 per 100 persons, SE=33.3)

The text box shows annual visit rates for more detailed age groups (infants, children, adolescents and young adults, adults, middle-aged persons, and seniors). The visit rate to physician offices was highest for infants under 1 year of age and the elderly 65 years and over (662.8 and 663.7 visits per 100 persons, respectively). The visit rate declined from infancy to young adulthood (13–21 years of age), then rose as age increased.

Trends in visit rates by these detailed age groups are displayed in figure 3. The figure also shows the effects of the revised weight for 2001–03 estimates (dotted line) relative to the original weight (solid line). Although 2001 through 2003 visit rates derived using the revised weight were similar to rates derived using the original weight, the revised weight increased the magnitude of visit rates for most age groups. For comparability, all trends for the time period 1993–2001 using the original weight and for 2001–03 using the revised weight were tested separately. Between 1993 and 2001, the visit rate overall increased by 11 percent, driven by increasing visits by persons 22–49 years (up 4 percent),

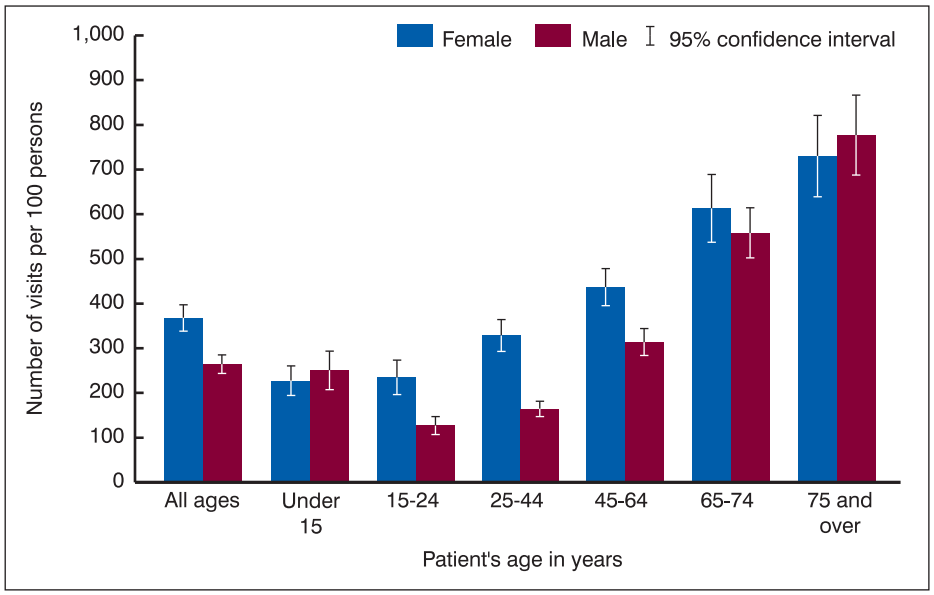


Figure 2. Annual rate of visits to office-based physicians by patient age and sex: United States, 2003

50–64 years (up 18 percent), and 65 years and over (up 24 percent). The overall visit rate remained stable between 2001 and 2003, as well as visit rates for all age groups shown in figure 3.

White persons represented 81 percent of the U.S. civilian noninstitutional population in 2003 and made 85.8 percent of all physician office visits. Overall, the visit rate for white persons (337.2 visits per 100 persons) was significantly higher than for black or African-American persons (235.9 visits per 100 persons) and was driven by significant differences for patients under 15 years and 15–24 years (figure 4). The visit rate for Asians (313.2 visits per 100 persons) was similar to the visit rate for white persons.

Historically, visit rates for black or African-American persons to physician offices tend to be lower than those for white persons. However, differences in visit rates by race can vary by type of health care setting utilized. Data from the 2003 NHAMCS indicate that the visit rate for black or African-American persons was higher than for white persons in both outpatient departments (58.0 visits per 100 black persons compared with 30.2 visits per 100 white persons) and emergency departments (69.3 visits per 100 black persons compared with 37.2 visits per 100 white persons) (1,2).

This report also includes data on patient ethnicity (Hispanic or Latino, Not Hispanic or Latino) in several tables. In the past, NAMCS reports have omitted these data because of high item nonresponse rates. However, nonresponse for this item declined by 34% since 2001 (from 26.8 to 17.8 in 2003) and the relative proportion of the Hispanic population has been increasing (7). In 2003, Hispanic or Latino persons represented 13.8 percent of the population and made 11.3 percent of all physician office visits. Their visit rate (260.8 per 100 persons) was not statistically different from that of non-Hispanic or Latino persons (326.4 per 100 persons).

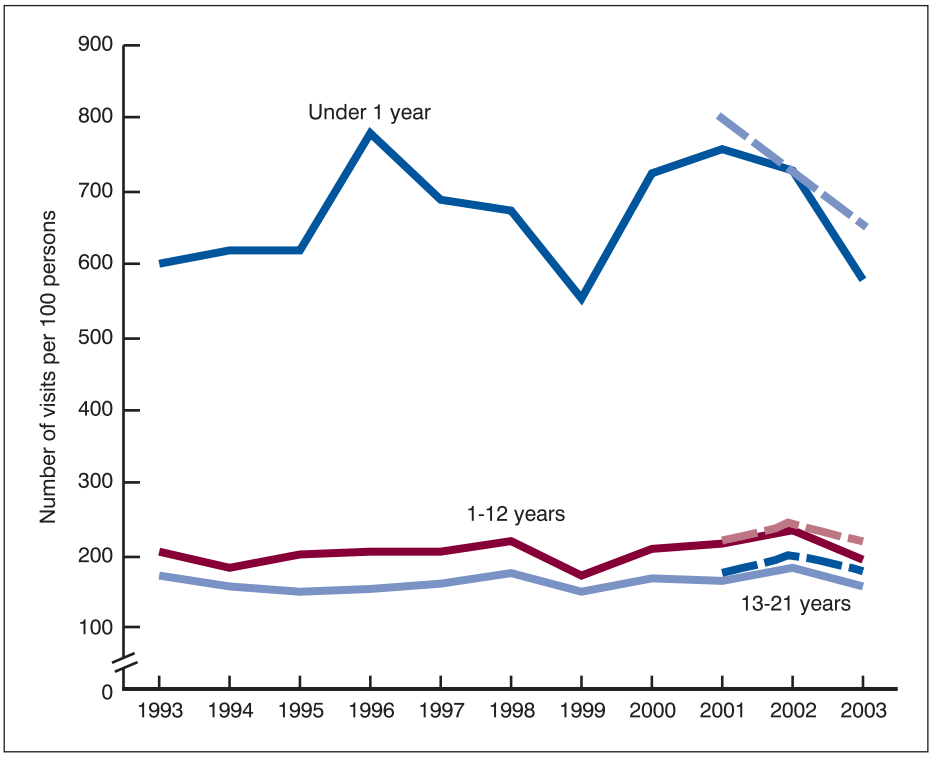
Continuity of care—Continuity of care is a goal of health care achieved through an interdisciplinary process involving patients, families, health care professionals, and providers in the management of a coordinated plan of care. It may involve multiple professionals from many different disciplines within multiple systems. The NAMCS collects information on aspects of care (e.g., whether the physician was the patient's primary care physician, whether the visit was a referral, and the number of visits within the past 12 months) that can help describe where the visit fits within the continuum of care for the patient.

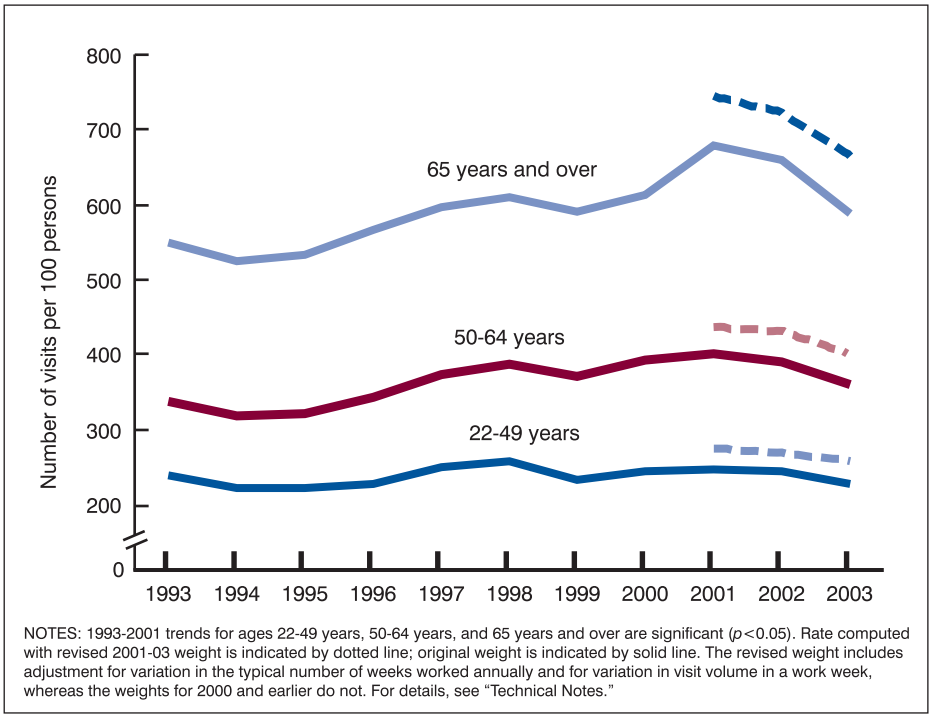
In 2003, 47.9 percent of physician office visits were to the patient's primary care physician or provider (PCP); 48.3 percent were to physicians other than the patient's PCP; and for 3.8 percent of visits, it was unknown if the physician was the PCP (table 4). Of the visits to physicians other than the patient's PCP, about one-third (30.0 percent) were referrals (calculated from table 4). Visits by new patients were more likely to be referrals than visits made by established patients (46.1 percent in contrast to 10.4 percent).

Table 5 describes visits to PCPs and non-PCPs in terms of referral status and physician specialty. Among visits to non-PCPs, the specialties with visits most frequently referred by other physicians were neurology (52.4 percent), general surgery (50.7 percent), and otolaryngology (36.9 percent). More than half of visits to ophthalmologists, dermatologists, orthopedic surgeons, and psychiatrists were self referrals. It should be noted that not all visits to the patient's PCP were to physicians who specialize in primary care. Among visits to the patients' PCP, 6.0 percent were to physicians specializing in either surgical or medical specialties (data not shown).

Table 6 shows the prior visit status, whether the care for the patient was shared by other physicians, and the episode of care. As shown, established patients accounted for 88.4 percent of office visits. Four-fifths of office visits (81.6 percent) were made by established patients who had at least one previous visit in the last 12 months, and 23.1 percent had six or more visits in the previous 12 months. New patients accounted for 11.6 percent of visits, representing a 26 percent decrease since 1993 (15.6 percent). Medical care specialists were more likely to share care with other physicians (32.9 percent) compared with primary care specialists (18.7 percent).

Primary expected source of payment—Private insurance was cited most frequently as the primary expected source of payment (56.2 percent of visits). Government sources combined





NOTES: 1993-2001 trends for ages 22-49 years, 50-64 years, and 65 years and over are significant ($p<0.05$). Rate computed with revised 2001-03 weight is indicated by dotted line; original weight is indicated by solid line. The revised weight includes adjustment for variation in the typical number of weeks worked annually and for variation in visit volume in a work week, whereas the weights for 2000 and earlier do not. For details, see "Technical Notes."

Figure 3. Trends in office visit rates by age: United States, 1993–2003

(Medicare, Medicaid, or State Children's Health Insurance Program (SCHIP)) accounted for 33.0 percent of office visits, most of which were Medicare (table 7).

From 2001 to 2003, office visits relying on Medicaid or SCHIP for payment increased by 42% (from 7.2 to 10.2 percent). Increased use of Medicaid or SCHIP between 2001 and 2003 may reflect increases in the number of beneficiaries of these programs. This increase may have been caused by the economic recession in 2001 and SCHIP program expansions (8,9).

As expected, source of payment varied by patient age (figure 5). Private insurance was the primary expected source of payment for a majority of visits by patients under age 65 years (69.9 percent), but represented only 15.2 percent of visits by persons age 65 years and over. Three-quarters of visits by elderly patients listed Medicare as the primary source of payment at office visits (76.4 percent). Although private insurance was the most frequent source of payment for office visits, the visit rate for Medicare patients (585.0 per 100 persons with Medicare) was higher than for Medicaid or SCHIP patients (306.5 per 100 persons with Medicaid or SCHIP), private insurance patients (264.2 per 100 persons with private insurance), and patients with no insurance, as measured by self pay, no charge, or charity (106.8 per 100 persons with no insurance) (data not shown).

Patient's principal reason for visit—The principal reason for visit is the main complaint, symptom, or reason listed for why the patient came to the physician's office. Up to three reasons for visit were coded according to *A Reason for Visit Classification for Ambulatory Care* (RVC) (10). The RVC is a classification scheme developed by NCHS that has been used for over 25 years to code patients' complaints or reasons for seeking care. It is divided into eight modules or groups of reasons as shown in table 8 and includes all the reasons for which patients see their physicians. This includes symptoms, followup for prior diagnoses, routine examinations and screening, treatment for conditions and operations, various therapies, and injuries. Also included are visits to receive test results and to fulfill third-party requirements for a physical examination, such as for employment or a driver's license. The symptoms module is further divided into symptoms that refer to specific body systems, such as digestive or respiratory. Each reason is assigned a three- or four-digit classification code (for example, S845-

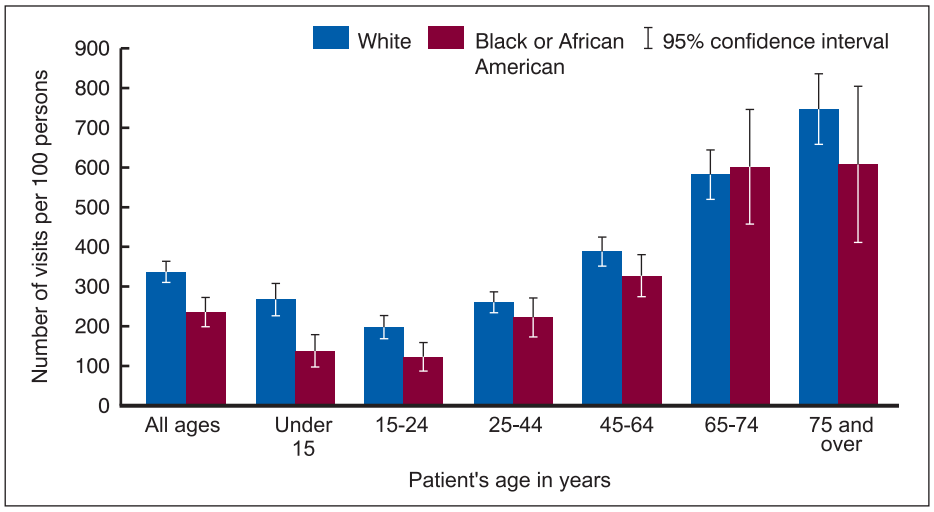


Figure 4. Annual rate of visits to office-based physicians by patient age and race: United States, 2003

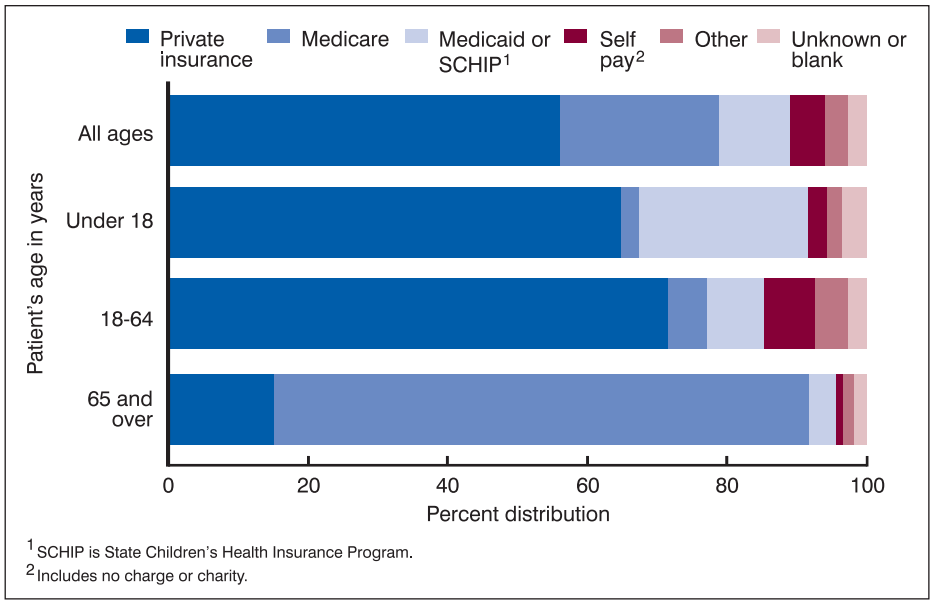


Figure 5. Percent distribution of office visits by primary expected source of payment according to patient age: United States, 2003

"Symptoms of skin mole" is further detailed to S845.1- "Change in size and color" and S845.2- "Bleeding mole").

In 2003, one-half of all visits were made for reasons classified as symptoms. Some of the more prominent symptoms included respiratory (10.4 percent), musculoskeletal (10.0 percent), and symptoms referable to the eyes and ears (5.4 percent) (table 8).

The 20 most frequently mentioned three-digit principal reasons for visit, representing 42.2 percent of all visits, are shown in table 9. General medical examination was the most frequently mentioned reason for visit at 6.6 percent of all office visits, and cough was the most frequently mentioned reason regarding an illness or injury (3.2 percent). All but three of the reasons for office visits in 2003 were listed in the 20 most frequently mentioned reasons in 2002, albeit in a different order. It should be noted that estimates differing in ranked order may not be significantly different from each other.

The major reason for this visit provides a better picture of the general nature of the office visit—whether for an acute problem; routine visit for a chronic problem; visit for a flare-up of a chronic problem; pre- or post-surgery visit; or for preventive care, including routine prenatal examinations, general medical examinations, well-baby examinations, screening, and examinations for insurance purposes. The major reason for visit item differs from the principal reason for visit item in that the former represents the physician's rather than the patient's perspective of the major reason the patient sought care. Acute problems comprised 35.7 percent of the visits, and routine chronic problems accounted for 31.9 percent (table 10). Approximately 15.7 percent of all visits were for preventive care. A higher percentage of female visits were for preventive care compared with male visits. The percentage of visits for acute and preventive care declined with patient age, whereas the percentage of visits for chronic conditions increased with patient age.

Table 11 describes the frequency of preventive care visits by patient, visit, and physician characteristics. The female visit rate for preventive care was significantly higher than the rate for males (68.6 and 29.9 visits per 100 persons). This sex difference reflects, in part, the fact that preventive care includes prenatal examinations that usually include multiple visits within 1 year. In 2003, 16.2 percent of the preventive visits made by females included a visit made for normal pregnancy (any diagnosis coded V22) (data not shown). However, even after removing visits for normal pregnancy, females still had a higher visit rate (52.9 visits per 100 persons) compared with males (29.9 visits per 100 persons) (data not shown). There were no differences in visit rates for preventive care by sex among children under 15 years of age or among the elderly (65 years and over). Uninsured persons (as measured by self pay, no charge, and charity visits) had a much lower preventive care visit rate compared with persons with private or public health insurance, placing them at a disadvantage for disease prevention and early diagnosis.

Primary diagnosis—Physicians were asked to record the primary diagnosis or problem associated with the

patient's most important reason for the current visit and any other significant current diagnoses. Up to three diagnoses were coded according to the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM) (11). Table 12 shows office visits by the physician's primary diagnosis using the major disease categories specified in the ICD–9–CM. The supplementary classification, used for diagnoses that are not classifiable to injury or illness (for example, general medical examination, routine prenatal examination, and health supervision of an infant or child), accounted for 17.5 percent of all office visits. Diseases of the respiratory system (12.6 percent), diseases of the nervous system and sense organs (9.4 percent), and diseases of the musculoskeletal and connective tissue (8.1 percent) were also prominent categories on the list.

The 20 most frequently reported primary diagnoses for 2003, accounting for 41.8 percent of all physician office visits, are shown in table 13. The grouped categories in this table are also based on the ICD–9–CM. The leading illness diagnoses include essential hypertension, acute upper respiratory infections (excluding pharyngitis), arthropathies and related disorders, diabetes mellitus, and spinal disorders. Table 14 presents the leading diagnosis by detailed age groups: infants (under 1 year)—acute upper respiratory infections (excluding pharyngitis); children (1–12 years)—otitis media and eustachian tube disorders; adolescents and young adults (13–21 years) and adults (22–49 years)—acute upper respiratory infections (excluding pharyngitis); middle-aged persons (50–64 years) and seniors (65 years and over)—essential hypertension (table 14).

Injury-related visits—Although there is a separate item or checkbox on the Patient Record form to indicate whether the visit was for an injury, poisoning, or adverse effect of medical treatment, sometimes an injury reason for visit is specified or an injury diagnosis is rendered without the injury item being checked. Therefore, the visit is counted as an injury visit and the injury checkbox is coded ''Yes'' if any of the three reasons for visit were in the injury module or any of the three diagnoses were in the injury or poisoning chapter of the ICD–9–CM (11). This provides a better indicator that the visit involves an injury than using the reason for visit module, ICD–9–CM injury diagnosis, or the unedited injury item alone. A more detailed discussion is documented elsewhere (12).

There were an estimated 99.9 million injury- or poisoning-related office visits in 2003, representing 11.0 percent of all visits and yielding a rate of 35.0 visits per 100 persons (table 15). The injury-related visit rate increased significantly with patient age. The rate for patients 75 years and over (63.8 visits per 100 persons) was approximately double that of the three age groups under 45 years. The injury-related visit rate for females was not significantly different from the rate for males nor were there differences between the female and male rates when compared by each of the specific age groups. The overall injury-related visit rate for white persons (38.3 visits per 100 persons) was higher than the injury-related rate for black or African-American persons (22.5 visits per 100 persons) and persons of ''other'' race (19.1 visits per 100 persons). Small sample sizes preclude analysis by age within race groups other than white or black or African American. Therefore, they were combined into an ''other'' group. The injury rate for non-Hispanic or non-Latino persons (36.8 visits per 100 persons) exceeded the injury rate for Hispanic or Latino persons (23.5 per 100 visits). Half of the injury visits were to primary care physicians (50.5 percent) with no significant difference between white and black or African-American persons (data not shown). Further information on injury visits to physician offices is available on the public-use file, including E-codes and a narrative of the cause of injury.

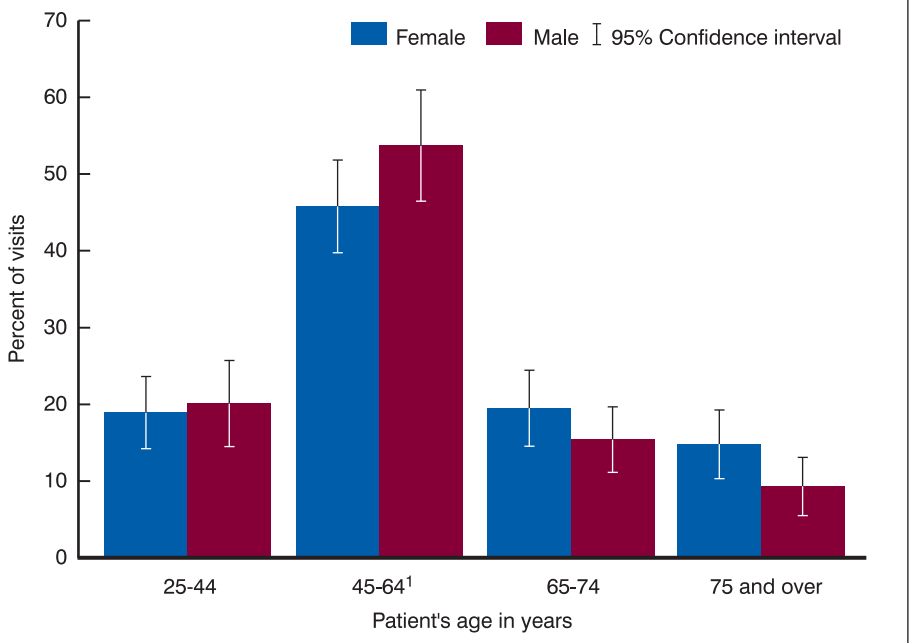
Office visits by intent and mechanism of the first-listed external cause-of-injury codes (E-codes) are shown in table 16. Up to three external causes of injury were coded according to the ''Supplementary Classification of External Causes of Injury and Poisoning'' in the ICD–9–CM. Cause of injury was not recorded for 35.3 percent of injury-related visits so the observed distribution could change with more complete reporting. For a detailed description of the cause of injury codes, see the ''Technical Notes.''

Diagnostic and screening services—Table 17 displays examinations and diagnostic and screening services ordered or provided by physicians during office visits. At least one such service was provided at 85.7 percent of office visits. Information on diagnostic services was missing for 1.2 percent of visits.

The most frequently occurring diagnostic service was a general medical examination; one-half of all visits (50.4 percent) included a general medical examination. Some of the most frequent laboratory tests ordered include complete blood count (9.5 percent), urinalysis (8.6 percent), and lipids or cholesterol (6.5 percent) (table 17). Imaging was ordered or provided at 10.1 percent of visits; the majority of imaging services were x rays. Visits by females were more likely to have imaging performed compared with visits by males, a difference due mostly to mammographies. Visits by females were also more likely to have the following tests performed compared with visits by males: blood pressure, urinalysis, and urine culture.

Beginning in 2003, data were collected on two vital signs: temperature and blood pressure. When the patient's temperature was taken (30.1 percent of visits), the mean temperature for office visits was 98.0°F (36.7° C). The average temperature was 99.0°F (37.2°C) at visits where fever was the reason for visit (table 18). At 0.8 percent of illness visits, the patient had a fever of 102°F (38.9°C) or higher (data not shown).

The patient's blood pressure was measured at 52.4 percent of visits. The overall means for systolic and diastolic blood pressures were 125.9 and 75.6 mmHg, respectively. However, when the diagnosis was essential hypertension, the systolic and diastolic blood pressures were 140.1 and 81.2 mmHg, respectively. Figure 6 highlights the percentage of visits made by patients with high blood pressure measurements, defined as systolic blood pressure ≥ 140



NOTE: Estimates based on visits with blood pressure measured (52.4 percent of all visits) and with high blood pressure, defined as either systolic measurement ≥140 mmHg or diastolic measurement≥90 mmHg.

[1] Percentages for 45-64 age group are significantly higher than other age groups ($p<0.05$).

Figure 6. Percent of office visits where patients have high blood pressure measurement, by patient age and sex: United States, 2003

mmHg or diastolic blood pressure ≥ 90 mmHg. Among these visits, there were significantly higher percentages of visits by those aged 45–64 years who had high blood pressure compared with younger patients aged 25–44 years and the elderly aged 65 years and over. The lower percentage of visits with high blood pressure by persons aged 65 years and over may be related to better control and patient followup of this condition; a higher percentage of these visits were followup visits among the elderly (65.2 percent) than among younger patients aged 25–64 years (56.8 percent) (data not shown). Patients younger than 65 years of age may also have had less access to care because 87.1 percent of these visits by patients aged 25–64 years were covered by private insurance, Medicaid, or Medicare compared with 96.7 percent of visits by patients 65 years and over (data not shown). There was no significant difference in percentage of visits with high blood pressure by sex.

Counseling or education and therapeutic services—Table 19 shows that therapeutic and preventive services (excluding medication therapy, which was reported separately) were ordered or provided at 41.5 percent of all office visits during 2003. The most frequent counseling or education provided at office visits related to diet or nutrition (14.3 percent) and exercise (10.1 percent). Females were just as likely as males to have any one of the 10 listed counseling, education, or therapeutic services ordered or provided at an office visit. Information regarding therapeutic services was missing for 3.3 percent of visits.

Procedures—In item 8 of the Patient Record form, physicians were instructed to record up to two ambulatory surgical procedures ordered, scheduled, or performed at the visit. Item 6, ''Diagnostic and screening services,'' included two open-ended ''other'' categories in addition to the checkbox categories. After analyzing data from the ''other'' categories and the ambulatory surgery checkbox (item 8), it was discovered that the same procedure was being recorded in different places on different records. Table 20 presents data from item 8 and the open-ended responses to item 6 as coded to ICD–9–CM volume 3 codes in the range of 01–86 (11). During 2003, there were an estimated 74.8 million ambulatory surgical procedures ordered or performed during visits to office-based physicians. About 7.0 percent of all visits had such procedures ordered or performed.

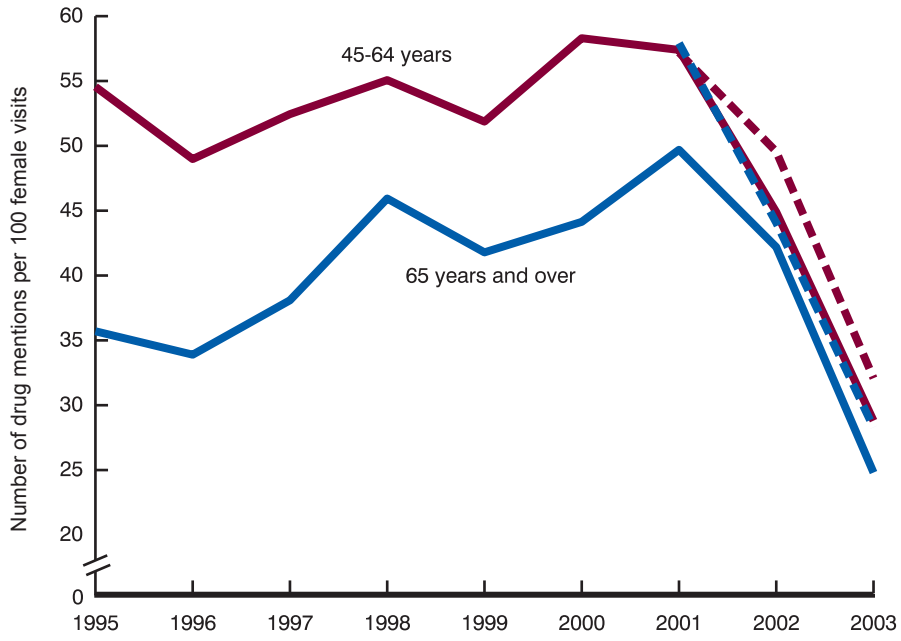
Medication therapy—NAMCS respondents were instructed to record all new or continued medications ordered, supplied, or administered at the visit. This included prescription and nonprescription preparations, immunizations, desensitizing agents, and anesthetics. For the first time, up to eight medications, referred to in this survey as drug mentions, were coded according to a classification system developed at NCHS. A report describing the method and instruments used to collect and process drug information is available (13). As used in the NAMCS, the term ''drug'' is interchangeable with the term ''medication,'' and the term ''prescribing'' is used broadly to mean ordering or providing any medication, whether prescription or over the counter. Visits with one or more drug mentions are termed ''drug visits'' in the NAMCS. Data on medication therapy are in tables 21–25.

Medication therapy was reported at 595.3 million office visits, accounting for 65.7 percent of all office visits (table 21). Multiple drugs were recorded at 39.5 percent of all visits. Although the maximum number of drug mentions listed increased from six to eight in 2003, the percentage of visits with six or more drug mentions (7.7 percent) was not significantly different from the percentage in 2002 (5.9 percent, estimate recomputed using revised weight). Similarly, the percentage of visits with any drug mentioned did not change between 2002 and 2003. During 2003, there were about 1.6 billion drugs mentioned resulting in an overall drug mention rate of 172.4 mentions per 100 visits (table 22). Data on drug visits and drug mentions by physician specialty are shown in table 22. The percentage of visits with at least one drug mention ranged from 88.2 percent for psychiatrists to 20.5 percent for general surgeons.

Table 23 presents the 20 most frequent therapeutic classes of drug

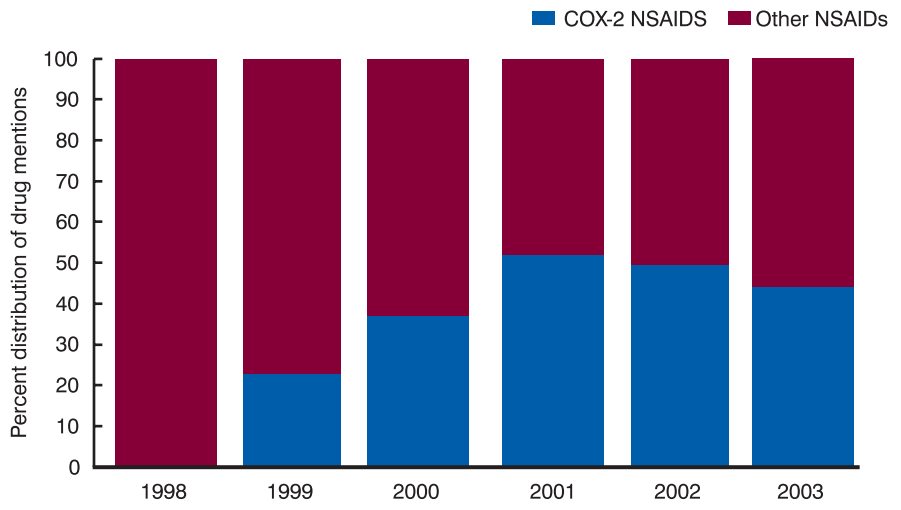
mentions by four-digit therapeutic classification codes used in the *National Drug Code Directory,* 1995 edition. Drugs may have more than one therapeutic application, and up to three therapeutic drug classes are recorded for each drug (14). Prior to 2002, a drug was classified under its primary therapeutic use and data were presented for two-digit therapeutic classification codes. Beginning in 2002, drug data are shown for up to three therapeutic subclassifications at the four-digit level. In 2003, the leading drug subclasses were nonsteroidal anti-inflammatory drugs (NSAIDs) (5.1 percent), followed by antidepressants (4.9 percent), hyperlipidemia (4.0 percent), antihistamines (3.8 percent), and antiasthmatics or bronchodilators (3.8 percent).

Changes in drug mention rates by therapeutic class can be driven by numerous factors including the prevalence of the condition the drug treats, evidence supporting therapeutic efficacy of the drug, and the level of marketing the drug receives. For example, until recently, hormone replacement therapy (HRT) or the use of estrogen and progestin to reduce postmenopausal symptoms was thought to be associated with protective effects against osteoporosis and heart disease. Between 1995 and 2001, estrogen and progestin drug mention rates for women 65 years and over increased (figure 7), but were stable for females aged 45–64 years. Since 2001, overall rates of HRT for women 45 years and over declined from 55.6 to 30.7 drug mentions per 100 females between 2001 and 2003 (data not shown). The decline between 2001 and 2003 was more rapid among females 65 years and over (by 51%) than for females aged 45–64 years (by 44%) (figure 7). The declines in rates of HRT reflect the immediate effects of findings from two large clinical trials, the Heart and Estrogen/Progestin Replacement Study (HERS) and the Women's Health Initiative (WHI) on physician prescribing patterns (15). Study findings released in July 2002 found increases in coronary heart events associated with hormone replacement therapy.



NOTES: Rates are based on visits made by females. Trend for 65 years and over for 1995-2001 is significant. All trends for 2001-03 are significant ($p<0.05$). Rate computed with revised 2001-03 weight is indicated by dotted line; original weight is indicated by solid line. The revised weight includes adjustment for variation in the typical number of weeks worked annually and for variation in visit volume in a work week, whereas the weights for 2000 and earlier do not.

Figure 7. Trends in estrogen or progestin drug mention population rates at office visits by patient age: United States, 1995–2003



NOTES: NSAID is nonsteroidal anti-inflamatory drug. COX-2 is cyclooxygenase-2 inhibitor. Other NSAIDs excludes COX-2 and Salicylates. Increasing trend in COX-2 NSAID percentages for 1999-2001 and decreasing trend in COX-2 NSAID percentages for 2001-03 are significant ($p<0.05$). Percentage for 2001-03 are computed with revised weight. The revised weight includes adjustment for variation in the typical number of weeks worked annually and for variation in visit volume in a work week, but the weights for 2000 and earlier do not.

Figure 8. Percent of nonsteroidal anti-inflammatory drug prescriptions for patients aged 18 years and over by type of nonsteroidal anti-inflammatory drug: United States, 1998–2003

The 20 most frequently used generic substances for 2003 are shown in table 24. Drug products containing more than one ingredient (combination products) are included in the data for each ingredient. For example, acetaminophen with codeine is included in both the count for acetaminophen and the count for codeine. Compared with the 19 other generic substances and consistent with previous years, acetaminophen was most frequently

used in drugs ordered or provided by the physician at office visits, occurring in 3.3 percent of drug mentions. This was followed by aspirin, amoxicillin, hydrochlorothiazide, and atorvastatin calcium.

Nonsteroidal anti-inflammatory drugs (NSAIDs) are used to treat a range of complaints—from headaches to persistent joint inflammation due to arthritis. In 2003, NSAIDs were the most frequent therapeutic class of drugs mentioned in physician offices. Two classes of NSAIDs are principally used to control pain and reduce inflammation: selective cyclooxygenase-2 (COX-2) inhibitors, first introduced in 1999, and nonselective COX inhibitors or traditional NSAIDs. Although traditional NSAIDs have quick pain-relieving properties, prolonged use by some patients was associated with gastrointestinal bleeding, and COX-2 inhibitors were not (16). Among NSAIDs prescribed to patients 18 years and over, the percentage of COX-2 inhibitor NSAIDs prescribed increased 129% between 1999 and 2001 (from 22.8 to 52.2 percent using the original weight) (figure 8). However, between 2001 and 2003, the percentage of COX-2 inhibitor NSAIDs prescribed declined by 15%, and the percentage of traditional NSAIDs prescribed increased by 17% (from 47.8 to 55.7 percent using the revised weight). The widespread prescribing of COX-2 inhibitor NSAIDs following its introduction to the market in 1999 has been attributed to extensive marketing to both physicians and consumers (16). However, the decline in percentage of COX-2 inhibitor prescriptions after 2001 may be related to early reports of increased risks of cardiovascular events associated with their use (17). In 2004, the COX-2 inhibitor, Vioxx, was removed from the market (18). Changes in prescribing patterns are expected in the next several years of NAMCS data. For this analysis, salicylates (predominantly aspirin), the remaining class of NSAIDs, were excluded because they are commonly prescribed to prevent heart disease, stroke, and, recently, for certain types of cancers.

Table 25 presents the 20 medications most frequently mentioned by physicians in the NAMCS according to the name written on the Patient Record form. This could be a brand name, generic name, or therapeutic effect. Lipitor accounted for 30.4 million mentions (1.9 percent of the total) and was followed by aspirin (A.S.A), Albuterol, Synthroid, and Lasix. Fifteen of these drugs were among the top 20 drug entry names mentioned in 2002.

Providers seen—In this item, staff were asked to check all the providers seen during the visit. Overall, 95.5 percent of visits were attended by a physician (table 26). Medical or nursing assistants were seen at 21.6 percent of office visits. Midlevel providers, such as physician assistants, nurse practitioners, and midwives, were seen at 2.6 percent of physician office visits.

Visit disposition—Staff were asked to record all visit dispositions and instructed that multiple responses could be coded for this item. For 6 out of 10 visits (62.9 percent), patients were told to return to the office by appointment (table 27). ''Return if needed'' and ''no followup planned'' were indicated at 28.2 and 6.9 percent of visits, respectively. Patients were referred to other physicians at 6.0 percent of visits.

Time spent with physician—Data on the duration of office visits are presented in tables 28 and 29. Time spent in face-to-face contact between the physician and the patient is estimated and recorded by the physician. It excludes time spent waiting to see the physician, time spent receiving care from someone other than the physician without the presence of the physician, and time spent by the physician in reviewing patient records and test results. In cases where the patient received care from a nonphysician member of the physician's staff but did not see the physician during the visit, the duration was recorded as ''0'' minutes.

In 2003, 88.3 percent of office visits with face-to-face contact between the physician and patient had a duration between 6 and 30 minutes (table 28). At 41 million visits, or 4.5 percent, there was no face-to-face contact between the physician and patient. Table 29 shows the mean duration for all visits at which a physician was seen as well as the mean duration at each quartile by physician specialty. Overall, the mean time spent with a physician was 19.7 minutes. The visit duration for psychiatrists had the largest variability (a difference of 29.2 minutes between the first and third quartiles).

Additional information about physician office utilization is available from the NCHS Ambulatory Health Care Web site: http://www.cdc.gov/nchs/about/major/ahcd/ahcd1.htm. Individual-year reports and public-use data files are available for download from the Web site. Data from the 2003 NAMCS will also be available on CD-ROM. These and other products can be obtained by contacting the NCHS Ambulatory Care Statistics Branch at (301) 458–4600. Queries regarding NAMCS data may be sent to NCHS via nchsquery@cdc.gov.

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Table 1. Number, percent distibution, and annual rate of office visits with corresponding standard errors, by selected physician practice characteristics: United States, 2003

Physician practice characteristics	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent	Number of visits per 100 persons per year[1,2]	Standard error of rate
All visits	906,023	34,276	100.0	. . .	317.3	12.0
Physician specialty						
General and family practice	223,067	15,184	24.6	1.5	78.1	5.3
Internal medicine	141,366	17,616	15.6	1.7	49.5	6.2
Pediatrics	93,947	9,343	10.4	1.0	[3]154.8	15.4
Obstetrics and gynecology	80,177	10,104	8.8	1.0	[4]68.9	8.7
Ophthalmology	49,293	6,727	5.4	0.7	17.3	2.4
Orthopedic surgery	43,770	5,901	4.8	0.6	15.3	2.1
Dermatology	29,801	3,069	3.3	0.3	10.4	1.1
Psychiatry	28,646	3,298	3.2	0.4	10.0	1.2
Cardiovascular diseases	25,200	3,119	2.8	0.3	8.8	1.1
Otolaryngology	21,406	1,997	2.4	0.2	7.5	0.7
General surgery	19,490	3,018	2.2	0.3	6.8	1.1
Urology	18,352	2,074	2.0	0.2	6.4	0.7
Neurology	12,878	1,566	1.4	0.2	4.5	0.5
All other specialties	118,631	13,234	13.1	1.4	41.5	4.6
Professional identity						
Doctor of medicine	839,358	33,534	92.6	0.9	294.0	11.7
Doctor of osteopathy	66,665	8,073	7.4	0.9	23.3	2.8
Specialty type[5]						
Primary care	534,058	29,459	58.9	1.7	187.0	10.3
Surgical specialty	182,707	11,192	20.2	1.2	64.0	3.9
Medical specialty	189,258	14,038	20.9	1.5	66.3	4.9
Geographic region						
Northeast	189,369	13,293	20.9	1.4	353.5	24.8
Midwest	182,142	15,097	20.1	1.5	282.9	23.5
South	338,963	23,786	37.4	2.0	331.6	23.3
West	195,549	15,589	21.6	1.5	299.2	23.9
Metropolitan status						
MSA[6]	797,992	32,470	88.1	1.7	334.7	13.6
Not MSA[6]	108,031	15,897	11.9	1.7	229.3	33.7

. . . Category not applicable.

[1]Visit rates for age, sex, race, and region are based on the July 1, 2003, set of estimates of the civilian noninstitutional population of the United States as developed by the Population Division, U.S. Census Bureau. These population estimates reflect Census 2000 data and are available from the U.S. Census Bureau. See "Technical Notes" for more details.

[2]Population estimates of metropolitan statistical area status are based on data from the 2003 National Health Interview Survey, National Center for Health Statistics, adjusted to the U.S. Census Bureau definition of core-based statistical areas as of December 2003. See http://www.census.gov/population/www/estimates/metrodef.html for more about metropolitan statistical area definitions.

[3]Number of visits (numerator) and population estimate (denominator) include children under 15 years of age.

[4]Number of visits (numerator) and population estimate (denominator) include females 15 years of age and over.

[5]Specialty type is defined in table IV of the "Technical Notes."

[6]MSA is metropolitan statistical area.

NOTE: Numbers may not add to totals because of rounding.

Table 2. Number and percent distribution of office visits with corresponding standard errors, by selected physician practice characteristics: United States, 2003

Physician practice characteristics	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent
All visits	906,023	34,276	100.0	. . .
Employment status				
Owner	691,728	34,665	76.3	1.9
Employee	194,420	17,208	21.5	1.9
Contractor	19,874	5,033	2.2	0.5
Ownership				
Physician or group	787,246	35,363	86.9	1.7
Other health care corporation	37,050	8,493	4.1	1.0
Other hospital	29,630	8,512	3.3	0.9
Medical or academic health center	26,411	7,382	2.9	0.8
HMO[1]	*9,707	3,704	*1.1	0.4
Other[2]	15,979	4,579	1.8	0.5
Practice size				
Solo	349,149	26,427	38.5	2.3
2–4	313,924	21,995	34.6	2.2
5–9	149,929	15,496	16.5	1.6
10–39	80,176	9,978	8.8	1.1
40 or more	*12,845	6,468	*1.4	0.7
Blank	*	. . .	*	. . .
Type of practice				
Single-specialty group	398,615	24,267	44.0	2.2
Multispecialty group	158,258	14,655	17.5	1.6
Solo	349,149	26,427	38.5	2.3
Office type				
Private practice	808,631	35,395	89.3	1.6
Clinic or urgicenter	66,607	13,186	7.4	1.5
Other[3]	30,785	6,166	3.4	0.7

* Figure does not meet standard of reliability or precision.
. . . Category not applicable.
[1]HMO is health maintenance organization.
[2]"Other" includes owners such as local government (State, county, or city) and charitable organizations.
[3]"Other" includes the following office types: HMO, non-Federal government clinic, mental health center, federally qualified health center, and facility practice plan.

NOTE: Numbers may not add to totals because of rounding.

Table 3. Number, percent distribution, and annual rate of office visits with corresponding standard errors, by patient characteristics: United States, 2003

Patient characteristics	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent	Number of visits per 100 persons per year[1]	Standard error of rate
All visits	906,023	34,276	100.0	. . .	317.3	12.0
Age						
Under 15 years	145,245	11,417	16.0	1.0	239.3	18.8
15–24 years	72,447	4,925	8.0	0.4	180.6	12.3
25–44 years	203,553	9,709	22.5	0.7	247.5	11.8
45–64 years	257,258	11,483	28.4	0.7	377.2	16.8
65–74 years	106,424	5,422	11.7	0.5	588.2	30.0
75 years and over	121,096	6,962	13.4	0.7	748.2	43.0
Sex and age						
Female	537,298	22,053	59.3	0.7	367.8	15.1
Under 15 years	67,442	4,980	7.4	0.5	227.5	16.8
15–24 years	46,705	3,930	5.2	0.4	234.9	19.8
25–44 years	136,881	7,576	15.1	0.6	328.7	18.2
45–64 years	153,417	7,463	16.9	0.5	436.7	21.2
65–74 years	60,449	3,814	6.7	0.4	613.3	38.7
75 years and over	72,404	4,626	8.0	0.5	730.1	46.6
Male	368,724	14,819	40.7	0.7	264.4	10.6
Under 15 years	77,802	6,845	8.6	0.6	250.6	22.0
15–24 years	25,742	2,056	2.8	0.2	127.2	10.2
25–44 years	66,672	3,520	7.4	0.3	164.3	8.7
45–64 years	103,841	5,047	11.5	0.4	313.9	15.3
65–74 years	45,975	2,362	5.1	0.2	558.2	28.7
75 years and over	48,692	2,861	5.4	0.3	776.8	45.6
Race and age[2]						
White	777,112	31,113	85.8	1.0	337.2	13.5
Under 15 years	123,902	9,707	13.7	0.9	267.2	20.9
15–24 years	61,914	4,638	6.8	0.4	197.8	14.8
25–44 years	171,171	8,749	18.9	0.6	260.5	13.3
45–64 years	221,430	10,670	24.4	0.8	388.2	18.7
65–74 years	90,885	4,965	10.0	0.4	582.0	31.8
75 years and over	107,811	6,548	11.9	0.7	747.0	45.4
Black or African American	84,268	6,708	9.3	0.7	235.9	18.8
Under 15 years	13,038	1,963	1.4	0.2	138.0	20.8
15–24 years	7,138	1,063	0.8	0.1	123.2	18.3
25–44 years	22,957	2,589	2.5	0.3	222.3	25.1
45–64 years	23,933	1,983	2.6	0.2	327.4	27.1
65–74 years	9,924	1,215	1.1	0.1	601.5	73.6
75 years and over	7,277	1,202	0.8	0.1	607.6	100.3
All other races[2]						
Asian	37,122	6,840	4.1	0.7	313.2	57.7
Native Hawaiian or other Pacific Islander	*2,914	1,036	*0.3	0.1	*599.3	213.1
Amercan Indian or Alaska Native	*2,071	623	*0.2	0.1	*75.8	22.8
Mutiple races	2,536	559	0.3	0.1	59.6	13.1
Ethnicity[2]						
Hispanic or Latino	102,687	13,908	11.3	1.4	260.8	35.3
Not Hispanic or Latino	803,335	31,670	88.7	1.4	326.4	12.9

* Figure does not meet standard of reliability or precision.

. . . Category not applicable.

[1]Visit rates for age, sex, race, and ethnicity are based on the July 1, 2003, set of estimates of the civilian noninstitutional population of the United States as developed by the Population Division, U.S. Census Bureau. These population estimates reflect Census 2000 data and are available from the U.S. Census Bureau. See "Technical Notes" for more details.

[2]The race groups, white, black or African American, Asian, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native, and multiple races, include persons of Hispanic and not Hispanic origin. Persons of Hispanic origin may be of any race. Starting with data year 1999, race-specific estimates have been tabulated according to 1997 Standards for Federal Data on Race and Ethnicity and are not strictly comparable with estimates for earlier years. However, the percent of visit records with multiple races indicated is small and lower than what is typically found for self-reported race. See "Technical Notes" for more details.

NOTE: Numbers may not add to totals because of rounding.

Table 4. Number and percent distribution of office visits with corresponding standard errors by selected visit characteristics, according to prior-visit status: United States, 2003

Primary care physician and referral status	All visits	Prior-visit status	
		Established patient	New patient
		Number of visits in thousands	
All visits	906,023	800,892	105,130
Visit to PCP[1]	433,832	414,064	19,767
Visit to non-PCP[1]	437,917	360,077	77,840
Referred by other physician	131,538	83,059	48,479
Not referred by other physician	248,443	230,253	18,190
Unknown if referred	57,936	46,765	11,171
Unknown if PCP[1] visit	34,274	26,751	7,523
		Standard error in thousands	
All visits	34,276	31,035	5,515
Visit to PCP[1]	25,777	24,283	2,687
Visit to non-PCP[1]	20,099	16,709	4,905
Referred by other physician	8,287	6,436	3,278
Not referred by other physician	14,725	13,683	2,139
Unknown if referred	6,423	5,504	1,324
Unknown if PCP[1] visit	5,022	4,228	1,327
		Percent distribution	
All visits	100.0	100.0	100.0
Visit to PCP[1]	47.9	51.7	18.8
Visit to non-PCP[1]	48.3	45.0	74.0
Referred by other physician	14.5	10.4	46.1
Not referred by other physician	27.4	28.7	17.3
Unknown if referred	6.4	5.8	10.6
Unknown if PCP[1] visit	3.8	3.3	7.2
		Standard error of percent	
All visits	. . .	. . .	. . .
Visit to PCP[1]	1.8	1.8	2.4
Visit to non-PCP[1]	1.8	1.8	2.5
Referred by other physician	0.9	0.8	2.5
Not referred by other physician	1.4	1.6	1.7
Unknown if referred	0.6	0.6	1.0
Unknown if PCP[1] visit	0.5	0.5	1.2

. . . Category not applicable.
[1]PCP is patient's primary care physician or provider.

NOTE: Numbers may not add to totals because of rounding.

Table 5. Percent distribution of office visits with corresponding standard errors by physician specialty, according to primary care physician and referral status: United States, 2003

Physician specialty	Total	Visit to PCP[1]	Visit to non-PCP[2]			Unknown if PCP[1] visit
			Referred by other physician	Not referred by other physician	Unknown if referred	
			Percent distribution			
All visits	100.0	47.9	14.5	27.4	6.4	3.8
General and family practice	100.0	84.4	1.3	7.5	2.4	4.3
Internal medicine	100.0	85.0	*2.6	4.7	*	*6.4
Pediatrics	100.0	88.4	*3.0	*4.5	*2.0	2.1
Obstetrics and gynecology	100.0	21.5	13.9	46.2	*14.4	*3.9
Ophthalmology	100.0	*3.1	22.4	63.0	9.9	*1.6
Orthopedic surgery	100.0	*	29.2	53.2	14.1	*
Dermatology	100.0	*	19.7	60.9	16.2	3.0
Psychiatry	100.0	*8.7	22.5	51.8	12.0	*5.1
Cardiovascular diseases	100.0	16.4	29.4	44.5	8.0	*
Otolaryngology	100.0	*	36.9	46.5	12.5	*2.9
General surgery	100.0	*9.4	50.7	31.9	7.0	*
Urology	100.0	*4.3	32.6	47.3	11.6	*4.2
Neurology	100.0	*3.7	52.4	33.8	8.3	*1.9
All other specialties	100.0	*11.0	31.0	47.3	7.3	*3.5
			Standard error of percent			
All visits	. . .	1.8	0.9	1.4	0.6	0.5
General and family practice	. . .	2.3	0.3	1.7	0.6	0.8
Internal medicine	. . .	3.3	0.8	1.3	. . .	2.3
Pediatrics	. . .	2.4	1.1	1.7	0.7	0.5
Obstetrics and gynecology	. . .	5.7	3.5	6.1	4.8	1.3
Ophthalmology	. . .	1.7	4.5	5.5	2.3	0.6
Orthopedic surgery	. . .	. . .	2.7	4.0	2.2	. . .
Dermatology	. . .	. . .	3.1	4.1	3.0	0.8
Psychiatry	. . .	5.0	4.5	6.3	3.5	3.1
Cardiovascular diseases	. . .	4.5	3.9	5.3	1.9	. . .
Otolaryngology	. . .	. . .	3.0	3.9	3.2	1.3
General surgery	. . .	4.3	6.1	5.7	1.7	. . .
Urology	. . .	1.8	4.5	4.4	2.4	1.6
Neurology	. . .	1.4	4.3	4.1	2.0	0.6
All other specialties	. . .	3.5	4.0	4.6	1.2	1.5

. . . Category not applicable.
* Figure does not meet standard of reliability or precision.
[1]PCP is patient's primary care physician or provider.
[2]Referral status only asked for visits to nonprimary care physicians or providers.

NOTE: Numbers may not add to totals because of rounding.

Table 6. Number and percent distribution of office visits with corresponding standard errors, by continuity-of-care visit characteristics according to specialty type: United States, 2003

Continuity-of-care visit characteristics	All specialties	Specialty type			All specialties	Specialty type		
		Primary care	Surgical specialties	Medical specialties		Primary care	Surgical specialties	Medical specialties
	Number of visits in thousands				Standard error in thousands			
All visits	906,023	534,058	182,707	189,258	34,276	29,459	11,192	14,038
Prior-visit status and number of visits in last 12 months								
Established patient	800,892	492,291	147,634	160,968	31,035	27,157	9,375	12,345
None	62,237	33,652	18,502	10,083	4,598	3,637	2,278	1,157
1–2 visits	275,147	159,389	59,403	56,354	12,805	10,960	4,227	4,837
3–5 visits	254,210	164,404	44,063	45,743	12,039	10,953	3,147	4,182
6 or more visits	209,299	134,845	25,666	48,788	11,967	10,197	2,677	5,951
New patient	105,130	41,767	35,073	28,290	5,515	3,749	2,777	2,800
Do other physicians share care for this problem?								
Yes	213,651	99,818	51,532	62,301	12,034	9,225	4,828	6,975
No	587,943	377,831	110,246	99,867	28,189	23,396	8,614	8,940
Unknown or blank	104,428	56,409	20,929	27,090	10,573	7,685	3,188	4,732
Episode of care								
Initial visit for problem	278,777	193,011	49,896	35,871	12,966	11,890	3,635	3,609
Followup visit for problem	425,334	182,362	111,964	131,007	18,046	12,986	7,232	10,837
Unknown or blank	59,977	34,008	13,888	12,082	6,998	6,171	2,006	2,322
Not applicable (preventive care visit)[1]	141,935	124,677	6,959	*10,298	9,977	9,515	1,349	3,111
	Percent distribution				Standard error of percent			
All visits	100.0	100.0	100.0	100.0	. . .	. . .	. . .	. . .
Prior-visit status and number of visits in last 12 months								
Established patient	88.4	92.2	80.8	85.1	0.5	0.5	1.0	1.1
None	6.9	6.3	10.1	5.3	0.5	0.6	1.1	0.6
1–2 visits	30.4	29.8	32.5	29.8	0.8	1.2	1.2	1.3
3–5 visits	28.1	30.8	24.1	24.2	0.7	1.1	1.0	1.4
6 or more visits	23.1	25.2	14.0	25.8	1.0	1.4	1.1	2.2
New patient	11.6	7.8	19.2	14.9	0.5	0.5	1.0	1.1
Do other physicians share care for this problem?								
Yes	23.6	18.7	28.2	32.9	1.3	1.4	2.3	2.8
No	64.9	70.7	60.3	52.8	1.5	1.8	2.6	3.0
Unknown or blank	11.5	10.6	11.5	14.3	1.1	1.3	1.5	2.1
Episode of care								
Initial visit for problem	30.8	36.1	27.3	19.0	0.9	1.4	1.2	1.5
Followup visit for problem	46.9	34.1	61.3	69.2	1.1	1.4	1.4	2.3
Unknown or blank	6.6	6.4	7.6	6.4	0.7	1.1	0.9	1.2
Not applicable (preventive care visit)[1]	15.7	23.3	3.8	5.4	0.9	1.2	0.7	1.5

* Figure does not meet standard of reliability or precision.

. . . Category not applicable.

[1]Preventive care includes routine prenatal, general medical, well-baby, and screening or insurance examinations.

NOTE: Numbers may not add to totals because of rounding.

Table 7. Number and percent distribution of office visits with corresponding standard errors, by primary expected source of payment: United States, 2003

Primary expected source of payment	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent
All visits	906,023	34,276	100.0	. . .
Private insurance	508,903	22,454	56.2	1.3
Medicare	206,345	10,587	22.8	0.9
Medicaid or SCHIP[1]	92,191	8,772	10.2	0.8
Self-pay	41,521	4,036	4.6	0.4
Worker's compensation	10,412	1,681	1.1	0.2
No charge or charity	2,677	622	0.3	0.1
Other	20,520	2,920	2.3	0.3
Unknown or blank	23,455	2,947	2.6	0.3

. . . Category not applicable.
[1]SCHIP is State Children's Health Insurance Program.

NOTE: Numbers may not add to totals because of rounding.

Table 8. Number and percent distribution of office visits with corresponding standard errors, by patient's principal reason for visit: United States, 2003

Principal reason for visit and RVC code[1]		Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent
All visits		906,023	34,276	100.0	. . .
Symptom module	S001–S999	458,478	19,003	50.6	1.0
General symptoms	S001–S099	49,933	3,187	5.5	0.3
Symptoms referable to psychological and mental disorders	S100–S199	28,599	2,768	3.2	0.3
Symptoms referable to the nervous system (excluding sense organs)	S200–S259	25,938	1,789	2.9	0.2
Symptoms referable to the cardiovascular and lymphatic system	S260–S299	4,603	753	0.5	0.1
Symptoms referable to the eyes and ears	S300–S399	48,722	4,189	5.4	0.4
Symptoms referable to the respiratory system	S400–S499	94,409	7,065	10.4	0.6
Symptoms referable to the digestive system	S500–S639	37,430	3,077	4.1	0.3
Symptoms referable to the genitourinary system	S640–S829	34,614	2,817	3.8	0.3
Symptoms referable to the skin, hair, and nails	S830–S899	43,685	3,104	4.8	0.3
Symptoms referable to the musculoskeletal system	S900–S999	90,545	6,658	10.0	0.6
Disease module	D001–D999	107,331	6,200	11.8	0.6
Diagnostic, screening, and preventive module	X100–X599	160,406	10,252	17.7	0.9
Treatment module	T100–T899	122,615	8,850	13.5	0.8
Injuries and adverse effects module	J001–J999	21,273	2,146	2.3	0.2
Test results module	R100–R700	20,223	1,987	2.2	0.2
Administrative module	A100–A140	7,249	1,366	0.8	0.1
Other[2]	U990–U999	8,448	1,253	0.9	0.1

. . . Category not applicable.

[1]Based on *A Reason for Visit Classification for Ambulatory Care* (RVC) (10).

[2]Includes problems and complaints not elsewhere classified, entries of "none," blanks, and illegible entries.

NOTE: Numbers may not add to totals because of rounding.

Table 9. Number and percent distribution of office visits with corresponding standard errors, by the 20 principal reasons for visit most frequently mentioned by patients, according to patient's sex: United States, 2003

Principal reason for visit and RVC code[1]	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error or percent	Female[2]		Male[3]	
					Percent distribution	Standard error of percent	Percent distribution	Standard error of percent
All visits	906,023	34,276	100.0	. . .	100.0	. . .	100.0	. . .
General medical examination X100	59,838	5,244	6.6	0.5	5.7	0.6	8.0	0.7
Progress visit, not otherwise specified T800	42,504	5,335	4.7	0.5	4.0	0.6	5.6	0.6
Cough S440	28,759	2,598	3.2	0.3	2.9	0.3	3.6	0.4
Prenatal examination, routine X205	24,457	3,859	2.7	0.4	4.6	0.6	. . .	. . .
Postoperative visit T205	24,202	2,322	2.7	0.2	2.9	0.3	2.3	0.2
Symptoms referable to throat S455	23,314	2,557	2.6	0.2	2.5	0.3	2.7	0.3
Medication, other and unspecified kinds T115	15,758	1,718	1.7	0.2	1.7	0.2	1.9	0.2
Gynecological examination X225	15,553	2,741	1.7	0.3	2.9	0.5	. . .	. . .
Knee symptoms S925	15,501	1,997	1.7	0.2	1.8	0.2	1.6	0.2
Back symptoms S905	15,023	1,673	1.7	0.2	1.5	0.2	1.8	0.2
Vision dysfunctions S305	13,568	2,820	1.5	0.3	1.4	0.3	1.6	0.4
Stomach pain, cramps, and spasms S545	13,429	1,284	1.5	0.1	1.8	0.2	1.1	0.1
Skin rash S860	12,955	1,183	1.4	0.1	1.3	0.1	1.6	0.2
Hypertension D510	12,012	1,788	1.3	0.2	1.4	0.3	1.3	0.2
Nasal congestion S400	11,897	1,851	1.3	0.2	1.3	0.2	1.4	0.2
Earache or ear infection S355	11,800	1,099	1.3	0.1	1.1	0.1	1.6	0.2
Fever S010	10,723	1,221	1.2	0.1	0.9	0.1	1.6	0.2
Well baby examination X105	10,620	1,727	1.2	0.2	0.9	0.2	1.6	0.3
Headache, pain in head S210	10,408	990	1.1	0.1	1.4	0.1	0.7	0.1
Depression S110	10,216	1,404	1.1	0.2	1.3	0.2	0.9	0.1
All other reasons	523,485	20,277	57.8	1.0	56.9	1.1	59.1	1.1

. . . Category not applicable.
[1]Based on *A Reason for Visit Classification for Ambulatory Care* (RVC) (10).
[2]Based on 537,298,000 visits made by females.
[3]Based on 368,724,000 visits made by males.
NOTE: Numbers may not add to totals because of rounding.

Table 10. Number and percent distribution of office visits with corresponding standard errors by major reason for this visit, according to selected patient and visit characteristics: United States, 2003

Selected patient and visit characteristics	Total	Acute problem	Chronic problem, routine	Chronic problem, flare-up	Pre- or post-surgery	Preventive care[1]	Unknown or blank
			Number of visits in thousands				
All visits	906,023	323,411	288,808	76,074	50,735	141,935	25,060
Age							
Under 15 years	145,245	74,394	22,033	7,404	2,603	35,355	*3,456
15–24 years	72,447	30,382	13,889	4,457	2,954	18,939	1,826
25–44 years	203,553	73,808	51,492	15,872	13,512	42,165	*6,702
45–64 years	257,258	81,643	98,328	25,069	15,279	29,350	7,589
65–74 years	106,424	31,189	47,357	9,537	7,240	8,390	2,711
75 years and over	121,096	31,995	55,709	13,736	9,147	7,735	2,776
Sex							
Female	537,298	186,192	159,954	44,380	30,838	100,220	15,715
Male	368,724	137,219	128,854	31,694	19,897	41,715	9,345
Race[2]							
White	777,112	276,517	248,355	66,836	44,600	121,900	18,904
Black or African American	84,268	30,387	26,031	7,099	4,487	12,404	*3,861
Other	44,643	16,507	14,422	2,140	1,649	7,631	*2,295
Ethnicity[2]							
Hispanic or Latino	102,687	37,213	30,042	6,995	5,059	20,364	*3,014
Not Hispanic or Latino	803,335	286,198	258,766	69,079	45,676	121,570	22,046
Primary expected source of payment							
Private insurance	508,903	194,289	141,031	41,084	25,152	94,121	13,226
Medicaid or SCHIP[3]	92,191	37,803	24,478	6,458	3,157	18,441	1,854
Medicare	206,345	57,367	92,241	21,425	14,238	16,415	4,660
Self-pay, no charge, or charity	44,197	12,892	15,665	4,208	4,651	5,836	946
Other[4]	54,387	21,061	15,393	2,900	3,537	7,121	4,375
			Standard error in thousands				
All visits	34,276	14,276	15,375	5,993	3,478	9,977	5,671
Age							
Under 15 years	11,417	5,950	3,323	980	655	4,205	1,038
15–24 years	4,925	2,363	1,213	666	402	2,637	378
25–44 years	9,709	4,017	3,305	2,376	1,481	4,359	2,139
45–64 years	11,483	4,111	6,150	2,552	1,353	3,154	2,107
65–74 years	5,422	2,480	3,045	1,047	781	1,024	591
75 years and over	6,962	2,606	3,764	1,310	1,367	1,013	580
Sex							
Female	22,053	8,832	8,837	3,768	2,406	8,403	3,494
Male	14,819	6,434	7,390	2,671	1,726	3,452	2,316
Race[2]							
White	31,113	12,885	13,536	5,236	3,138	9,165	3,469
Black or African American	6,708	2,994	3,004	1,038	787	1,789	1,526
Other	7,586	3,623	2,955	478	403	1,515	1,475
Ethnicity[2]							
Hispanic or Latino	13,908	6,083	5,654	1,070	1,098	3,414	1,223
Not Hispanic or Latino	31,670	13,492	13,443	5,813	3,327	8,324	4,604
Primary expected source of payment							
Private insurance	22,454	9,312	9,027	4,772	1,707	6,952	3,719
Medicaid or SCHIP[3]	8,772	4,260	3,258	997	533	3,128	527
Medicare	10,587	4,020	5,679	1,937	1,768	2,068	1,294
Self-pay, no charge, or charity	4,111	1,366	2,175	799	1,262	2,049	306
Other[4]	4,830	2,195	1,589	526	583	1,378	1,018

See footnotes at end of table.

Table 10. Number and percent distribution of office visits with corresponding standard errors by major reason for this visit, according to selected patient and visit characteristics: United States, 2003—Con.

Selected patient and visit characteristics	Total	Acute problem	Chronic problem, routine	Chronic problem, flare-up	Pre- or post-surgery	Preventive care[1]	Unknown or blank
				Percent distribution			
All visits	100.0	35.7	31.9	8.4	5.6	15.7	2.8
Age							
Under 15 years	100.0	51.2	15.2	5.1	1.8	24.3	2.4
15–24 years	100.0	41.9	19.2	6.2	4.1	26.1	2.5
25–44 years	100.0	36.3	25.3	7.8	6.6	20.7	*3.3
45–64 years	100.0	31.7	38.2	9.7	5.9	11.4	3.0
65–74 years	100.0	29.3	44.5	9.0	6.8	7.9	2.5
75 years and over	100.0	26.4	46.0	11.3	7.6	6.4	2.3
Sex							
Female	100.0	34.7	29.8	8.3	5.7	18.7	2.9
Male	100.0	37.2	34.9	8.6	5.4	11.3	2.5
Race[2]							
White	100.0	35.6	32.0	8.6	5.7	15.7	2.4
Black or African American	100.0	36.1	30.9	8.4	5.3	14.7	*4.6
Other	100.0	37.0	32.3	4.8	3.7	17.1	*5.1
Ethnicity[2]							
Hispanic or Latino	100.0	36.2	29.3	6.8	4.9	19.8	*2.9
Not Hispanic or Latino	100.0	35.6	32.2	8.6	5.7	15.1	2.7
Primary expected source of payment							
Private insurance	100.0	38.2	27.7	8.1	4.9	18.5	2.6
Medicaid or SCHIP[3]	100.0	41.0	26.6	7.0	3.4	20.0	2.0
Medicare	100.0	27.8	44.7	10.4	6.9	8.0	2.3
Self-pay, no charge, or charity	100.0	29.2	35.4	9.5	10.5	13.2	2.1
Other[4]	100.0	38.7	28.3	5.3	6.5	13.1	8.0
				Standard error of percent			
All visits	...	0.9	1.3	0.5	0.4	0.9	0.6
Age							
Under 15 years	...	1.9	1.9	0.6	0.4	1.9	0.7
15–24 years	...	1.7	1.8	0.8	0.5	2.5	0.5
25–44 years	...	1.5	1.4	1.0	0.7	1.7	1.0
45–64 years	...	1.2	1.6	0.8	0.5	1.1	0.8
65–74 years	...	1.6	1.7	0.8	0.7	0.9	0.6
75 years and over	...	1.5	1.8	0.8	1.0	0.8	0.5
Sex							
Female	...	1.0	1.3	0.6	0.4	1.2	0.6
Male	...	1.1	1.5	0.6	0.4	0.8	0.6
Race[2]							
White	...	0.9	1.3	0.5	0.4	0.9	0.4
Black or African American	...	2.1	2.7	1.1	0.9	1.8	1.7
Other	...	3.8	4.2	1.1	1.1	2.9	2.8
Ethnicity[2]							
Hispanic or Latino	...	2.6	3.1	0.7	1.0	2.7	1.2
Not Hispanic or Latino	...	0.9	1.2	0.6	0.4	0.8	0.6
Primary expected source of payment							
Private insurance	...	1.1	1.4	0.8	0.3	1.0	0.7
Medicaid or SCHIP[3]	...	2.3	2.5	1.0	0.6	2.6	0.6
Medicare	...	1.3	1.7	0.8	0.7	0.9	0.6
Self-pay, no charge, or charity	...	2.8	3.6	1.6	2.7	4.2	0.7
Other[4]	...	2.2	2.4	0.8	1.1	1.8	1.7

* Figure does not meet standard of reliability or precision.

. . . Category not applicable.

[1]Preventive care includes prenatal, general medical, well-baby, and screening or insurance examinations.

[2]"Other" race includes visits by Asians, Native Hawaiians or other Pacific Islanders, American Indians or Alaska Natives, and multiple races. All race categories include visits by persons of Hispanic and not Hispanic origin. Persons of Hispanic origin may be of any race. Starting with data year 1999, race-specific estimates have been tabulated according to 1997 Standards for Federal Data on Race and Ethnicity and are not strictly comparable with estimates for earlier years.

[3]SCHIP is State Children's Health Insurance Program.

[4]"Other" includes worker's compensation, unknown or blank, and payments not classified elsewhere.

NOTE: Numbers may not add to totals because of rounding.

Table 11. Number, percent distribution, and annual rate of preventive care office visits and percent of visits to primary care specialists with corresponding standard errors, by selected patient and visit characteristics: United States, 2003

Patient and visit characteristics	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent	Number of visits per 100 persons per year[1]	Standard error of rate	Percent of preventive care visits made to primary care specialists	Standard error of percent
All preventive care visits[2]	141,935	9,977	100.0	. . .	49.7	3.5	87.8	2.2
Age								
Less than 15 years	35,355	4,205	24.9	2.6	58.3	6.9	98.1	0.8
15–24 years	18,939	2,637	13.3	1.4	47.2	6.6	95.5	1.4
25–44 years	42,165	4,359	29.7	1.9	51.3	5.3	90.7	3.0
45–64 years	29,350	3,154	20.7	1.8	43.0	4.6	79.9	3.3
65–74 years	8,390	1,024	5.9	0.6	46.4	5.7	67.9	7.0
75 years and over	7,735	1,013	5.4	0.7	47.8	6.3	58.8	6.6
Sex and age								
Female	100,220	8,403	70.6	2.1	68.6	5.8	89.2	2.5
Under 15 years	16,353	1,844	11.5	1.2	55.2	6.2	98.0	0.8
15–24 years	16,163	2,558	11.4	1.4	81.3	12.9	97.2	1.5
25–44 years	36,879	4,204	26.0	2.0	88.6	10.1	92.2	2.9
45–64 years	19,925	2,414	14.0	1.4	56.7	6.9	82.3	3.9
65–74 years	5,483	803	3.9	0.5	55.6	8.1	72.3	7.3
75 years and over	5,416	830	3.8	0.5	54.6	8.4	60.0	7.0
Male	41,715	3,452	29.4	2.1	29.9	2.5	84.7	2.7
Under 15 years	19,001	2,609	13.4	1.7	61.2	8.4	98.1	0.9
15–24 years	2,777	563	2.0	0.4	13.7	2.8	85.7	4.2
25–44 years	5,286	713	3.7	0.5	13.0	1.8	80.1	7.7
45–64 years	9,426	1,312	6.6	0.9	28.5	4.0	74.6	5.2
65–74 years	2,907	430	2.0	0.3	35.3	5.2	59.7	8.2
75 years and over	2,319	451	1.6	0.3	37.0	7.2	55.9	9.7
Race[3]								
White	121,900	9,165	85.9	1.7	52.9	4.0	86.9	2.5
Black or African American	12,404	1,789	8.7	1.2	34.7	5.0	93.8	2.0
Other	7,631	1,515	5.4	1.0	39.5	7.8	93.7	3.1
Ethnicity[3]								
Hispanic or Latino	20,364	3,414	14.3	2.0	51.7	8.7	96.3	1.6
Not Hispanic or Latino	121,570	8,324	85.7	2.0	49.4	3.4	86.4	2.5
Primary expected source of payment								
Private insurance	94,121	6,952	66.3	2.5	48.9	3.6	89.8	2.1
Medicaid or SCHIP[4]	18,441	3,128	13.0	1.9	61.3	10.4	97.5	0.9
Medicare	16,415	2,068	11.6	1.2	46.5	5.9	66.1	6.6
Self-pay, no charge, or charity	*5,836	2,049	*4.1	1.4	*14.1	5.0	91.0	3.9
Other[5]	7,121	1,378	5.0	0.9	. . .	. . .	84.8	6.4

. . . Category not applicable.

[1]Visit rates for age, sex, race, and ethnicity are based on U.S. Census Bureau estimates of the civilian noninstitutional population of the United States as of July 1, 2003. These population estimates reflect Census 2000 and are available from the U.S. Census Bureau. See "Technical Notes" for more detail.

[2]Preventive care includes prenatal, general medical, well-baby, and screening or insurance examinations.

[3]"Other" race includes visits by Asian, Native Hawaiian or other Pacific Islander, American Indian or Alaska Native, and multiple races. All race categories include visits by persons of Hispanic origin and not Hispanic origin. Persons of Hispanic origin may be of any race. Starting with data year 1999, race-specific estimates have been tabulated according to 1997 Standards for Federal Data on Race and Ethnicity and are not strictly comparable with estimates for earlier years. However, the percent of visit records with multiple races indicated is small and lower than what is typically found for self-reported race. See "Technical Notes" for more details.

[4]SCHIP is State Children's Health Insurance Program.

[5]"Other" includes worker's compensation, unknown or blank, and payments not classified elsewhere.

Table 12. Number and percent distribution of office visits with corresponding standard errors, by physician's primary diagnosis: United States, 2003

Major disease category and ICD–9–CM code range[1]	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent
All visits	906,023	34,276	100.0	. . .
Infectious and parasitic diseases 001–139	25,908	3,226	2.9	0.3
Neoplasms 140–239	26,257	2,910	2.9	0.3
Endocrine, nutritional, metabolic diseases, and immunity disorders 240–279	47,784	4,414	5.3	0.4
Mental disorders 290–319	45,543	3,676	5.0	0.4
Diseases of the nervous system and sense organs 320–389	85,556	6,029	9.4	0.6
Diseases of the circulatory system 390–459	70,681	4,997	7.8	0.5
Diseases of the respiratory system 460–519	114,526	9,265	12.6	0.9
Diseases of the digestive system 520–579	33,934	3,012	3.7	0.3
Diseases of the genitourinary system 580–629	42,649	3,448	4.7	0.3
Diseases of the skin and subcutaneous tissue 680–709	38,966	2,743	4.3	0.3
Diseases of the musculoskeletal system and connective tissue 710–739	73,474	6,495	8.1	0.6
Symptoms, signs, and ill-defined conditions 780–799	58,681	3,373	6.5	0.3
Injury and poisoning 800–999	44,845	3,713	4.9	0.4
Supplementary classification V01–V82	158,239	10,597	17.5	0.9
All other diagnoses[2]	23,669	2,438	2.6	0.3
Unknown[3]	15,310	1,850	1.7	0.2

. . . Category not applicable.

[1]Based on the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM) (11).

[2]Includes diseases of the blood and blood-forming organs (280–289); complications of pregnancy, childbirth, and the puerperium (630–677); congenital anomalies (740–759); and certain conditions originating in the perinatal period (760–779).

[3]Includes blank diagnoses, uncodable diagnoses, and illegible diagnoses.

NOTE: Numbers may not add to totals because of rounding.

Table 13. Number and percent distribution of office visits with corresponding standard errors by the 20 leading primary diagnosis groups, according to patient's sex: United States, 2003

Primary diagnosis group and ICD-9-CM code(s)[1]	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent	Female[2]		Male[3]	
					Percent distribution	Standard error of percent	Percent distribution	Standard error of percent
All visits	906,023	34,276	100.0	. . .	100.0	. . .	100.0	. . .
Essential hypertension 401	35,023	3,180	3.9	0.3	3.6	0.4	4.3	0.4
Acute upper respiratory infections, excluding pharyngitis 460–461,463–466	33,527	3,506	3.7	0.3	3.6	0.4	3.9	0.4
Routine infant or child health check V20.2	29,661	3,716	3.3	0.4	2.5	0.3	4.4	0.6
Arthropathies and related disorders 710–719	28,921	3,973	3.2	0.4	3.6	0.5	2.6	0.3
Diabetes mellitus 250	23,144	2,710	2.6	0.3	2.2	0.3	3.1	0.3
Normal pregnancy V22	22,940	3,587	2.5	0.4	4.3	0.6	*	. . .
Spinal disorders 720–724	20,985	2,300	2.3	0.2	2.1	0.3	2.7	0.3
General medical examination V70	19,292	3,193	2.1	0.3	2.0	0.5	2.4	0.4
Rheumatism, excluding back 725–729	17,923	1,810	2.0	0.2	2.2	0.2	1.7	0.2
Otitis media and eustachian tube disorders 381–382	17,267	1,645	1.9	0.2	1.5	0.2	2.5	0.3
Malignant neoplasms 140–208,230–234	16,368	2,363	1.8	0.3	1.5	0.3	2.3	0.3
Gynecological examination V72.3	15,944	2,752	1.8	0.3	3.0	0.5	*	. . .
Allergic rhinitis 477	15,220	4,341	1.7	0.5	1.5	0.4	1.9	0.6
Chronic sinusitis 473	14,895	1,365	1.6	0.1	1.6	0.2	1.7	0.2
Asthma 493	12,855	1,932	1.4	0.2	1.3	0.2	1.5	0.2
Heart disease, excluding ischemic 391–392.0,393–398,402,404,415–416,420–429	12,050	1,240	1.3	0.1	1.2	0.2	1.5	0.2
Potential health hazards related to personal and family history V10–V19	11,588	1,366	1.3	0.2	1.3	0.2	1.2	0.2
Chronic and unspecified bronchitis 490–491	10,662	1,380	1.2	0.1	1.1	0.2	1.3	0.2
Acute pharyngitis 462	10,135	1,398	1.1	0.1	1.1	0.2	1.2	0.2
Benign neoplasms 210–229,235–239	9,889	988	1.1	0.1	1.1	0.1	1.1	0.1
All other diagnoses	527,735	19,722	58.2	0.9	57.9	1.1	58.7	1.0

. . . Category not applicable.

* Figure does not meet standard of reliability or precision.

[1]Based on the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM) (11). However, certain codes have been combined in this table to form larger categories that better describe the utilization of ambulatory care services.

[2]Based on 537,298,000 visits made by females.

[3]Based on 368,724,000 visits made by males.

NOTE: Numbers may not add to totals because of rounding.

Table 14. Number and percent distribution of office visits with corresponding standard errors by patient's age, according to the five leading primary diagnosis groups: United States, 2003

Primary diagnosis group and ICD-9-CM code(s)[1]	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent	Number of visits per 100 persons per year[2]	Standard error of rate
All visits	906,023	34,276	100.0	. . .	317.3	12.0
Under 1 year						
All visits	26,514	3,023	100.0	. . .	662.9	75.6
Routine infant or child health check V20.2	11,004	1,731	41.5	3.1	275.1	43.3
Acute upper respiratory infections, excluding pharyngitis 460–461,463–466	3,224	583	12.2	1.8	80.6	14.6
Otitis media and eustachian tube disorders 381–382	2,223	404	8.4	1.4	55.6	10.1
Certain conditions originating in the perinatal period 760–779	*	. . .	*	. . .	*	. . .
Congenital anomalies 740–759	*569	209	*2.1	0.8	14.2	5.2
All other diagnoses	8,703	947	32.8	2.5	217.6	23.7
1–12 years						
All visits	104,638	8,200	100.0	. . .	217.2	17.0
Routine infant or child health check V20.2	15,593	2,029	14.9	1.6	32.4	4.2
Otitis media and eustachian tube disorders 381–382	10,455	1,264	10.0	0.9	21.7	2.6
Acute upper respiratory infections, excluding pharyngitis 460–461,463–466	9,655	1,195	9.2	0.9	20.0	2.5
Acute pharyngitis 462	4,181	768	4.0	0.7	8.7	1.6
Asthma 493	4,095	831	3.9	0.7	8.5	1.7
All other diagnoses	60,659	5,056	58.0	1.8	125.9	10.5
13–21 years						
All visits	65,101	4,414	100.0	. . .	177.7	12.0
Normal pregnancy V22	4,511	1,120	6.9	1.5	[3]25.0	6.2
Acute upper respiratory infections, excluding pharyngitis 460–461,463–466	3,709	778	5.7	1.0	10.1	2.1
Routine infant or child health check V20.2	3,063	630	4.7	0.9	8.4	1.7
Acne 706.0–706.1	2,764	374	4.2	0.6	7.5	1.0
Chronic sinusitis 473	1,982	428	3.0	0.7	5.4	1.2
All other diagnoses	49,072	3,226	75.4	1.8	133.9	8.8
22–49 years						
All visits	296,307	13,389	100.0	. . .	256.0	11.6
Normal pregnancy V22	18,429	2,813	6.2	0.8	[4]31.4	4.8
General medical examination V70	10,079	1,759	3.4	0.6	8.7	1.5
Gynecological examination V72.3	9,996	1,705	3.4	0.5	[4]17.04	2.9
Acute upper respiratory infections, excluding pharyngitis 460–461,463–466	9,503	1,475	3.2	0.4	8.2	1.3
Spinal disorders 720–724	8,588	1,049	2.9	0.3	7.4	0.9
All other diagnoses	239,712	10,334	80.9	1.3	207.1	8.9
50–64 years						
All visits	185,942	8,531	100.0	. . .	398.5	18.3
Essential hypertension 401	11,354	1,336	6.1	0.6	24.3	2.9
Arthropathies and related disorders 710–719	9,221	1,610	5.0	0.8	19.8	3.5
Diabetes mellitus 250	8,426	1,023	4.5	0.5	18.1	2.2
Rheumatism, excluding back 725–729	6,307	773	3.4	0.4	13.5	1.7
Spinal disorders 720–724	5,983	855	3.2	0.5	12.8	1.8
All other diagnoses	144,651	6,619	77.8	1.2	310.0	14.2
65 years and over						
All visits	227,520	11,404	100.0	. . .	663.7	33.3
Essential hypertension 401	17,328	1,860	7.6	0.7	50.6	5.4
Arthropathies and related disorders 710–719	10,925	1,409	4.8	0.5	31.9	4.1
Diabetes mellitus 250	10,142	1,558	4.5	0.6	29.6	4.5
Malignant neoplasms 140–208,230–234	9,165	1,160	4.0	0.5	26.7	3.4
Heart disease, excluding ischemic 391–392.0,393–398,402,404,415–416,420–429	7,479	789	3.3	0.3	21.8	2.3
All other diagnoses	172,482	8,632	75.8	1.1	503.2	25.2

* Figure does not meet standard of reliability or precision.

. . . Category not applicable.

[1]Based on the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM) (11). However, certain codes have been combined in this table to form larger categories.

[2]Visit rates by age are based on the July 1, 2003, set of estimates of the civilian noninstitutional population of the United States as developed by the Population Division, U.S. Census Bureau. These population estimates reflect Census 2000 data and are available from the U.S. Census Bureau. See "Technical Notes" for more details.

[3]Number of visits (numerator) and population estimate (denominator) include females 13–21 years of age.

[4]Number of visits (numerator) and population estimate (denominator) include females 22–49 years of age.

NOTE: Numbers may not add to totals because of rounding.

Table 15. Number, percent distribution, and annual rate of injury-related office visits with corresponding standard errors, by selected patient characteristics: United States, 2003

Patient characteristics	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent	Number of visits per 100 persons per year[1]	Standard error of rate
All injury-related visits	99,927	6,219	100.0	. . .	35.0	2.2
Age						
Under 15 years	13,096	1,272	13.1	1.1	21.6	2.1
15–24	10,723	1,097	10.7	0.9	26.7	2.7
25–44	26,709	2,245	26.7	1.3	32.5	2.7
45–64	29,068	2,412	29.1	1.2	42.6	3.5
65–74	9,998	1,047	10.0	0.8	55.3	5.8
75 years and over	10,332	1,325	10.3	1.3	63.8	8.2
Sex and age						
Female	55,049	3,530	55.1	1.3	37.7	2.4
Under 15 years	6,586	743	6.6	0.7	22.2	2.5
15–24	4,566	626	4.6	0.6	23.0	3.2
25–44	15,084	1,377	15.1	1.0	36.2	3.3
45–64	16,590	1,494	16.6	1.0	47.2	4.3
65–74	5,409	752	5.4	0.6	54.9	7.6
75 years and over	6,815	1,063	6.8	1.1	68.7	10.7
Male	44,877	3,211	44.9	1.3	32.2	2.3
Under 15 years	6,510	766	6.5	0.7	21.0	2.5
15–24	6,157	826	6.2	0.7	30.4	4.1
25–44	11,625	1,252	11.6	0.9	28.6	3.1
45–64	12,478	1,196	12.5	0.8	37.7	3.6
65–74	4,590	553	4.6	0.5	55.7	6.7
75 years and over	3,517	460	3.5	0.4	56.1	7.3
Race[2]						
White	88,180	5,737	88.2	1.1	38.3	2.5
Black or African American	8,049	888	8.1	0.7	22.5	2.5
Other	3,698	814	3.7	0.8	19.1	4.2
Ethnicity[2]						
Hispanic or Latino	9,257	1,083	9.3	1.1	23.5	2.8
Not Hispanic or Latino	90,670	5,999	90.7	1.1	36.8	2.4

. . . Category not applicable.

[1]Visit rates for age, sex, race, and ethnicity are based on the July 1, 2003, set of estimates of the civilian noninstitutional population of the United States as developed by the Population Division, U.S. Census Bureau. These population estimates reflect Census 2000 data and are available from the Census Bureau. See "Technical Notes" for more details.

[2]"Other" race includes visits by Asians, Native Hawaiians or other Pacific Islanders, American Indians or Alaska Natives, and multiple races. All race categories include visits by persons of Hispanic and not Hispanic origin. Persons of Hispanic origin may be of any race. Starting with data year 1999, race-specific estimates have been tabulated according to 1997 Standards for Federal Data on Race and Ethnicity and are not strictly comparable with estimates for earlier years. However, the percent of visit records with multiple races indicated is small and lower than what is typically found for self-reported race. See "Technical Notes" for more details.

NOTE: Numbers may not add to totals because of rounding.

Table 16. Number and percent distribution of injury-related office visits with corresponding standard errors, by intent and mechanism of external cause: United States, 2003

Intent and mechanism[1]	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent
All injury related visits	99,927	6,219	100.0	. . .
Unintentional injuries	55,334	4,481	55.4	2.0
Falls	11,705	1,320	11.7	1.0
Overexertion and strenuous movements	7,155	966	7.2	0.8
Motor vehicle traffic	6,011	859	6.0	0.7
Struck against or struck accidentally by objects or persons	5,228	725	5.2	0.6
Natural and environmental factors	3,808	493	3.8	0.5
Cutting or piercing instruments or objects	1,982	405	2.0	0.4
Other and not elsewhere classified[2]	14,959	1,526	15.0	1.0
Mechanism unspecified	4,485	758	4.5	0.7
Intentional injuries[3]	946	233	0.9	0.2
Injuries of undetermined intent	*	. . .	*	. . .
Adverse effects of medical treatment	7,986	933	8.0	0.9
Blank cause[4]	35,228	2,581	35.3	1.9

. . . Category not applicable.

* Figure does not meet standard of reliability or precision.

[1]Based on the "Supplementary Classification of External Cause of Injury and Poisoning," *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM) (11). A detailed description of the ICD–9–CM E-codes used to create the groupings in this table is provided in the "Technical Notes."

[2]Includes suffocation, poisoning, other transportation, machinery, firearm, fire and flames, drowning or submersion, nontraffic motor vehicle, and pedal cycle.

[3]Includes assault, self-inflicted, and other causes of violence.

[4]Includes illegible entries and blanks.

NOTE: Numbers may not add to totals because of rounding.

Table 17. Number and percent of office visits with corresponding standard errors, by diagnostic and screening services ordered or provided and patient's sex: United States, 2003

Diagnostic and screening services ordered or provided	Number of visits in thousands[1]	Standard error in thousands	Percent of visits	Standard error of percent	Female[2]		Male[3]	
					Percent of visits	Standard error of percent	Percent of visits	Standard error of percent
All visits	906,023	34,276	. . .	. . .	. . .	. . .	. . .	. . .
One or more diagnostic and screening services listed	776,815	30,243	85.7	1.1	85.9	1.2	85.5	1.2
None	118,346	11,164	13.1	1.1	13.1	1.2	13.0	1.2
Blank	10,861	2,729	1.2	0.3	1.0	0.3	1.5	0.4
Examinations								
General medical examination	456,194	21,270	50.4	1.7	48.8	1.7	52.6	1.8
Other examination	212,472	14,236	23.5	1.3	25.5	1.4	20.4	1.5
Vital signs								
Temperature	272,817	20,428	30.1	1.8	29.0	1.8	31.7	2.1
Blood pressure	474,514	25,144	52.4	1.7	55.2	1.8	48.2	1.7
Diagnostic tests								
EKG[4]	26,960	2,957	3.0	0.3	2.3	0.3	3.9	0.5
Any scope procedure	22,795	3,119	2.5	0.4	2.6	0.4	2.4	0.4
Sigmoidoscopy or colonoscopy	11,025	2,413	1.2	0.3	1.3	0.3	1.1	0.3
Endoscopy	7,920	1,156	0.9	0.1	0.9	0.1	0.8	0.2
Cystoscopy	2,088	303	0.2	0.0	0.2	0.0	0.3	0.1
Laboratory tests								
CBC[5]	85,988	6,850	9.5	0.7	9.2	0.7	9.9	0.9
Urinalysis	78,202	7,068	8.6	0.7	9.7	0.9	7.0	0.6
Lipids or cholesterol	58,699	5,535	6.5	0.6	5.5	0.5	7.8	0.8
PSA[6]	14,196	1,724	1.6	0.2	. . .	. . .	3.8	0.4
Hematocrit or hemoglobin	15,285	1,818	1.7	0.2	1.5	0.2	1.9	0.3
Pap test	28,035	3,699	3.1	0.4	5.2	0.6	. . .	. . .
Glucose	48,450	5,202	5.3	0.5	5.0	0.6	5.8	0.7
HgbA1C[7]	19,255	2,768	2.1	0.3	2.1	0.3	2.2	0.3
Electrolytes	39,061	4,596	4.3	0.5	4.2	0.5	4.5	0.6
Other blood test	85,280	6,831	9.4	0.7	9.5	0.7	9.3	0.8
Cultures								
Throat or rapid strep test	15,718	2,076	1.7	0.2	1.5	0.2	2.1	0.3
Urine	10,478	1,462	1.2	0.2	1.4	0.2	0.8	0.2
Stool	3,393	733	0.4	0.1	*0.3	0.1	*	. . .
Cervical or urethral	5,455	953	0.6	0.1	0.9	0.2	*	. . .
Imaging								
Any imaging	91,483	6,015	10.1	0.5	11.0	0.7	8.8	0.5
X ray	46,970	3,972	5.2	0.4	4.7	0.4	5.8	0.5
Mammography	17,128	2,078	1.9	0.2	3.2	0.3	. . .	. . .
Other imaging	33,290	2,796	3.7	0.3	3.7	0.3	3.6	0.3
Ultrasound	15,530	2,054	1.7	0.2	1.8	0.2	1.5	0.3
Other service	101,390	6,740	11.2	0.6	11.7	0.7	10.4	0.7

. . . Category not applicable.
0.0 Quantity more than zero, but less than 0.05.
* Figure does not meet standard of reliability or precision.
[1]Total exceeds "All visits" because more than one service may be reported per visit.
[2]Based on 537,298,000 visits made by females.
[3]Based on 368,724,000 visits made by males.
[4]EKG is electrocardiogram.
[5]CBC is complete blood count.
[6]PSA is prostate-specific antigen.
[7]HgbA1C is glycohemoglobin.

Table 18. Mean vital signs for patients seen at office visits with corresponding standard errors and percentiles by type of vital sign and patient's age: United States, 2003

Type of vital sign	Mean	Standard error in of mean	25th percentile	Median	75th percentile
Temperature in Fahrenheit					
All visits	98.0	0.0	97.3	97.9	98.5
Under 5 years	98.1	0.1	97.2	97.9	98.7
5 years and over	98.0	0.0	97.3	97.9	98.5
Reason for visit-fever	99.0	0.1	97.8	98.8	100.0
Systolic blood pressure in mmHg[1]					
All visits	125.9	0.6	111.2	123.3	137.9
18–44 years	118.9	0.5	109.3	119.0	127.2
45–64 years	130.0	0.5	119.2	129.2	139.5
65 years and over	135.6	0.8	119.9	133.7	147.3
Diagnosis of hypertension	140.1	1.0	127.4	139.2	149.8
Diastolic blood pressure in mmHg[1]					
All visits	75.6	0.3	69.1	75.8	81.0
18–44 years	74.9	0.4	69.0	73.8	79.8
45–64 years	79.3	0.3	69.9	79.3	85.4
65 years and over	75.0	0.4	69.0	75.5	79.9
Diagnosis of hypertension	81.2	0.5	71.1	79.4	89.2

0.0 Quantity more than zero but less than 0.05.
[1]mmHg is millimeters of mercury.

Table 19. Number and percent of office visits with corresponding standard errors, by counseling, education, or therapeutic services ordered or provided and patient's sex: United States, 2003

Counseling, education, or therapeutic services ordered or provided	Number of visits in thousands[1]	Standard error in thousands	Percent of visits	Standard error of percent	Female[2]		Male[3]	
					Percent of visits	Standard error of percent	Percent of visits	Standard error of percent
All visits	906,023	34,276	. . .	. . .	. . .	. . .	. . .	. . .
One or more counseling, education, or therapeutic services listed	375,777	18,225	41.5	1.5	42.3	1.6	40.2	1.6
None	500,658	25,324	55.3	1.6	54.8	1.7	56.0	1.7
Blank	29,588	4,907	3.3	0.5	2.9	0.5	3.8	0.6
Diet or nutrition	129,743	9,526	14.3	0.9	14.6	1.1	13.9	0.9
Exercise	91,409	8,067	10.1	0.8	10.2	0.9	10.0	0.9
Mental health or stress management	37,264	3,670	4.1	0.4	4.3	0.4	3.8	0.5
Growth or development	26,816	4,010	3.0	0.4	2.6	0.4	3.4	0.5
Weight reduction	26,284	3,235	2.9	0.3	3.0	0.4	2.8	0.3
Tobacco use or exposure	25,946	2,926	2.9	0.3	2.7	0.3	3.1	0.4
Psychotherapy	19,901	2,421	2.2	0.3	2.0	0.2	2.4	0.4
Physiotherapy	19,611	2,916	2.2	0.3	2.1	0.3	2.2	0.3
Asthma education	15,472	1,577	1.7	0.2	1.7	0.2	1.8	0.2
Other	174,683	11,635	19.3	1.1	20.2	1.3	17.9	1.2

. . . Category not applicable.
[1]Numbers may not add to totals because more than one type of counseling, education, or therapeutic service may be reported per visit.
[2]Based on 537,298,000 visits made by females.
[3]Based on 368,724,000 visits made by males.

Table 20. Number and percent of write-in surgical procedures ordered or performed with corresponding standard errors, by procedure category: United States, 2003

Procedure or operation category[1]	ICD-9-CM codes	Number of procedures in thousands	Standard error in thousands	Percent distribution	Standard error of percent
All write-in procedures		74,778	4,510	100.0	. . .
Nervous system	01–05	*2,256	683	3.0	0.9
Eye	08–16	7,658	1,657	10.2	2.1
Ear	18–20	1,645	266	2.2	0.4
Nose, mouth, and pharynx	21–29	3,239	431	4.3	0.6
Cardiovascular system	35–39	3,849	951	5.1	1.2
Digestive system	42–54	4,901	1,120	6.5	1.4
Urinary system	55–59	1,379	307	1.8	0.4
Male genital organs	60–64	1,973	314	2.6	0.4
Female genital organs	65–71	5,925	1,382	7.9	1.7
Obstetrical procedures	72–75	2,993	803	4.0	1.1
Musculoskeletal system	76–84	9,865	1,477	13.2	1.7
Integumentary system	85–86	27,977	2,572	37.4	2.6
Other procedures[2]		*1,118	347	*1.5	0.5

. . . Category not applicable.

* Figure does not meet standard of reliability or precision.

[1]Based on the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM) (11).

[2]Includes operations on the endocrine system (ICD–9–CM codes 06–07), operations on the respiratory system (ICD–9–CM codes 30–34), and operations on the hemic and lymphatic system (ICD–9–CM codes 40–41).

NOTES: Included are responses to the ambulatory surgery item on the Patient Record form (Item 8) (up to two procedures could be reported), and the diagnostic or screening services item (Item 6) (up to two procedures can be reported in the "Scope procedure-Specify" and the "Other service-Specify" categories). Miscellaneous diagnostic and therapeutic procedures (nonsurgical procedures) were not included in the total. These procedures, coded to ICD–9–CM volume 3, range 87–99, represented 122,008,621 procedures.

Table 21. Number and percent distribution of office visits with corresponding standard errors, by medication therapy and number of medications provided or prescribed, according to patient's sex: United States, 2003

					Female[1]		Male[2]	
Visit characteristic	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent	Percent distribution	Standard error of percent	Percent distribution	Standard error of percent
Medication therapy[3]								
All visits	906,023	34,276	100.0	. . .	100.0	. . .	100.0	. . .
Drug visits[4]	595,339	24,209	65.7	1.1	65.2	1.2	66.4	1.2
Visits without mention of medication	310,684	15,711	34.3	1.1	34.8	1.2	33.6	1.2
Number of medications provided or prescribed by a physician								
All visits	906,023	34,276	100.0	. . .	100.0	. . .	100.0	. . .
0	310,684	15,711	34.3	1.1	34.8	1.2	33.6	1.2
1	237,349	11,397	26.2	0.7	26.1	0.9	26.4	0.8
2	139,770	6,750	15.4	0.4	15.0	0.5	16.0	0.5
3	73,990	4,510	8.2	0.4	7.7	0.4	8.8	0.5
4	45,682	2,915	5.0	0.3	5.1	0.3	5.0	0.4
5	29,904	2,344	3.3	0.2	3.4	0.3	3.1	0.3
6	23,196	2,297	2.6	0.2	2.6	0.3	2.5	0.3
7	12,305	1,483	1.4	0.2	1.4	0.2	1.2	0.2
8	33,143	4,053	3.7	0.4	3.8	0.4	3.5	0.5

. . . Category not applicable.

[1]Based on 537,298,000 visits made by females.

[2]Based on 368,724,000 visits made by males.

[3]Includes prescription drugs, over-the-counter preparations, immunizations, and desensitizing agents.

[4]Visits at which one or more drugs were provided or prescribed by the physician.

NOTE: Numbers may not add to totals because of rounding.

Table 22. Number and percent distribution of drug visits and drug mentions, and percent drug visits and drug mention rates per 100 visits with corresponding standard errors, by physician specialty: United States, 2003

Physician specialty	Drug visits				Drug mentions				Percent drug visits		Drug mention rates	
	Number in thousands[1]	Standard error in thousands	Percent distribution	Standard error of percent	Number in thousands[2]	Standard error in thousands	Percent distribution	Standard error of percent	Percent drug visits[3]	Standard error of percent	Number of drug mentions per 100 visits[4]	Standard error of rate
All specialties	595,339	24,209	100.0	. . .	1,561,556	81,598	100.0	. . .	65.7	1.1	172.4	6.7
General and family practice	170,967	11,820	28.7	1.7	442,767	38,909	28.4	2.2	76.6	1.5	198.5	11.2
Internal medicine	111,224	14,200	18.7	2.0	354,098	52,035	22.7	2.7	78.7	2.8	250.5	25.4
Pediatrics	62,953	6,370	10.6	1.0	125,952	14,509	8.1	0.9	67.0	2.3	134.1	8.1
Obstetrics and gynecology	35,389	5,850	5.9	0.9	61,861	11,462	4.0	0.7	44.1	4.1	77.2	10.0
Ophthalmology	26,126	4,143	4.4	0.7	55,613	11,136	3.6	0.7	53.0	4.5	112.8	17.2
Psychiatry	25,277	3,085	4.2	0.5	58,396	8,043	3.7	0.5	88.2	1.6	203.9	12.6
Cardiovascular diseases	20,237	2,705	3.4	0.5	100,440	14,659	6.4	0.9	80.3	3.5	398.6	28.8
Dermatology	18,970	1,948	3.2	0.3	34,175	3,795	2.2	0.3	63.7	2.3	114.7	6.7
Orthopedic surgery	17,502	2,796	2.9	0.5	32,221	6,439	2.1	0.4	40.0	3.6	73.6	11.0
Otolaryngology	11,850	1,601	2.0	0.3	23,845	4,057	1.5	0.3	55.4	3.5	111.4	12.5
Urology	9,513	1,205	1.6	0.2	15,260	2,156	1.0	0.2	51.8	2.5	83.2	7.5
Neurology	9,134	1,144	1.5	0.2	23,856	3,559	1.5	0.2	70.9	2.5	185.2	20.2
General surgery	4,005	929	0.7	0.2	9,040	2,401	*0.6	0.2	20.5	4.4	46.4	11.8
All other specialties	72,192	9,636	12.1	1.6	224,033	34,126	14.3	2.1	60.9	4.2	188.8	22.9

. . . Category not applicable.

[1]Visits at which one or more drugs were provided or prescribed by the physician.

[2]Number of drugs mentioned at visits (up to eight per visit).

[3]Percent of visits that included one or more drug mentions (number of drug visits divided by number of office visits multiplied by 100).

[4]Average number of drugs that were mentioned per 100 visits (number of drug mentions divided by total number of visits multiplied by 100).

NOTE: Numbers may not add to totals because of rounding.

Table 23. Number and percentage of drug mentions for the 20 most frequently occurring therapeutic classes at office visits with corresponding standard errors: United States, 2003

Therapeutic classification[1]	Number of occurrences in thousands	Standard error in thousands	Percent of drug mentions[2]	Standard error of percent
NSAIDs[3]	80,086	5,515	5.1	0.3
Antidepressants	76,986	5,222	4.9	0.2
Hyperlipidemia	62,357	5,403	4.0	0.2
Antihistamines	60,079	5,029	3.8	0.3
Antiarthritics	60,041	5,693	3.8	0.3
Antiasthmatics or bronchodilators	59,802	6,080	3.8	0.3
Antihypertensive agents	57,916	5,590	3.7	0.2
Analgesics, nonnarcotic	54,872	4,897	3.5	0.2
Acid or peptic disorders	54,164	4,195	3.5	0.2
Antipyretics	49,882	4,667	3.2	0.2
Blood glucose regulators	49,638	5,032	3.2	0.2
Vaccines or antisera	47,800	5,004	3.1	0.3
Diuretics	43,063	3,823	2.8	0.2
Vitamins or minerals	42,390	5,240	2.7	0.3
ACE inhibitors[4]	41,923	3,724	2.7	0.2
Beta blockers	37,848	3,402	2.4	0.1
Analgesics, narcotic	37,614	2,935	2.4	0.2
Penicillins	36,285	3,351	2.3	0.2
Calcium channel blockers	33,894	3,217	2.2	0.1
Adrenal corticosteroids	31,941	2,908	2.0	0.2

[1]Based on the standard four-digit drug classification used in the *National Drug Code Directory*, 1995 edition (14).
[2]Based on an estimated 1,561,556,000 drug mentions at office visits in 2003.
[3]NSAIDs are nonsteroidal anti-inflammatory drugs.
[4]ACE is angiotensin-converting enzyme.

Table 24. Number and rate of generic substances for the 20 most frequently occurring generic substances in drug mentions at office visits with corresponding standard errors: United States, 2003

Generic substance	Number of occurrences in thousands[1]	Standard error in thousands	Number of generic substances per 100 drug mentions[2]	Standard error of rate
Acetaminophen	50,797	3,713	3.3	0.2
Aspirin	36,288	4,243	2.3	0.2
Amoxicillin	34,192	3,296	2.2	0.2
Hydrochlorothiazide	31,597	3,046	2.0	0.1
Atorvastatin calcium	31,182	2,909	2.0	0.1
Albuterol	23,342	2,334	1.5	0.1
Fluticasone propionate	23,275	2,336	1.5	0.1
Hydrocodone	22,437	2,293	1.4	0.1
Ibuprofen	22,187	2,369	1.4	0.1
Levothyroxine	21,635	2,127	1.4	0.1
Furosemide	19,231	2,107	1.2	0.1
Metoprolol	18,221	1,806	1.2	0.1
Amlodipine	18,150	2,164	1.2	0.1
Lisinopril	18,123	2,116	1.2	0.1
Pseudoephedrine	18,110	2,296	1.2	0.1
Guaifenesin	16,859	2,158	1.1	0.1
Metformin	16,056	1,908	1.0	0.1
Azithromycin	15,425	1,636	1.0	0.1
Atenolol	15,300	1,732	1.0	0.1
Rofecoxib	14,113	1,503	0.9	0.1

[1]Frequency of mention combines single-ingredient agents with mentions of the agent as an ingredient in a combination drug.
[2]Based on an estimated 1,561,556,000 drug mentions at office visits in 2003.

Table 25. Number, percent distribution, and therapeutic class for the 20 drugs most frequently prescribed at office visits with corresponding standard errors, by entry name of drug: United States, 2003

Entry name of drug[1]	Number of drug mentions in thousands	Standard error in thousands	Percent distribution	Standard error of percent	Therapeutic class[2]
All drug mentions	1,561,556	81,598	100.0	. . .	. . .
Lipitor	30,382	2,717	1.9	0.1	Hyperlipidemia
A.S.A.[3]	20,202	2,752	1.3	0.1	Nonnarcotic analgesics; antiarthritics; antipyretics
Albuterol	17,011	1,895	1.1	0.1	Antiasthmatics or bronchodilators
Synthroid	16,884	1,805	1.1	0.1	Thyroid or antithyroid
Lasix	15,922	1,813	1.0	0.1	Diuretics
Tylenol	14,395	1,813	0.9	0.1	Nonnarcotic analgesics; antipyretics
Vioxx	14,054	1,504	0.9	0.1	NSAIDs[4]
Norvasc	13,904	1,448	0.9	0.1	Calcium channel blockers
Amoxicillin	13,830	1,770	0.9	0.1	Penicillins
Hydrochlorothiazide	13,056	1,633	0.8	0.1	Diuretics
Prednisone	12,933	2,013	0.8	0.1	Adrenal corticosteroids
Zocor	12,816	1,763	0.8	0.1	Hyperlipidemia
Atenolol	12,697	1,543	0.8	0.1	Beta blockers
Zyrtec	12,480	1,566	0.8	0.1	Antihistamines
Celebrex	12,207	1,276	0.8	0.1	NSAIDs[4]
Influenza virus vaccine	12,040	2,932	0.8	0.2	Vaccines
Allergy relief or shots	*11,958	4,954	*0.8	0.3	Allergenic extracts
Zoloft	11,582	1,120	0.7	0.1	Antidepressants
Augmentin	11,576	1,593	0.7	0.1	Penicillins
Allegra	11,080	1,361	0.7	0.1	Antihistamines
All other	1,270,544	65,669	81.4	0.5	. . .

* Figure does not meet standard of reliability or precision.
. . . Category not applicable.
[1]The entry made by the physician on the prescription or other medical records. This may be a trade name, generic name, or desired therapeutic effect.
[2]Therapeutic class is based on the *National Drug Code Directory*, 1995 edition (14). In cases where a drug had more than one therapeutic use, it was classified under each therapeutic class.
[3]A.S.A. is acetylsalicylic acid.
[4]NSAIDs are nonsteroidal anti-inflammatory drugs.

NOTE: Numbers may not add to totals because of rounding.

Table 26. Number and percent of office visits with corresponding standard errors, by providers seen: United States, 2003

Type of provider	Number of visits in thousands[1]	Standard error in thousands	Percent of visits	Standard error of percent
All visits	906,023	34,276	. . .	. . .
Physician	864,937	32,816	95.5	0.6
Medical or nursing assistant	195,782	15,348	21.6	1.6
R.N.[2]	143,893	15,510	15.9	1.6
L.P.N.[3]	102,840	13,278	11.4	1.4
Medical technician or technologist	47,397	7,781	5.2	0.8
Physician assistant	12,895	3,106	1.4	0.3
Nurse practitioner or midwife	10,423	2,988	1.2	0.3
Other	22,229	3,988	2.5	0.5

. . . Category not applicable.
[1]Total exceeds "All visits" because more than one provider may be reported per visit.
[2]R.N. is registered nurse.
[3]L.P.N. is licensed practical nurse.

Table 27. Number and percent of office visits with corresponding standard errors, by visit disposition: United States, 2003

Disposition	Number of visits in thousands[1]	Standard error in thousands	Percent of visits	Standard error of percent
All visits	906,023	34,276	. . .	. . .
Return at specified time	570,175	23,745	62.9	1.4
Return if needed, P.R.N.[2]	255,548	17,843	28.2	1.5
No followup planned	62,365	6,045	6.9	0.6
Refer to other physician	54,161	3,726	6.0	0.3
Telephone followup planned	18,692	2,297	2.1	0.2
Admit to hospital	4,428	662	0.5	0.1
Other disposition	15,526	1,964	1.7	0.2
Blank	12,451	1,496	1.4	0.2

. . . Category not applicable.
[1]Total exceeds "All visits" because more than one disposition may be reported per visit.
[2]P.R.N. is "as needed."

Table 28. Number and percent distribution of office visits with corresponding standard errors, by time spent with physician: United States, 2003

Time spent with physician	Number of visits in thousands	Standard error in thousands	Percent distribution	Standard error of percent
All visits	906,023	34,276	100.0	. . .
Visits at which no physician was seen	41,086	5,982	4.5	0.6
Visits at which a physician was seen	864,937	32,816	95.5	0.6
Total	864,937	32,816	100.0	. . .
1–5 minutes	31,384	6,893	3.6	0.7
6–10 minutes	155,440	11,209	18.0	1.0
11–15 minutes	293,598	14,987	33.9	1.2
16–30 minutes	314,474	15,166	36.4	1.4
31–60 minutes	63,490	4,522	7.3	0.5
61 minutes and over	6,551	1,662	0.8	0.2

. . . Category not applicable.

NOTE: Numbers may not add to totals because of rounding.

Table 29. Mean time spent with physician with corresponding standard errors and percentiles, by physician specialty: United States, 2003

Physician specialty	Mean time in minutes spent with physician[1]	Standard error in of mean	25th percentile	Median	75th percentile
All visits	19.7	0.3	14.0	14.8	24.1
Psychiatry	32.2	1.8	14.9	27.2	44.1
Neurology	26.8	0.9	14.8	19.9	29.8
Cardiovascular diseases	22.3	1.0	14.0	18.4	28.3
Urology	20.1	0.7	14.0	15.0	24.2
Internal medicine	20.1	1.2	14.3	18.2	24.6
General and family practice	18.7	0.5	14.1	14.7	19.8
General surgery	17.7	0.7	9.8	14.2	19.5
Obstetrics and gynecology	17.6	0.7	14.0	14.7	19.3
Ophthalmology	17.6	1.6	9.3	14.1	19.5
Otolaryngology	17.4	0.6	11.5	14.7	19.6
Orthopedic surgery	16.4	0.9	8.6	13.1	19.0
Pediatrics	16.3	0.5	9.8	14.6	18.8
Dermatology	15.8	0.8	9.8	14.4	18.2
All other specialties	24.8	1.6	14.3	19.4	29.2

[1]Only visits where a physician was seen are included.

Technical Notes

Data collection

The NAMCS data collection is authorized under Section 308d of the Public Health Service Act (Title 42 U.S. Code), S242k. Participation is voluntary. In 2003, of the 1,407 in-scope physicians who participated in the NAMCS, 1,114 of them completed 25,288 Patient Record forms (PRFs), and 293 physicians saw no patients during their sampled week. Of the 1,114 physicians who completed PRFs, 94.2 percent (N=1,049) provided at least half the PRFs expected for their sampled visits and were considered to be fully or adequately responding. The unweighted physician response rate of 66.9 percent includes both physicians responding fully or adequately and physicians who saw no patients during that week.

The U.S. Census Bureau, acting as the data collection agent for the survey, provided training to field representatives (FRs) throughout the Nation. The FRs oversaw data collection at the physician's office. FRs contacted physicians for induction into the survey after an advance letter was mailed by NCHS notifying the physicians of their selection for the survey. In most cases, physicians or their staff completed the information requested on the PRFs (see figure I). However, in 27.0 percent of the offices, FRs abstracted the data from medical records or computer printouts, either alone or with the doctor or office staff.

Health Insurance Portability and Accountability Act

In April 2003, the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) was implemented to establish minimum Federal standards for safeguarding the privacy of individually identifiable health information. No personally identifying information, such as patient's name, address, or Social Security number, is collected in the NAMCS. Data collection is authorized by Section 306 of the Public Health Service Act (Title 42, U.S. Code, 242k). All information collected is held in the strictest confidence according to law [Section 308(d) of the Public Health Service Act (42, U.S. Code, 242m(d))] and the Confidential Information Protection and Statistical Efficiency Act (Title 5 of PL 107–347). The NAMCS protocol was approved by the NCHS Research Ethics Review Board in February 2003. Waivers of the requirements to obtain informed consent of patients and patient authorization for release of patient medical record data by health care providers were granted.

In spring 2003, the NAMCS implemented additional data collection procedures to help providers ensure patient confidentiality. Census Bureau field representatives were trained on how the Privacy Rule allows physicians to make disclosures of protected health information without patient authorization for public health purposes and for research that has been approved by a Research Ethics Review Board. Physicians were encouraged to accept a data use agreement between themselves and CDC's NCHS because the Privacy Rule allows physicians to disclose limited data sets (i.e., data sets with no direct patient identifiers) for research and public health purposes if such an agreement exists.

Sampling errors

The standard error is primarily a measure of the sampling variability that occurs by chance when only a sample, rather than an entire universe, is surveyed. The standard error does not measure any systematic biases in the data.

The standard errors presented in the tables and used in tests of significance for this report were estimated using SUDAAN software. SUDAAN computes standard errors by using a first-order Taylor approximation of the deviation of estimates from their expected values. A description of the software and the approach it uses has been published (5). The relative standard error (RSE) of an estimate is obtained by dividing the standard error by the estimate itself. The result is then expressed as a percentage of the estimate. When it is not feasible to use statistical software (such as SUDAAN or STATA) for analyzing complex survey data, one may calculate approximate RSEs for aggregate estimates using generalized variance curve parameters that are described in the *Public Use File Documentation* (19).

Published and flagged estimates

Estimates are not presented unless a reasonable assumption regarding their probability distributions is possible on the basis of the Central Limit Theorem. This theorem states that given a sufficiently large sample size, the sample estimate approximates the population estimate and, upon repeated sampling, its distribution would be approximately normal.

In this report, estimates are not presented if they are based on fewer than 30 cases in the sample data; only an asterisk (*) appears in the tables. Estimates based on 30 or more cases include an asterisk only if the RSE of the estimate exceeds 30 percent.

Estimation

Statistics from the NAMCS are derived by a multistage estimation procedure that produces essentially unbiased national estimates. The estimation procedure has four basic components:

- inflation by reciprocals of the sampling selection probabilities
- adjustment for nonresponse
- a calibration ratio adjustment
- weight smoothing

Estimates from the NAMCS data were adjusted to account for in-scope physicians who did not provide PRFs (non-PRF physicians) either because they saw no patients during their sample week or failed to provide PRFs for visits by patients they did see during their sample week. Starting with 2003, the adjustment for non-PRF physicians differs from the adjustment used in prior years (20). Previously, due to lack of information on the subject, it was assumed that non-PRF physicians saw patients the same number of weeks annually as PRF physicians (physicians who provided PRFs), and among physicians who did see patients during

their sampled weeks, the numbers of visits (visit volume) seen during that week were assumed to be the same for PRF and non-PRF physicians. However, research done for the first time on the 2003 data showed these two assumptions were not always true. In general, the weekly visit volume for non-PRF physicians was larger than for PRF physicians. Also, physicians who saw no patients during their sample week tended to see patients fewer weeks annually than did physicians who saw patients during their week (4). To minimize understatement (and in some cases, overstatement) of visits, the nonresponse adjustment factor was revised to include information on the number of weeks physicians actually practiced during a typical year and the number of visits physicians reported during a week (20). Both data items were collected during the induction interview instrument for both responding and nonresponding physicians starting with the 2001 NAMCS.

The 2003 weight with the revised nonresponse adjustment increases the overall visit estimate by 12 percent over the same estimate obtained using the original weight ($p < 0.05$, data not shown). For this reason, 2003 visit estimates are not comparable to visit estimates computed using the original weighting formula. In this report, 2001 and 2002 visit estimates were recomputed using revised weights for those years so that the estimates could be validly compared with 2003 estimates. The increased estimates due to the revised weights are reflected in figures 3 and 7. Table I also compares effects of the revised weight on 2003 visit rates and percentages for selected characteristics relative to estimates using the original weight. Overall, using the revised weight increased the visit rate by 12 percent ($p < 0.05$). Increases in visit rate estimates due to the revised estimator ranged from 8% for the visit rate in the South to 16% for the visit rate for black persons 75 years and over (table I). However, other than the total, none of the visit rate differences in table I were statistically significant. Percentages were slightly affected by the change in estimators; the percentage change in percentage estimates due to the revised weight ranged from –3 to 3%. The effect of the revised weight on percentage of drug mentions was minimal (figure 8) because the revised weights are used in both the numerator and denominator. However, population-based drug mention rates (drug mentions per 100 persons) as shown in figure 7 are affected by the weight change because only the numerator is subject to the revised weight.

Table I. Comparison of visit rate and percentages by selected characteristics based on original and revised weight: National Ambulatory Medical Care Survey, 2003

Characteristic	Visit rate			Percent of visits		
	Original weight	Revised weight	Percent change	Original weight	Revised weight	Percent change
Total	284.3	317.3	11.6	. . .	. . .	. . .
Age						
Under 15 years	214.5	239.3	11.6	16.0	16.0	0.0
15–24 years	161.9	180.6	11.6	8.0	8.0	0.0
25–44 years	222.7	247.5	11.1	22.6	22.5	-0.4
45–64 years	339.2	377.2	11.2	28.5	28.4	-0.4
65–74 years	526.5	588.2	11.7	11.7	11.7	0.0
75 years and over	660.0	748.2	13.4	13.2	13.4	1.5
Race and age						
White	303.0	337.2	11.3	86.0	85.8	-0.2
Under 15 years	240.0	267.2	11.3	13.7	13.7	0.0
15–24 years	177.6	197.8	11.4	6.8	6.8	0.0
25–44 years	234.9	260.5	10.9	19.0	18.9	-0.5
45–64 years	350.0	388.2	10.9	24.6	24.4	-0.8
65–74 years	523.8	582.0	11.1	10.1	10.0	-1.0
75 years and over	663.4	747.0	12.6	11.8	11.9	0.8
Black or African American	210.2	235.9	12.2	9.3	9.3	0.0
Under 15 years	120.5	138.0	14.5	1.4	1.4	0.0
15–24 years	113.1	123.2	8.9	0.8	0.8	0.0
25–44 years	198.5	222.3	12.0	2.5	2.5	0.0
45–64 years	293.8	327.4	11.4	2.6	2.6	0.0
65–74 years	539.6	601.5	11.5	1.1	1.1	0.0
75 years and over	524.2	607.6	15.9	0.8	0.8	0.0
Geographic region						
Northeast	312.1	353.5	13.3	20.6	20.9	1.5
Midwest	247.0	282.9	14.5	19.6	20.1	2.6
South	306.8	331.6	8.1	38.6	37.4	-3.1
West	263.0	299.2	13.8	21.2	21.6	1.9

. . . Category not applicable.

When analysis includes both published estimates based on the old weights (for years prior to 2003) and estimates based on the revised weights (2003 and subsequent years), the analyst should emphasize to the reader that estimates from the two time periods are not comparable because of differences in weighting procedures and reasons for the weighting differences. A possible statement about the weighting differences is: ''The weights for 2003 and later years include adjustments for variation in the typical number of weeks worked annually and for variation in visit volume in a work week, whereas the weights for earlier years do not. The revised weighting algorithm increased visit estimates.''

Nonsampling errors

As in any survey, results are subject to both sampling and nonsampling errors. Nonsampling errors include reporting and processing errors as well as biases due to nonresponse and incomplete response. The magnitude of the nonsampling errors cannot be computed. However, these errors were kept to a minimum by procedures built into the operation of the survey. To eliminate ambiguities and encourage uniform reporting, attention was given to the phrasing of items, terms, and definitions. Also, pretesting of most data items and survey procedures was

performed. Quality control procedures and consistency and edit checks reduced errors in data coding and processing. Coding error rates ranged from 0.1 to 1.1% for various data items.

Adjustments for survey nonresponse—The weighted response rate for the 2003 NAMCS was 66.3 percent. Table II presents weighted characteristics of NAMCS respondents and nonrespondents, along with weighted response rates. Distributions were similar, with the exception of physician sex, specialty, and annual visit volume; female physicians, pediatricians, and practices with low annual visit volume were more likely to cooperate. The effect of this differential response is minimized in the visit estimates in most cases as NAMCS uses a nonresponse adjustment factor that takes annual visit volume, specialty, geographic region, and MSA into account.

Adjustments for item nonresponse—Item nonresponse rates in the NAMCS are generally low (5 percent or less). However, levels of nonresponse can vary considerably in the survey. Most nonresponse occurs when the needed information is not available in the medical record or is unknown to the person filling out the survey instrument. Nonresponse can also result when the information is available, but survey procedures are not followed, and the item is left blank. In this report, the majority of tables include a combined entry of ''unknown'' or ''blank'' to display missing data. For items where combined item nonresponse is between 30 and 50 percent, percent distributions are not discussed in the text. However, the information is shown in the tables. These data should be interpreted with caution. If nonresponse is random, the observed distribution for the reported item (i.e., excluding causes for which the information is unknown) would be close to the true distribution. However, if nonresponse is not random, the observed distribution could vary significantly from the actual distribution. Researchers need to decide how best to treat items with high levels of missing responses. For items with a nonresponse greater than 50 percent, data are not presented.

Weighted item nonresponse rates (i.e., if the item was left blank or the ''unknown'' box was marked) were 5.0 percent or less for data items with the following exceptions: was patient referred for this visit (16.8 percent), episode of care (7.8 percent), do other physicians share patient's care for this problem or diagnosis (11.5 percent), and cause of injury (35.2 percent of injury visits).

For some items, missing values were imputed by randomly assigning a value from a Patient Record form with similar characteristics and were based on physician specialty, geographic region, and 3-digit ICD–9–CM codes for primary diagnosis. Imputations were performed for the following variables: birth year (3.6 percent), sex (3.6 percent), ethnicity (17.8 percent), race (16.5 percent), patient seen before in practice (0.4 percent), how many past visits in last 12 months (4.3 percent), and time spent with physician (14.6 percent). This represents a change from previous survey years when imputations were also performed for disposition and providers seen. Beginning in 1997, these latter items were no longer imputed. Blank or otherwise missing responses are noted in the data. The 2003 NAMCS is the first year that the two variables, ''patient seen before in practice'' and ''how many past visits in last 12 months'' were imputed. The variable ''ethnicity,'' not imputed in 1997–2002, was imputed in 2003 because the percentage of visits missing this information continues to decrease as more States mandate its collection. Ethnicity was imputed by randomly assigning a value from a Patient Record form with similar characteristics based on physician specialty, State, and 3-digit ICD–9–CM codes for primary diagnosis

Tests of significance and rounding

In this report, the determination of statistical inference is based on a two-tailed *t*-test. The Bonferroni inequality was used to establish the critical value for statistically significant differences (0.05 level of significance) based on the number of possible comparisons within a particular variable (or combination of variables) of interest. Terms relating to differences such as ''greater than'' or ''less than'' indicate that the difference is statistically significant. A lack of comment regarding the difference between any two estimates does not mean that the difference was tested and found to be not significant.

A weighted least-squares regression analysis was used to determine the significance of trends. For the weighted least-squares test, the null hypothesis is that the slope, β, of the regression line between the two variables of interest does not significantly differ from zero, and the alternative hypothesis is that it does differ from zero (i.e., H_0: $\beta=0$, and H_A: $\beta \neq 0$).

In this modified least-squares regression, each estimate is weighted by the inverse of the standard error (21). In the tables, estimates of office visits have been rounded to the nearest thousand. Consequently, estimates will not always add to totals. Rates and percents were calculated from original unrounded figures and do not necessarily agree with figures calculated from rounded data.

Race and ethnicity

The instruction for the race item on the Patient Record form was changed in 1999 to be consistent with standards issued by the Office of Management and Budget to promote comparability of data among Federal data sources and so that more than one race could be recorded per person (22). The new race item includes the following groups: white, black or African American, Asian, Native Hawaiian or Other Pacific Islander, and American Indian or Alaska Native. Respondents could check multiple categories for each patient. Prior to 1999, only a single race category could be checked per person. Because of the difference between single and multiple race reporting, race-specific estimates prior to 1999 are not strictly comparable with those from 1999 and subsequent years. From 1999 to the present, only a small proportion of records had multiple races indicated. Where reliable multiple-race estimates can be obtained, they are presented in

Table II. Characteristics of the 2003 National Ambulatory Medical Care Survey, physician respondents and nonrespondents

Physician characteristic[1]	Number of sampled in-scope physicians[2]	Total sample percent distribution[3] (weighted)	Responding physician distribution[4] (weighted)	Nonresponding physician distribution[5] (weighted)	Weighted response rate[6]
All office-based physicians	2,007	100.0	100.0	100.0	0.663
Age					
Under 50 years	960	50.3	51.1	48.7	0.673
50 years and over	1,047	49.7	48.9	51.3	0.652
Sex[7]					
Male	1,649	79.2	77.1	83.5	0.645
Female	358	20.8	22.9	16.5	0.732
Region					
Northeast	473	22.0	21.4	23.1	0.645
Midwest	446	22.5	22.4	22.5	0.662
South	623	32.9	34.4	29.7	0.695
West	465	22.7	21.7	24.6	0.634
Metropolitan status					
MSA[8]	1,805	88.6	87.8	90.2	0.657
Not MSA[8]	202	11.4	12.2	9.8	0.708
Type of doctor					
Doctor of medicine	1,850	94.0	93.8	94.5	0.661
Doctor of osteopathy	157	6.0	6.2	5.5	0.688
Specialty[7]					
General and family practice	287	18.0	19.0	16.1	0.699
Internal medicine	123	15.0	14.0	16.9	0.620
Pediatrics	111	8.6	10.2	5.3	0.789
General surgery	121	3.9	4.3	3.3	0.718
Obstetrics and gynecology	121	7.9	6.9	9.8	0.579
Orthopedic surgery	117	4.9	4.8	5.1	0.650
Cardiovascular diseases	165	4.6	4.3	5.3	0.615
Dermatology	96	2.2	2.4	1.8	0.717
Urology	121	2.2	2.1	2.3	0.649
Psychiatry	151	5.3	5.1	5.5	0.649
Neurology	163	2.0	1.9	2.2	0.625
Ophthalmology	102	4.1	4.2	4.0	0.675
Otolaryngology	117	2.1	2.4	1.6	0.747
All other specialties	212	19.2	18.4	20.7	0.635
Specialty type[9]					
Primary care	625	48.2	48.8	47.1	0.670
Surgical	649	23.4	23.9	22.4	0.677
Medical	733	28.4	27.3	30.5	0.638
Practice type					
Solo	610	28.2	27.7	29.2	0.651
Two physicans	147	6.9	6.8	7.1	0.653
Group or HMO[10]	706	33.8	34.4	32.8	0.674
Medical school or government	50	2.4	2.6	1.8	0.743
Other	40	2.1	2.4	1.7	0.729
Unclassified	454	26.5	26.1	27.3	0.652
Annual visit volume[7,11]					
Low	686	33.0	35.7	27.8	0.716
Medium	670	33.3	31.0	37.8	0.617
High	651	33.7	33.4	34.3	0.656

[1]Characteristic information is from the master files of the American Medical Association and the American Osteopathic Association.
[2]In-scope physicians are those who verified that they were non-Federal and involved in direct patient care in an office-based setting, excluding the specialties of radiology, pathology, and anesthesiology.
[3]Total physicians are those who were selected from the master files of the American Medical Association and the American Osteopathic Association.
[4]Responding physicians are those who were in-scope and agreed to participate in the NAMCS.
[5]Nonresponding physicians are those who were in-scope and refused to participate in the NAMCS.
[6]Numerator is the number of in-scope physicians who participated in the NAMCS or who did not see any patients during their sampled reporting week. Denominator is all in-scope sampled physicians.
[7]Chi-square test of association is significant at $p < 0.05$ level.
[8]MSA is metropolitan statistical area.
[9]Specialty type is defined in table IV of the ''Technical Notes.''
[10]HMO is health maintenance organization.
[11]Low is the lowest third of annual visit volume, medium is the middle third, and high is the highest third.

Table III. Reclassification of external cause-of-injury codes for use with National Ambulatory Medical Care Survey data

Intent and mechanism of injury	Cause of injury code[1]
Unintentional injuries	E800–E869, E880–E929
Falls	E880.0–E886.9, E888
Motor vehicle traffic	E810–E819
Striking against or struck accidentally by objects or persons	E916–E917
Overexertion and strenuous movements	E927
Cutting or piercing instruments or objects	E920
Natural and environmental factors	E900–E909, E928.0–E928.2
Poisoning by drugs, medical substances, biologicals, other solid and liquid substances, gases, and vapors	E850–E869
Fire and flames, hot substance or object, caustic or corrosive material, and steam	E890–E899, E924
Machinery	E919
Pedal cycle, nontraffic, and other	E800–E807(.3), E820–E825(.6), E826.1, E826.9
Motor vehicle, nontraffic	E820–E825 (.0–.5,.7–.9)
Other transportation	E800–E807(.0–.2,.8–.9),E826 (.0,.2–.8), E827–E829, E831, E833–E845
Firearm missile	E922
Other and not elsewhere classified	E830, E832, E846–E848, E910–E913, E914–E915, E918, E923, E925–E926, E928.3, E928.8, E929.0–E929.5
Mechanism unspecified	E887, E928.9, E929 (.8–.9)
Intentional injuries	E950–E959, E960–E969, E970–E978, E990–E999
Assault	E960–E969
Self-inflicted	E950–E959
Other causes of violence	E970–E978, E990–E999
Injuries of undetermined intent	E980–E989
Adverse effects of medical treatment	E870–E879, E930–E949

[1]Based on the "Supplementary Classification of External Causes of Injury and Poisoning," *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM) (10).

one category. Estimates for specific race categories reflect visits where only a single race was reported. See "Population figures and rate calculation" in the "Technical Notes" for more information.

According to the same standards, data on race and Hispanic or Latino origin were collected separately. Consequently, all race categories include visits by persons of Hispanic or Latino and not Hispanic or Latino origin. Persons of Hispanic or Latino origin may be of any race.

Finally, this report presents data on patient ethnicity, which has previously not been included in NAMCS summaries because of high item nonresponse rates. Fewer than half of U.S. States require hospitals to collect data on patient race and ethnicity (23). However, about 8 out of 10 Hispanic or Latino residents of the United States live in States that do mandate such collection according to the Census Bureau's State population projections by Hispanic or Latino origin for the year 2000 (24). A previous report found that the item nonresponse rate for NHAMCS ethnicity data was 14.9 percent in the States that do mandate such collection compared with 24.4 percent for States that do not (25). It is possible that there is a "spillover" effect in reporting of ethnicity in physician offices because the item nonresponse rate for this item has declined by 34 percent since 2001 (26).

Injury groupings

Table 16 presents data on the intent and mechanism producing the injuries that resulted in visits to physician offices. Cause of injury is collected for each sampled visit in the NAMCS and is coded according to the ICD-9-CM's "Supplementary Classification of External Causes of Injury and Poisoning." However, for table 16, the first-listed cause-of-injury data were regrouped to highlight the interaction between intentionality of the injury and the mechanism that produced the injury. Table III shows the E-code groupings used to produce this table.

Physician specialty groups

The NAMCS survey design grouped physicians into 15 strata, or specialty groups, for sampling purposes. One stratum, doctors of osteopathy, was based on information from the American Osteopathic Association. The other groups (general and family practice, internal medicine, pediatrics, general surgery, obstetrics and gynecology, orthopedic surgery, cardiovascular diseases, dermatology, urology, psychiatry, neurology, ophthalmology, otolaryngology, and a residual category of other specialties) were developed based on information from the American Medical Association (AMA). Estimates are presented in this report with doctors of osteopathy combined with doctors of medicine unless otherwise noted. Table IV shows physician specialty groups split into three major categories: primary care, surgical specialties, and medical specialties based on the AMA classification.

Population figures and rate calculation

The denominators used in calculating 2003 visit rates for age, sex, race, and geographic region are Census 2000-based postcensal estimates of the civilian noninstitutional population of the United States. The population estimates are special tabulations developed by the Population Division, U.S. Census Bureau, from the July 1, 2003, set of States population estimates

Table IV. Reclassification of physician specialty for use with National Ambulatory Medical Care Survey data

Physician specialty group	Physician specialty
Primary care specialties	Family practice, geriatric medicine (family practice), sports medicine (family practice), general practice, internal medicine or pediatrics, internal medicine, adolescent medicine, pediatrics, pediatric sports medicine, adolescent medicine (internal medicine), gynecology, maternal and fetal medicine, obstetrics and gynecology, obstetrics, geriatric medicine (internal medicine), and sports medicine (internal medicine).
Surgical specialties	Hand surgery, adult reconstructive orthopedics, foot and ankle orthopedics, musculoskeletal oncology, pediatric orthopedics, orthopedic surgery, sports medicine (orthopedic surgery), orthopedic surgery of the spine, orthopedic trauma, gynecological oncology, urology, pediatric urology, ophthalmology, pediatric ophthalmology, otology, otology-neurotology, otolaryngology, pediatric otolaryngology, general surgery, critical care medicine (obstetrics and gynecology), critical care (neurology), critical care (surgery), abdominal surgery, cardiovascular surgery, colon and rectal surgery, cardiothoracic surgery, facial plastic surgery, head and neck surgery, hand surgery (plastic surgery), oral and maxillofacial surgery, plastic surgery within the head and neck, neurological surgery, pediatric surgery (neurology), pediatric surgery, vascular surgery, plastic surgery, surgical oncology, thoracic surgery, transplant surgery, and traumatic surgery.
Medical specialties	Allergy, addiction medicine, addiction psychiatry, allergy and immunology, allergy and immunology or diagnostic laboratory, immunology, clinical genetics, clinical biochemical genetics, clinical cytogenetics, clinical molecular genetics, clinical neurophysiology, critical care medicine, dermatological immunology or diagnostic laboratory, immunology, diabetes, emergency medicine, endocrinology, sports medicine (emergency medicine), medical toxicology (emergency medicine), gastroenterology, general preventive medicine, hematology, hepatology, hematology or oncology, cardiac electrophysiology, infectious diseases, immunology, legal medicine, medical management, medical genetics, nephrology, nutrition, occupational medicine, medical oncology, clinical pharmacology, pulmonary critical care medicine, pediatric emergency medicine (emergency medicine), public health and general preventive medicine, pediatric or diagnostic laboratory, immunology, palliative medicine, physical medicine and rehabilitation, pain medicine, medical toxicology (preventive medicine), pulmonary diseases, rheumatology, spinal cord injury, sleep medicine, and undersea medicine.

by age, sex, and race. Population estimates of MSA status are based on data from the 2003 National Health Interview Survey (NHIS), NCHS, adjusted to the U.S. Census Bureau definition of core-based statistical areas as of December 2003. See http://www.census.gov/population/www/estimates/metrodef.html for more about MSA definitions.

Estimates of visit rates for MSAs and non-MSAs in 2003 may differ somewhat from those reported in 2002 and previous years because of methodological differences in how the denominators were calculated. In survey years 1992–2002, the NHIS used a 1992 definition of MSAs and non-MSAs. The NHIS also used 1990-based census estimates as controls for calculating population estimates through 2002. Because the NHAMCS used Census 2000-based estimates beginning in 2001, adjustments needed to be made to the MSA figures obtained from the NHIS in 2001 and 2002. For 2003, special tabulations were obtained from the Office of Analysis and Epidemiology, NCHS, where 2003 NHIS data were matched to the December 2003 U.S. Census Bureau definition of core-based statistical areas. The estimates were further adjusted based on the 2003 population estimates obtained from the Census Bureau.

Denominators used in computing estimates of visit rates by expected source of payment were obtained from the 2003 NHIS, adjusted to 2003 noninstitutional census totals. Individuals reporting multiple insurance categories in the NHIS were counted in each category they reported with the exception of Medicaid and SCHIP, which were combined into a single category.

Population estimates for race groups in the 2003 NAMCS and NHAMCS are based on Census 2000, in which respondents were able to indicate more than one race category (as requested by the 1997 Standards for Federal Data on Race and Ethnicity) (22). Starting with 2001, the denominators used for calculating race-specific visit rates reflect the transition to multiple-race reporting. Specific race denominators reflect persons with a single race identification, and a separate denominator is available for persons of multiple races. In this report, a visit rate for white persons, for example, uses a denominator that reflects the ''white only'' population, and the numerator is the number of visits in which white and no other race category was reported as the patient's race by the health care provider.

Data indicate that multiple races are recorded less frequently in medical records than occur in the general population. The 2003 population estimates indicate that multiple-race persons account for 1.5 percent of the total population, whereas multiple-race patients (as indicated by the provider) account for 0.3 percent of physician office visits. This difference exists because physicians are less likely to know and record the multiple-race preference of the patient and not because, after age-adjusting, persons with multiple races make fewer doctor visits. This implies that the race population rates calculated in 2003 are probably slight overestimates for the single-race categories and underestimates for the multiple-race category.

Definition of terms

Continuity of care—Continuity of care is a goal of health care achieved through an interdisciplinary process involving patients, families, health care professionals, and providers in the management of a coordinated plan of care. Based on changing needs and available resources, the process optimizes quality outcomes in the health status of clients. It may involve professionals from many different disciplines within multiple systems.

Drug mention—A drug mention is the physician's entry on the Patient Record form of a pharmaceutical agent—by any route of administration—for prevention, diagnosis, or treatment. Generic as well as brand-name drugs are included, as are

nonprescription and prescription drugs. Along with all new drugs, the physician records continued medications if the patient was specifically instructed during the visit to continue the medication. Physicians may report up to eight medications per visit.

Drug visit—A drug visit is a visit at which medication was prescribed or provided by the physician.

Episode of care—An episode of care is a term used to try to measure the nature of the care provided at the visit, an initial visit in contrast to a followup visit. An episode of care begins with the initial visit for care for a particular problem and ends when the patient is no longer continuing treatment. A problem may recur later, but that is considered a new episode of care. An initial visit may be diagnostic in nature whereas a followup visit may be to check progress or continue therapy.

Followup visit—A followup visit is a second or subsequent one in which care was previously provided for a specified problem or complaint.

Illness-related visit—A visit is considered illness-related if it was not defined as an injury visit as in the definition for an injury-related visit.

Initial visit—An initial visit is the first visit to this physician by this patient for care of a particular problem or complaint.

Injury-related visit—A visit is injury-related if ''Yes'' was checked in response to item 4a, ''Is this visit related to injury, or poisoning, or adverse effect of medical treatment?'' if a cause of injury or a nature of injury diagnosis was provided, or if an injury-related reason for the visit was reported.

In-scope physician—An in-scope physician is a duly licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is currently in office-based practice and who spends some time caring for ambulatory patients. Excluded from the NAMCS are physicians who are hospital-based; who specialize in anesthesiology, pathology, or radiology; who are federally employed; who treat only institutionalized patients; or who are employed full time by an institution and spend no time seeing ambulatory patients.

Office—An office is the space identified by a physician as a location for his or her ambulatory practice. Offices customarily include consultation, examination, or treatment spaces that patients associate with the particular physician.

Patient—A patient is an individual seeking personal health care services who is not currently admitted to any health care institution on the premises.

Primary care physician/provider—A primary care physician or provider (PCP) plans and provides the comprehensive health care of the patient. A visit to the patient's PCP is one in which health care is provided by the patient's PCP or by a provider substituting for the patient's PCP.

Primary care specialist—A primary care specialist has designated a primary care specialty of general and family practice, internal medicine, pediatrics, etc. Primary care specialists are grouped and presented in table IV of the ''Technical Notes.'' The terms ''primary care specialties'' and ''primary care specialists'' are used interchangeably throughout this report and refer to the self-designated classification by physicians in the AMA and AOA masterfiles.

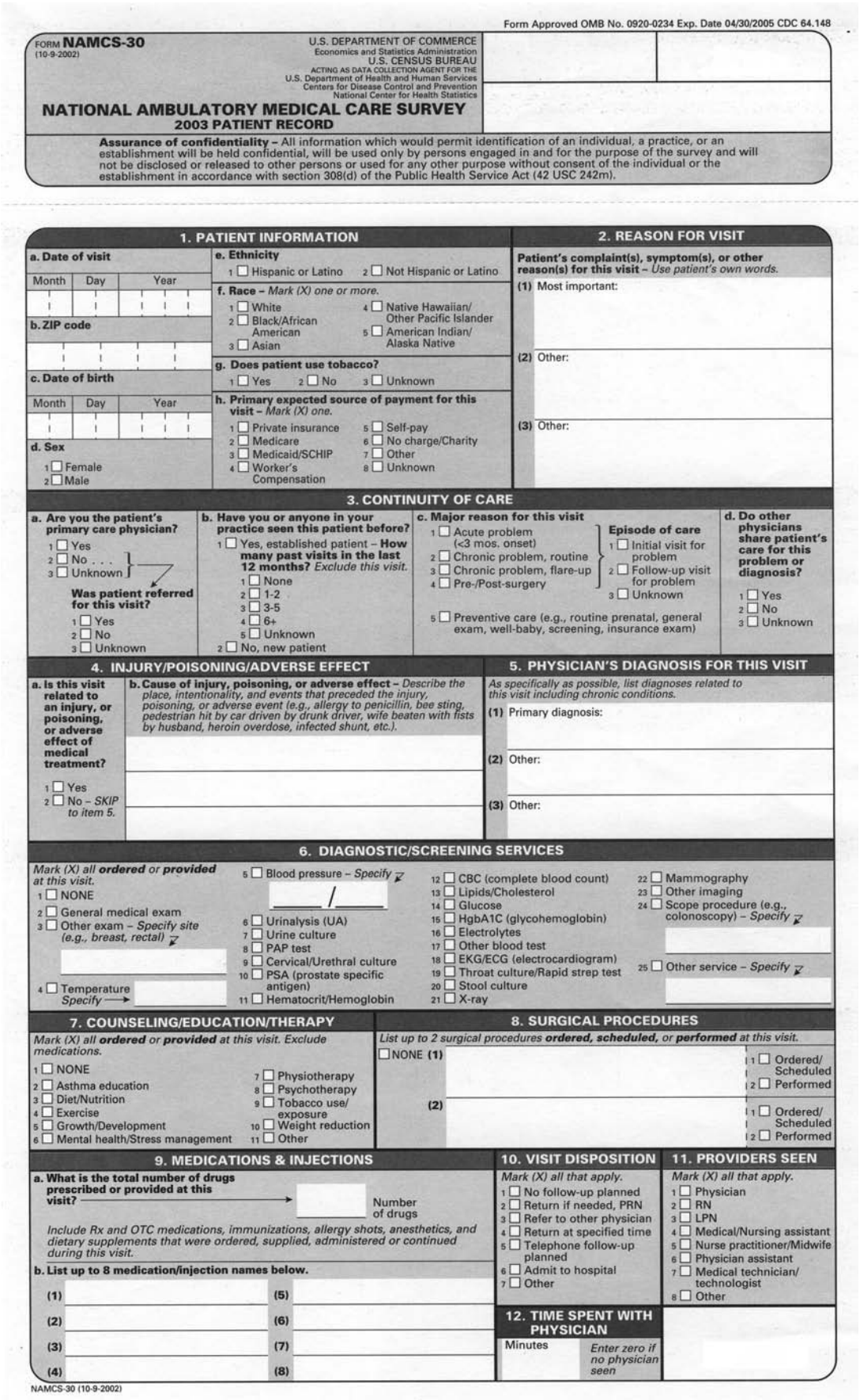
Primary expected source of payment—The primary expected source of payment is the source that to the best of the physician's or physician's staff's knowledge describes how charges incurred for this visit will be paid:

- Self-pay—Charges billed directly to the patient that will not be reimbursed by a third party. Does not include prepaid plans for which copayment is charged.
- Medicare—Charges paid in part or in full by a Medicare plan, including payments made directly to the physician as well as payments to the patient.
- Medicaid or SCHIP—Charges paid in part or in full by a Medicaid or State Children's Health Insurance Program (SCHIP), including payments made directly to the hospital as well as payments to the patient. SCHIP, enacted as part of the Balanced Budget Act of 1997, gave States the opportunity to provide free or low-cost insurance coverage to low-income children not otherwise eligible to be covered by Medicaid. States begin enrolling children in 1998 using Medicaid or State-specific programs separate from Medicaid or both. By 2000, all States had implemented their SCHIP programs.
- Private insurance—Charges paid in part or in full by a private insurance company, health maintenance organization (HMO) plan, or other prepayment plan, including independent practice associations (IPAs) and preferred provider organizations (PPOs).
- No charge or charity—Visits for which no fee is charged (not including visits paid for as part of a total care package, e.g., postoperative visits included in a surgical fee, pregnancy visits for which a flat fee was charged, and HMO and prepaid systems).
- Other sources—All other sources of payment not in the preceding categories. Charges paid under any other local, State, or Federal health care program such as worker's compensation programs and CHAMPUS.
- Unknown—Cases where none of the previous sources of payment categories was checked.

Visit—A visit is a direct, personal exchange between an ambulatory patient seeking care and a physician or a staff member working under the physician's supervision for the purpose of rendering personal health services. Excluded from the NAMCS are encounters where medical care was not provided, such as phone consultations and e-mail consultations, or at visits made to drop off specimens, pay bills, or make appointments.

Visit rate—The visit rate is a basic measure of service utilization for event-based surveys. The numerator is the number of estimated visits and the denominator is the corresponding U.S. population estimate for those who possibly could have made the visits. The interpretation is that for every person in the population there are x visits made. It

does not mean that *x* percent of the population made visits because some persons in the population make no visits and others make multiple visits within a given year. The only exception is when an event can occur just once for a person (e.g., if an appendectomy were performed during the visit). The visit rate is best used to compare amounts of utilization across various subgroups of interest such as age, race, or geographic region (e.g., the rate of U.S. physician office visits in 2003 was 337.2 visits per 100 white persons and 235.9 visits per 100 black or African American persons).



Form Approved OMB No. 0920-0234 Exp. Date 04/30/2005 CDC 64.148

FORM **NAMCS-30** (10-9-2002)

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 AMBULATORY MEDICAL CARE SURVEY
2003 PATIENT RECORD

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).

1. PATIENT INFORMATION

a. Date of visit — Month | Day | Year

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. Does patient use tobacco?
1 ☐ Yes 2 ☐ No 3 ☐ Unknown

h. Primary expected source of payment for this visit – *Mark (X) one.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid/SCHIP
4 ☐ Worker's Compensation
5 ☐ Self-pay
6 ☐ No charge/Charity
7 ☐ Other
8 ☐ Unknown

2. 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:

3. CONTINUITY OF CARE

a. Are you the patient's primary care physician?
1 ☐ Yes
2 ☐ No . . .
3 ☐ Unknown
Was patient referred for this visit?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

b. Have you or anyone in your practice seen this patient before?
1 ☐ Yes, established patient – **How many past visits in the last 12 months?** *Exclude this visit.*
1 ☐ None
2 ☐ 1-2
3 ☐ 3-5
4 ☐ 6+
5 ☐ Unknown
2 ☐ No, new patient

c. Major reason for this visit
1 ☐ Acute problem (<3 mos. onset)
2 ☐ Chronic problem, routine
3 ☐ Chronic problem, flare-up
4 ☐ Pre-/Post-surgery
Episode of care
1 ☐ Initial visit for problem
2 ☐ Follow-up visit for problem
3 ☐ Unknown
5 ☐ Preventive care (e.g., routine prenatal, general exam, well-baby, screening, insurance exam)

d. Do other physicians share patient's care for this problem or diagnosis?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

4. INJURY/POISONING/ADVERSE EFFECT

a. Is this visit related to an injury, or poisoning, or adverse effect of medical treatment?
1 ☐ Yes
2 ☐ No – *SKIP to item 5.*

b. Cause of injury, poisoning, or adverse effect – *Describe the place, intentionality, and events that preceded the injury, poisoning, or adverse event (e.g., allergy to penicillin, bee sting, pedestrian hit by car driven by drunk driver, wife beaten with fists by husband, heroin overdose, infected shunt, etc.).*

5. PHYSICIAN'S DIAGNOSIS FOR THIS VISIT

As specifically as possible, list diagnoses related to this visit including chronic conditions.
(1) Primary diagnosis:
(2) Other:
(3) Other:

6. DIAGNOSTIC/SCREENING SERVICES

Mark (X) all ***ordered*** *or* ***provided*** *at this visit.*
1 ☐ NONE
2 ☐ General medical exam
3 ☐ Other exam – *Specify site (e.g., breast, rectal)*
4 ☐ Temperature *Specify* →
5 ☐ Blood pressure – *Specify* ____/____
6 ☐ Urinalysis (UA)
7 ☐ Urine culture
8 ☐ PAP test
9 ☐ Cervical/Urethral culture
10 ☐ PSA (prostate specific antigen)
11 ☐ Hematocrit/Hemoglobin
12 ☐ CBC (complete blood count)
13 ☐ Lipids/Cholesterol
14 ☐ Glucose
15 ☐ HgbA1C (glycohemoglobin)
16 ☐ Electrolytes
17 ☐ Other blood test
18 ☐ EKG/ECG (electrocardiogram)
19 ☐ Throat culture/Rapid strep test
20 ☐ Stool culture
21 ☐ X-ray
22 ☐ Mammography
23 ☐ Other imaging
24 ☐ Scope procedure (e.g., colonoscopy) – *Specify*
25 ☐ Other service – *Specify*

7. COUNSELING/EDUCATION/THERAPY

Mark (X) all ***ordered*** *or* ***provided*** *at this visit. Exclude medications.*
1 ☐ NONE
2 ☐ Asthma education
3 ☐ Diet/Nutrition
4 ☐ Exercise
5 ☐ Growth/Development
6 ☐ Mental health/Stress management
7 ☐ Physiotherapy
8 ☐ Psychotherapy
9 ☐ Tobacco use/ exposure
10 ☐ Weight reduction
11 ☐ Other

8. SURGICAL PROCEDURES

List up to 2 surgical procedures ***ordered, scheduled,*** *or* ***performed*** *at this visit.*
☐ NONE (1)
(2)
1 ☐ Ordered/ Scheduled
2 ☐ Performed

9. MEDICATIONS & INJECTIONS

a. What is the total number of drugs prescribed or provided at this visit? → 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.

b. List up to 8 medication/injection names below.
(1) (2) (3) (4) (5) (6) (7) (8)

10. VISIT DISPOSITION

Mark (X) all that apply.
1 ☐ No follow-up planned
2 ☐ Return if needed, PRN
3 ☐ Refer to other physician
4 ☐ Return at specified time
5 ☐ Telephone follow-up planned
6 ☐ Admit to hospital
7 ☐ Other

11. PROVIDERS SEEN

Mark (X) all that apply.
1 ☐ Physician
2 ☐ RN
3 ☐ LPN
4 ☐ Medical/Nursing assistant
5 ☐ Nurse practitioner/Midwife
6 ☐ Physician assistant
7 ☐ Medical technician/ technologist
8 ☐ Other

12. TIME SPENT WITH PHYSICIAN

Minutes — *Enter zero if no physician seen*

NAMCS-30 (10-9-2002)

Figure I. Patient record form

Trade name disclaimer

The use of trade names is for identification only and does not imply endorsement by the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

Suggested citation

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