

NAMCS MICRO-DATA TAPE DOCUMENTATION

1976

CORRECTIONS: P. 5, 8, +12 ✓ + 6 ✓ + 11 ✓

1976 NAMCS MICRO-DATA TAPE DOCUMENTATION

ABSTRACT

This material provides documentation for users of the Micro-Data tapes of the National Ambulatory Medical Care Survey (NAMCS) conducted by the National Center for Health Statistics. Section I, "Description of the National Ambulatory Medical Care Survey," includes information on the history of NAMCS, the scope of the survey, the sample, data collection procedures, symptom coding procedures, population estimates, and sampling errors. Section II provides technical details of the tape (number of tracks, record length, etc.). Section III provides a detailed description of the contents of each data record by location. An appendix defines certain terms used in this document.

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I. DESCRIPTION OF THE NATIONAL AMBULATORY MEDICAL CARE SURVEY

INTRODUCTION.--These Micro-Data Tapes comprise the data collected by the National Ambulatory Medical Care Survey (NAMCS) in 1976, conducted by the National Center for Health Statistics (NCHS). The National Ambulatory Medical Care Survey provides continuous data from samples of patient records selected from a national sample of office-based physicians. These national estimates describe the utilization of ambulatory medical care services in the coterminous United States. In 1976 there were approximately 51,000 patient records sampled from the 2,004 doctors that participated in the survey. For a description of the survey design and data collection procedures, see below. For a more detailed description of the survey design, data collection procedures, and the estimation process see reference 1.

HISTORY.--To provide more complete and precise information the the utilization of the nation's ambulatory care resources and on the nature and treatment of illness among the population seeking ambulatory care, the NCHS in 1967 began exploring possibilities for surveying morbidity in private physicians' offices. A national technical advisory group was established. Initial discussions resulted in a tentative protocol that called for periodic meetings of a working group comprised of the Director of the NCHS Division of Health Resources Statistics, the Project Officer and staff, the contractor's representatives, and a consultant group from The Johns Hopkins University in Baltimore.

The background and development of methods employed for the NAMCS required exploratory and feasibility studies conducted over a period of 6 years. Literature review and consultation documented needs and potential uses for national ambulatory medical care statistics. Information regarding accepted definitions, uniform terminology, procedural experience, or practical classifications for the problems and conditions encountered in ambulatory care settings was found to be limited. First, data collection forms and procedures were developed and tested by sample physicians in a national field survey, which demonstrated the difficulty of achieving high levels of participation. Refined data collection forms and improved procedures were further tested by a second sample of physicians in an extensive national survey lasting over 2 quarters in 1 year. Results demonstrated the usefulness of professional endorsement, procedural efficiency, and minimal work requirements in achieving physician-participation levels exceeding 80 percent.

Finally, with advice and support from the technical advisory group, the American Medical Association, individual experts, other professional groups, and elements of the Public Health Service, NCHS initiated the National Ambulatory Medical Care Survey in 1973.

SCOPE OF THE SURVEY.--The basic sampling unit for the NAMCS is the physician-patient encounter or visit. Only visits in the offices of nonfederally employed physicians classified by the American Medical Association (AMA) or the American Osteopathic Association (AOA) as "office-based, patient care" were included in the 1976 NAMCS. In addition, physicians in the specialties of anesthesiology,

pathology, and radiology were excluded from the physician universe. Major types of ambulatory encounters not included in the 1976 NAMCS were those made by telephone, those made outside of the physician's office, and those made in hospital or institutional settings. It is planned to extend the NAMCS to include these encounters in the future, though some complex methodological and sampling problems must be resolved first.

SAMPLING FRAME AND SIZE OF SAMPLE. The sampling frame for the NAMCS is composed of all physicians contained in the master files maintained by the AMA and AOA as of December 31, 1975, who met the following criteria:

Office-based, as defined by the AMA and AOA;

Principally engaged in patient care activities;

Nonfederally employed;

Not in specialties of anesthesiology, pathology, clinical pathology, forensic pathology, radiology, diagnostic radiology, pediatric radiology, or therapeutic radiology.

The 1976 NAMCS sample included 3,022 physicians: 2,876 MD's and 146 doctors of osteopathy. Sample physicians were screened at the time of the survey to assure that they met the above-mentioned criteria; 487 physicians did not meet all of the criteria and were, therefore, ruled out of scope (ineligible) for the study. The most frequent reasons for being out of scope were that the physician was retired, deceased, or employed in teaching, research, or administration. Of the 2,535 in-scope (eligible) physicians, 2,004 (79.1 percent) participated in the study. The physician universe, sample size, and response rates by physician specialty are shown in table I. Of the participating physicians, 288 physicians saw no patients during their assigned reporting period because of vacations, illness, or other reasons for being temporarily not in practice.

Sample Design. The 1976 NAMCS utilized a multistage probability design that involved probability samples of primary sampling units (PSU's), physician practices within PSU's, and patient visits within practices. The first-stage sample of 87 PSU's was selected by the National Opinion Research Center (NORC), the organization responsible for field operations under contract to the NCHS. A PSU is a county, a group of adjacent counties, or a standard metropolitan statistical area (SMSA). A modified probability proportional-to-size procedure using separate sampling frames for SMSA's and for nonmetropolitan counties was employed. After sorting and stratifying by size, region, and demographic characteristics, each frame was divided into sequential zones of 1 million residents, and a random number was drawn to determine which PSU came into the sample from each zone.

The second stage consisted of a probability sample of practicing physicians selected from the master files maintained by the American Medical Association (AMA) and American Osteopathic Association (AOA). Within each PSU, all eligible physicians were arranged by nine specialty groups: general and family practice, internal medicine, pediatrics, other medical specialties, general surgery, obstetrics and gynecology, other surgical specialties, psychiatry, and other specialties. Then, within each PSU, a systematic random sample of physicians was selected in such a way that the overall probability of selecting any physician in the United States was approximately constant.

The final stage was the selection of patient visits within the annual practices of sample physicians. This involved two steps. First, the total physician sample was divided into 52 random subsamples of approximately equal size, and each subsample was randomly assigned to 1 of the 52 weeks in the survey year. Second, a systematic random sample of visits was selected by the physician during the assigned week. The sampling rate varied for this final step from a 100-percent sample for very small practices to a 20-percent sample for very large practices as determined in a presurvey interview. The method by which the sampling rate was determined is described in reference 6.

Data Collection.--The actual data collection for the NAMCS was carried out by the physician aided by his office staff when possible. Two data collection forms were employed by the physician: the Patient Log and the Patient Record (Figure 1). The Patient Log is a sequential listing of patients seen in the physician's office during his assigned reporting week. This list served as the sampling frame to indicate the visit for which data were to be recorded. A perforation between the patient names and patient visit characteristics permitted the physician to remove patient names and protect confidentiality.

Based on the physician's estimate of the expected number of office visits each physician was assigned a patient-sampling ratio. These ratios were designed so that about 30 Patient Records were completed during the assigned reporting week. Physicians expecting 10 or fewer visits each day recorded data for all of them, while those expecting more than 10 visits per day recorded data for every second, third, or fifth visit based on the predetermined sampling interval. These procedures minimized the data collection workload and maintained approximate equal reporting levels among sample physicians regardless of practice size. For physicians assigned a patient sampling ratio, a random start was provided on the first page of the log, so that predesignated sample visits on each succeeding page of the log provided a systematic random sample of patient visits during the reporting period.

Data Processing and Medical Coding.--In addition to the completeness checks made by the field staff, clerical edits were performed upon receipt of the data for central processing. These procedures proved quite efficient, reducing the item nonresponse rates to a negligible amount--2 percent or less for all data items.

Information contained in item 5 (patient's problem) of the Patient Record was coded according to a special classification system developed for that purpose.² Diagnostic information, item 9 of the Patient Record, was coded according to the *Eighth Revision International classification of diseases, adapted for use in*

the United States (ICDA).³ A maximum of three problems and three diagnoses were coded. A two-way independent verification procedure with 100-percent verification was used to control the medical coding operation. Differences between coders were adjudicated at the National Center for Health Statistics.

Information from the Induction Interview and Patient Record was keypunched, with 100-percent verification, and converted to computer tape. At this time, extensive computer consistency and edit checks were performed. Data items still unanswered at this point were imputed by assigning a value from a Patient Record with similar characteristics; imputations were based on physician specialty, major reason for visit, and broad diagnostic categories.

Population Figures.--The base population used in computing annual visit rates is presented in table II. These figures are based on provisional estimates for the civilian noninstitutionalized population as of July 1, 1976, provided by the U.S. Bureau of the Census. Because the NAMCS includes data for only the coterminous United States, the original census estimates were modified to account for the exclusion of Alaska and Hawaii from the study. For this reason the population estimates should not be considered as official population estimates and are presented here solely for the purpose of providing denominators for rate computations.

Estimation Procedures.--Statistics produced from the 197⁶ National Ambulatory Medical Care Survey were derived by a multistage estimating procedure. The procedure produces essentially unbiased national estimates and has basically three components: (1) inflation by reciprocals of the probabilities of selection, (2) adjustment for nonresponse, and (3) a ratio adjustment to fixed totals. Each of these components is described briefly below.

Inflation by reciprocals of sampling probabilities.--Since the survey utilized a three-stage sample design, there were three probabilities: (1) The probability of selecting the PSU, (2) the probability of selecting a physician within the PSU, and (3) the probability of selecting a patient visit with the physician's practice. The last probability was defined to be the exact number of office visits during the physician's specified reporting week divided by the number of Patient Records completed. All weekly estimates were inflated by a factor of 52 to derive annual estimates.

Adjustment for nonresponse.--Estimates from the NAMCS data were adjusted to account for sample physicians who did not participate in the study. This was done in such a manner as to minimize the impact of nonresponse on final estimates by imputing to nonresponding physicians the practice characteristics of similar responding physicians. For this purpose, similar physicians were judged to be physicians having the same specialty designation and practicing in the same PSU.

Ratio adjustment.--A poststratification adjustment was made within each of nine physician specialty groups. The ratio adjustment was a multiplication factor which had as its numerator the number of physicians in the universe in each physician specialty group, and as its denominator the estimated number of physicians in that particular specialty group. The numerator was based on figures obtained from the AMA-AOA master files, and the denominator was based on data from the sample.

Sampling Errors.--Procedures for calculating sampling errors as well as estimates of standard errors of statistics derived from the NAMCS are described in the "Technical Notes" section of references 4 and 5.

Questions.--Questions concerning data in the tapes should be directed to Ambulatory Care Statistics Branch, Division of Health Resources Utilization Statistics, National Center for Health Statistics, Room 212, 3700 East-West Highway, Hyattsville, Maryland 20782.

Patient Weight.--The "patient weight" is a vital component in the process of producing national estimates from sample data and its use should be clearly understood by all micro-data tape users. The statistics contained on the micro-data tape reflect data concerning only a sample of patient visits -- and not a complete count of all the visits that occurred in the United States. The "patient weight" is an inflation factor assigned to each patient record. By aggregating the "patient weights" an estimated complete count or national estimate can be obtained.

References

NCHS published statistics from the NAMCS in Series 13 of VITAL AND HEALTH STATISTICS, PHS No. 1000, Public Health Service, Washington, U. S. Government Printing Office.

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2.--National Center for Health Statistics: The National Ambulatory Medical Care Survey: Symptom Classification, United States. VITAL AND HEALTH STATISTICS. Series 2-No. 63. DHEW Pub. No. (HRA) 74-1337. Health Resources Administration. Washington. U.S. Government Printing Office, May 1974.

3.--National Center for Health Statistics: Eighth Revision International Classification of Diseases, Adapted for Use in the United States (ICDA). PHS Pub. No. 1693. Public Health Service. Washington. U.S. Government Printing Office, 1967.

4.--National Center for Health Statistics: 1976 Summary: National Ambulatory Medical Care Survey, United States. Advance Data from VITAL AND HEALTH STATISTICS, No. 30. DHEW Pub. No. (PHS) 78-1250. Public Health Service. Hyattsville, Maryland. July 13, 1978.

5.--National Center for Health Statistics: Office Visits to Ophthalmologists: National Ambulatory Medical Care Survey. United States, 1976. Advance Data from VITAL AND HEALTH STATISTICS, NO. 31. DHEW Pub. No. (PHS) 78-1250. Public Health Service. Hyattsville, Maryland. July 14, 1978.

6.--Induction Interview Form. National Ambulatory Medical Care Survey. National Opinion Research Center. University of Chicago. OMB No. 68R1498.

7.--National Center for Health Statistics: The National Ambulatory Medical Care Survey: 1975 Summary, United States, January-December 1975. VITAL AND HEALTH STATISTICS. Series 13, No. 33. DHEW Pub. No. (PHS) 78-1784. Public Health Service. Washington. U.S. Government Printing Office, January 1978.

II. Technical Description of Tapes

Date Set Name:	NAMC1976
Number of Reels:	1
Number of Recording Tracks:	9
Density (bpi):	1600
Language:	EBEDIC
Parity:	ODD
Record Length:	92
Blocksize:	4,600
Number of Records:	62,697 51,224

III. TAPE RECORD FORMAT

This section consists of a detailed breakdown of each tape record, providing a brief description of each item of data included in the records. The data are arranged sequentially according to their physical location on the tape record. Unless otherwise stated in the "Item Description" column, the data are derived from the patient record (figure 1). The AMA and the induction interview (reference 6) are alternate sources of data, while the computer generates other items by recoding selected data items.

<u>Item No.</u>	<u>Field Length</u>	<u>Tape Location</u>	<u>Item Description and Codes</u>
1	4	1-4	Date of visit
1.1	2	1-2	Month of visit 01-12: January-December
1.2	2	2-4	Year of visit Last 2 digits of year
2	4	5-8	Date of birth
2.1	2	5-6	Month of birth 01-12: January-December
2.2	2	7-8	Year of birth Last 2 digits of year
3	1	9	Sex 1=Female 2=Male
4	1	10	Race 1=White 2=All other
5	12	11-22	Patient Problems (see reference 2 for codes)
5.1	4	11-14	Most important problem #1
5.2	4	15-18	Most important problem #2
5.3	4	19-22	Other problem
6	1	23	Seriousness of Problem 1=very serious 2=serious 3=slightly serious 4=not serious
7	1	24	Ever Seen Patient Before 1=no 2=yes, for problem in item 5 3=yes, but not for problem in item 5

<u>Item No.</u>	<u>Field Length</u>	<u>Tape Location</u>	<u>Item Description and Codes</u>
8	14	25-38	Major reason for this visit
	1	25	Acute problem (1=yes and 2=no)
	1	26	Acute problem, follow-up "
	1	27	Chronic problem, routine "
	1	28	Chronic problem, flare-up "
	1	29	Prenatal care "
	1	30	Postnatal care "
	1	31	Postoperative care "
	1	32	Well adult/child exam "
	1	33	Family planning "
	1	34	Counseling or advice "
	1	35	Immunization "
	1	36	Referral "
	1	37	Administrative "
	1	38	Other "
9	12	39-50	Physician's principal diagnosis (see reference 3 for codes)
9.1	4	39-42	First diagnosis associated with item 5A
9.2	4	43-46	Second diagnosis associated with item 5A
9.3	4	47-50	Other significant current diagnoses
10	18	51-68	Diagnostic/therapeutic services ordered/provided
10.1	1	51	None (1=yes and 2=no)
10.2	1	52	Limited history/exam "
10.3	1	53	General history/exam "
10.4	1	54	Clinical lab. test "
10.5	1	55	Blood pressure check "
10.6	1	56	EKG "
10.7	1	57	Hearing test "
10.8	1	58	Vision test "
10.9	1	59	Endoscopy "
10.10	1	60	Office surgery "
10.11	1	61	Drug prescribed or dispensed "
10.12	1	62	X-ray "
10.13	1	63	Injection "
10.14	1	64	Immunization/desensitization "
10.15	1	65	Physiotherapy "
10.16	1	66	Medical counseling "
10.17	1	67	Psychotherapy/therapeutic listening "
10.18	1	68	Other "

<u>Item No.</u>	<u>Field Length</u>	<u>Tape Location</u>	<u>Item Description and Codes</u>
11	8	69-76	Disposition of visit
11.1	1	69	No follow-up planned (1=yes and 2=no)
11.2	1	70	Return at specified time "
11.3	1	71	Return if needed "
11.4	1	72	Telephone follow-up "
11.5	1	73	Referral "
11.6	1	74	Return to referring physician "
11.7	1	75	Admit to hospital "
11.8	1	76	Other "
12	1	77	Duration of visit 1=0 minutes 2=1-5 minutes 3=6-10 minutes 4=11-15 minutes 5=16-30 minutes 6=31-60 minutes 7=60+ minutes
13	10	78-87	Patient Weight A right justified, alphanumeric integer developed by the NAMCS staff for the purpose of producing national estimates from sample estimates. See section on "Estimation Procedures" on page 43 of reference 7,
14	1	88	Geographic Region (Based on actual location of physician's practice. 1=Northeast 2=North Central 3=South 4=West
15	2	89-90	Metropolitan/Nonmetropolitan (Based on actual location in conjunction with the Bureau of the Census definition.) 01=Standard Metropolitan Statistical Area (SMSA) 02=Non-SMSA

←
and also notes on page 6 of
these documentation.

<u>Item No.</u>	<u>Field Length</u>	<u>Tape Location</u>	<u>Item Description and Codes</u>
16	1	91	<p>Physician Specialty Group (Derived from Induction Interview--see reference 6).</p> <p>1-General/Family Practice</p> <p><u>MEDICAL SPECIALTIES</u></p> <p>2-Internal Medicine 3-Pediatrics 4-Other</p> <p><u>SURGICAL SPECIALTIES</u></p> <p>5-General Surgery 6-Obstetrics and Gynecology 7-Other</p> <p><u>OTHER SPECIALTIES</u></p> <p>8-Psychiatry 9-Other</p>
17	1	92	<p>Type of practice (Derived from Induction Interview--see reference 6)</p> <p>1 = SOLO 2 = PARTNERSHIP 3 = GROUP 4 = OTHER</p>

APPENDIX

Definitions of Certain Terms Used in this Document.

Office(s).--Premises that the physician identifies as locations for his ambulatory practice. Responsibility over time for patient care and professional services rendered there generally resides with the individual physician rather than with any institution.

Ambulatory patient.--An individual presenting for personal health services, neither bedridden nor currently admitted to any health care institution on the premises.

Physician.--Can be classified as either:

In-Scope: All duly licensed doctors of medicine and doctors of osteopathy currently in practice who spend some time in caring for ambulatory patients at an office location.

Out-of-scope: Those physicians who treat patients only indirectly, including specialists in anesthesiology, pathology, forensic pathology, radiology, therapeutic radiology, and diagnostic radiology, and the following physicians.

physicians in military service

physicians who treat patients only in an institutional setting (e.g., patients in nursing homes and hospitals)

physicians employed full time by an industry or institution and having no private practice (e.g., physicians who work for the VA, the Ford Motor Company, etc.)

physicians who spend no time seeing ambulatory patients (e.g., physicians who only teach, are engaged in research, or are retired).

Patients.--Can be classified as either:

In-scope: All patients seen by the physician or member of his staff in his office(s).

Out-of-scope: Patients seen by the physician in a hospital, nursing home, or other extended care institution, or the patient's home. [Note: If the doctor has a *private* office (which fits definition of "office") located in a hospital, the ambulatory patients seen there would be considered "in-scope."] The following types of patients are also considered out of scope:

patients seen by the physician in any institution (including outpatient clinics of hospitals) for which the institution has the primary responsibility for the care of the patient over time

patients who telephone and receive advice from the physician

patients who come to the office only to leave a specimen, pick up insurance forms, or pay their bills

patients who come to the office only to pick up medications previously prescribed by the physician.

Visit.--A direct, personal exchange between ambulatory patient and the physician (or members of his staff) for the purpose of seeking care and rendering health services.

Physician specialty.--Principal specialty (including general practice) as designated by the physician at the time of the survey. Those physicians for whom a specialty was not obtained were assigned the principal specialty recorded in the Master Physician files maintained by the AMA or AOA.

Region of practice location.--The four geographic regions, excluding Alaska and Hawaii, which correspond to those used by the U.S. Bureau of the Census, are as follows:

<u>Region</u>	<u>States Included</u>
Northeast	Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
North Central	Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin
South	Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia
West	Arizona, California, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming

Metropolitan status of practice location.--Physician's practice is classified by its location in metropolitan or nonmetropolitan areas. Metropolitan areas are standard metropolitan statistical areas (SMSA's) as defined by the U.S. Office of Management and Budget.

The definition of an individual SMSA involves two considerations: first, a city or cities of specified population which constitute the central city and identify the county in which it is located as the central county; second, economic and social relationships with "contiguous" counties which are metropolitan in character, so that the periphery of the specific metropolitan area may be determined. SMSA's may cross State lines. In New England SMSA's consist of cities and towns, rather than counties.

PATIENT RECORD AND PATIENT LOG

B N^o 881078

ASSURANCE OF CONFIDENTIALITY—All information which would permit or identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey and will not be disclosed or released to other persons or used for any other purpose.

B N^o 881078

PATIENT LOG		PATIENT RECORD NATIONAL AMBULATORY MEDICAL CARE SURVEY									
1. DATE OF VISIT <i>Mo / Day / Yr</i>		2. DATE OF BIRTH <i>Mo / Day / Yr</i>		4. COLOR OR RACE <input type="checkbox"/> WHITE <input type="checkbox"/> NEGRO/BLACK <input type="checkbox"/> OTHER <input type="checkbox"/> UNKNOWN		5. PATIENT'S PRINCIPAL PROBLEM(S) COMPLAINT(S), OR SYMPTOM(S) THIS VISIT <i>(In patient's own words)</i> a. MOST IMPORTANT _____ b. OTHER _____		6. SERIOUSNESS OF PROBLEM IN ITEM 5a <i>(Check one)</i> <input type="checkbox"/> VERY SERIOUS <input type="checkbox"/> SERIOUS <input type="checkbox"/> SLIGHTLY SERIOUS <input type="checkbox"/> NOT SERIOUS		7. HAVE YOU EVER SEEN THIS PATIENT BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If YES, for the problem indicated in ITEM 5a?</i> <input type="checkbox"/> YES <input type="checkbox"/> NO	
2. PATIENT'S NAME		3. SEX <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE		3. MAJOR REASON(S) FOR THIS VISIT <i>(Check all major reasons)</i> 01 <input type="checkbox"/> ACUTE PROBLEM 02 <input type="checkbox"/> ACUTE PROBLEM, FOLLOW-UP 03 <input type="checkbox"/> CHRONIC PROBLEM, ROUTINE 04 <input type="checkbox"/> CHRONIC PROBLEM, FLARE-UP 05 <input type="checkbox"/> PRENATAL CARE 06 <input type="checkbox"/> POSTNATAL CARE 07 <input type="checkbox"/> POSTOPERATIVE CARE <i>(Operative procedure)</i> _____				9. PHYSICIAN'S PRINCIPAL DIAGNOSIS THIS VISIT a. DIAGNOSIS ASSOCIATED WITH ITEM 5a ENTRY _____ _____ b. OTHER SIGNIFICANT CURRENT DIAGNOSES <i>(In order of importance)</i> _____ _____			
3. TIME OF VISIT a.m. p.m.		10. DIAGNOSTIC/THERAPEUTIC SERVICES ORDERED/PROVIDED THIS VISIT <i>(Check all that apply)</i> 01 <input type="checkbox"/> NONE 02 <input type="checkbox"/> LIMITED HISTORY/EXAM 03 <input type="checkbox"/> GENERAL HISTORY/EXAM 04 <input type="checkbox"/> CLINICAL LAB. TEST 05 <input type="checkbox"/> BLOOD PRESSURE CHECK 06 <input type="checkbox"/> EKG 07 <input type="checkbox"/> HEARING TEST 08 <input type="checkbox"/> VISION TEST 09 <input type="checkbox"/> ENDOSCOPY 10 <input type="checkbox"/> OFFICE SURGERY				11. DISPOSITION THIS VISIT <i>(Check all that apply)</i> <input type="checkbox"/> NO FOLLOW-UP PLANNED <input type="checkbox"/> RETURN AT SPECIFIED TIME <input type="checkbox"/> RETURN IF NEEDED, P.R.N. <input type="checkbox"/> TELEPHONE FOLLOW-UP PLANNED <input type="checkbox"/> REFERRED TO OTHER PHYSICIAN/AGENCY <input type="checkbox"/> RETURNED TO REFERRING PHYSICIAN <input type="checkbox"/> ADMIT TO HOSPITAL <input type="checkbox"/> OTHER <i>(Specify)</i> _____				12. DURATION OF THIS VISIT <i>(Time actually spent with physician)</i> _____ MINUTES	
4. RECORD ITEMS 1-12 FOR THIS PATIENT		<p>CONTINUE LISTING PATIENTS ON NEXT PAGE</p>									

HRA-34-3
REV. 2-78

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
NATIONAL CENTER FOR HEALTH STATISTICS

OMB #68-11405

Table 1. Distribution of physicians in the universe (AMA and AOA) and in the National Ambulatory Medical Care Survey sample, by physician's specialty: United States, January-December 1976.

Physician's specialty	Universe	Gross Total	Out of Scope	Net Total	Non-re-spond-ents	Re-spond-ents
	Number of physicians					
All specialties	197,722	3,022	487	2,535	531	2,004
General and family practice.....	52,664	776	138	638	154	484
Medical Specialties.....	54,394	823	124	699	172	527
Internal medicine	28,339	433	65	368	103	265
Pediatrics	13,211	196	35	161	25	136
Other medical specialties	12,844	194	24	170	44	126
Surgical specialties	67,719	1,061	100	961	167	794
General surgery	19,970	308	32	276	50	226
Obstetrics and gynecology	15,606	247	23	224	41	183
Other surgical specialties	32,143	506	45	461	76	385
Other specialties	22,945	362	125	237	38	199
Psychiatry	13,619	226	47	179	25	154
Other specialties	9,326	136	78	58	13	45

Table II. Estimates of the civilian noninstitutionalized population of the United States,¹ by age, race, sex, geographic region and metropolitan and nonmetropolitan area as of July 1, 1976

Race, sex, geographic region, and area	Age					
	All ages	Under 15 years	15-24 years	25-44 years	45-64 years	65 years and over
<u>Race</u>						
All races.....	209,342	52,130	39,050	53,393	43,036	21,733
Male	100,991	26,583	19,158	25,785	20,530	8,935
Female	108,351	25,546	19,892	27,608	22,506	12,798
White	181,727	43,391	33,378	46,686	38,563	19,709
Male	88,038	22,186	16,488	22,827	18,471	8,065
Female	93,689	21,205	16,890	23,858	20,092	11,644
All other races	27,615	8,738	5,672	6,708	4,473	2,024
Male	12,954	4,397	2,670	2,958	2,059	870
Female	14,662	4,341	3,002	3,750	2,414	1,154
<u>Geographic region</u>						
Northeast	48,612					
North Central	56,233					
South	67,572					
West	36,925					
<u>Area</u>						
Metropolitan	143,333					
Nonmetropolitan	66,009					

¹Excludes Alaska and Hawaii.

1976 NAMCS USER QUESTIONNAIRE

In order to improve the NCHS Micro-Data Tape Release program, we would appreciate your assistance in regard to the following questionnaire.

Name: _____

Title: _____

Organization: _____

Address: _____

Date of tape purchase: _____

Type of organization (university, insurance, etc.): _____

1. Have you used this tape? (If not, please indicate why.)

2. Did you have any computer problems using the data?

3. Did you have any analytic problems with the data?

4. What output was produced using the tape?

5. How was this output used?

6. How was the overall quality of the documentation?

7. Did you find the explanation of the survey helpful? Was it clear, concise, etc.?

8. Was the description of the tape record format easy to use? Were the item descriptions understandable? Did you find any errors?

9. Do you have any other comments or complaints?

Return this questionnaire to the address on back. Please feel free to include additional comments. Thank you very much for your assistance.

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