Data from the
NATIONAL HEALTH SURVEY

Series 13
Number 39

Ambulatory Care Utilization Patterns of Children and Young Adults:

National Ambulatory Medical Care Survey

United States, January - December 1975

Using data obtained from a national probability sample of office-based physicians, statistics are presented on the utilization of ambulatory care by children and young adults under 22 years of age. Ambulatory care visits are described in terms of demographic utilization patterns and in terms of physician utilization patterns. Also shown are distributions of office visits according to the patient's prior-visit status, the patient's problem or complaint, seriousness of the problem, physician's diagnosis, diagnostic and therapeutic services ordered or provided, disposition, and duration of visit.

DHEW Publication No. (PHS) 78-1790

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
National Center for Health Statistics
Hyattsville, Md. August 1978

Library of Congress Cataloging in Publication Data

Ezzati, Trena M.
Ambulatory care utilization patterns of children and young adults.

(Vital and health statistics: Series 13, Data from the National Health Survey; no. 39) (DHEW publication; no. (PHS) 78-1790)
Includes bibliographical references.
1. Ambulatory medical care for children—United States—Utilization—Statistics. 2. Physician services utilization—United States—Statistics. 3. Children—Diseases—United States—Statistics. 4. Health surveys—United States. 5. United States—Statistics, Medical. I. United States. National Center for Health Statistics. II. Title. III. Series: United States. National Center for Health Statistics. Vital and health statistics: Series 13, Data from the National Health Survey, Data on health resources utilization; no. 39. IV. Series: United States. Dept. of Health, Education, and Welfare. DHEW publication; no. (PHS) 78-1790. [DNLM: 1. Ambulatory care—In infancy and childhood—Statistics. 2. Ambulatory care—In adolescence—Statistics. 3. Health services—Utilization—U.S. 4. Utilization review. W2 A N148vm no. 39 (P)]
RA407.3.A349 no. 39 [RJ102] 362.1'1'0973s [362.7'8'1]
ISBN 0-8406-0134-4 78-606086

NATIONAL CENTER FOR HEALTH STATISTICS

DIVISION OF HEALTH RESOURCES UTILIZATION STATISTICS

Vital and Health Statistics-Series 13-No. 39

DHEW Publication No. (PHS) 78-1790
Library of Congress Catalog Card Number 78-606086

CONTENTS

LIST OF TEXT FIGURES

LIST OF TEXT TABLES

SYMBOLS

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AMBULATORY CARE UTILIZATION PATTERNS OF CHILDREN AND YOUNG ADULTS

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INTRODUCTION

The data presented in this report on the utilization of office-based ambulatory care in the coterminous United States were obtained from the 1975 National Ambulatory Medical Care Survey. The survey is a continuous sample survey conducted by the Division of Health Resources Utilization Statistics of the National Center for Health Statistics. A complete description of the background and methodology of the survey was presented in an earlier report.[1]

During calendar year 1975, an estimated 567.6 million office visits were made to office-based physicians in the coterminous United States. An estimated 157 million visits, or about 28 percent, were made by persons under 22 years of age. The purpose of this report is to present data concerning the utilization of office-based ambulatory care by these children and young adults. The utilization statistics will be analyzed in terms of the demographic characteristics of the patient, characteristics of the visit, and characteristics of the physician's practice.

Scope of the Survey

The current scope of the National Ambulatory Medical Survey (NAMCS) includes all office visits within the coterminous United States made by ambulatory patients to nonfederally employed physicians who are in office-based practice. The basic sampling unit for NAMCS is the physician-patient encounter or visit. Excluded are visits to hospital-based physicians, visits to specialists in anesthesiology, pathology, and radiology, and visits to physicians principally engaged in teaching, research, or administration. Also excluded are visits made by telephone and those made outside of the physician's office.

Source and Limitations of Data

The estimates presented in this report are based on information obtained through completion of Patient Records (see appendix III) for a sample of visits provided by a national probability sample of office-based physicians. The sample for the 1975 NAMCS included 3,507 physicians, of whom 438 were found not eligible (out of scope) at the time of the survey. Of the 3,069 physicians who were eligible for participation in NAMCS, 2,472 (80.5 percent) actually participated in the survey (see appendix I).

Sample physicians maintained a listing of all office visits during a randomly assigned 7-day reporting period. For a systematic random sample of these visits, information was recorded on the Patient Record, an encounter form, provided for that purpose (see appendix III).

Because the estimates provided in this report are derived from a sample survey, the three appendixes provide information necessary for proper interpretation of the statistics presented. Appendix I contains a general description of the survey methods, the sample design, and the data collection and processing procedures. Methods of estimation and imputation are also presented. Because the statistics in this report are based on a sample of ambulatory visits rather than on all visits, they are subject to sampling errors. Therefore, particular attention should be paid to the section in appendix I entitled "Reliability of

Estimates." Charts of relative standard errors and instructions for their use are given in appendix I.

Definitions of the terms used in this report and in the survey operations are presented in appendix II. Facsimiles of survey materials—letter, Patient Record, and Induction Interview Form—are reproduced in appendix III.

By means of another program of the National Center for Health Statistics (NCHS), the Health Interview Survey (HIS), data are collected on the utilization of physician services from a sample survey of the civilian noninstitutionalized population of the United States. The estimates provided by HIS are generally larger for the number of visits than NAMCS estimates because of differences in collection procedures, population sampled, and definitions. Data from HIS are published in Series 10 of *Vital and Health Statistics.*

DEMOGRAPHIC UTILIZATION PATTERNS

During 1975, an estimated 157 million office visits were made by children and young adults (CYA's)—99 million visits by children under 15 years and 58 million by young adults aged 15-21 years (table A). It may be further noted from table A that for patients of all ages the number of office visits per person for the year varied from a low of 1.9 for persons aged 0-15 years to a high of 4.3 per year for persons 65 years and over, reflecting a positive correlation between the annual visit rate and patient age.

Throughout most of this report, ambulatory pediatric visits will be analyzed according to the following age groups since these groupings are believed to relate closely to both the epidemiology of diseases and to the patterns of health care of CYA's:

Under 2 years—infants

2-5 years—preschool age

6-14 years—preadolescents-adolescents

15-21 years—young adults

Examination of the annual visit rates for these age groups reveals that more visits were made by children under age 2 years (4.3 per person) than by CYA's of any other age (figure 1 and table 1). In comparison with the other age groups, the relatively large number of visits by children under age 2 reflects the large number of well-baby examinations for this age group.

Table A. Number, percent distribution, and number of office visits per person per year by age of patient: United States, 1975

Age of patient	Number of visits in thousands	Percent distribution of visits	Number of visits per person per year[1]
All ages	567,600	100.0	2.7
Under 15 years	99,010	17.4	1.9
15-21 years	58,421	10.3	2.1
22-44 years	171,675	30.2	2.7
45-64 years	145,434	25.6	3.4
65 years and over	93,061	16.4	4.3

[1]Rates are based on population estimates for July 1, 1975, furnished by the U.S. Bureau of the Census (see appendix I).

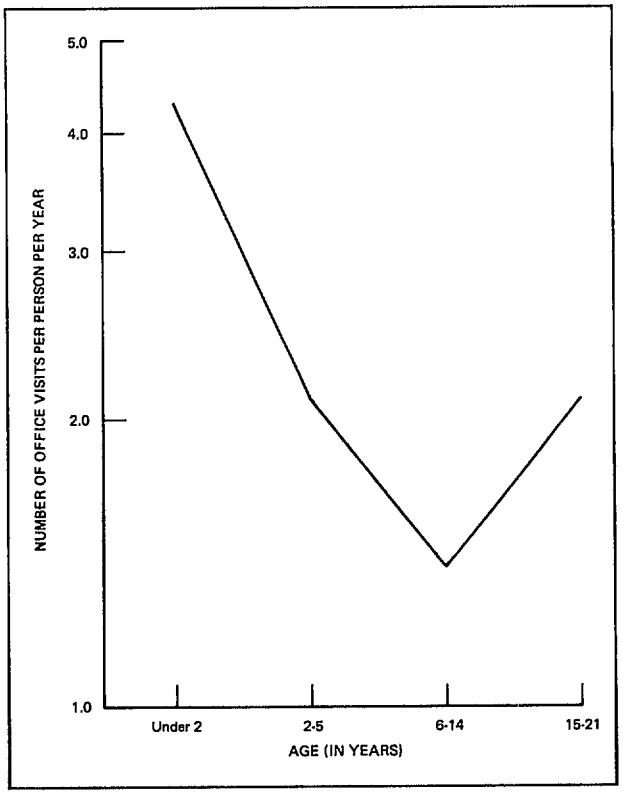

Figure 1. Annual office visit rates for children and young adults, by age: United States, 1975.

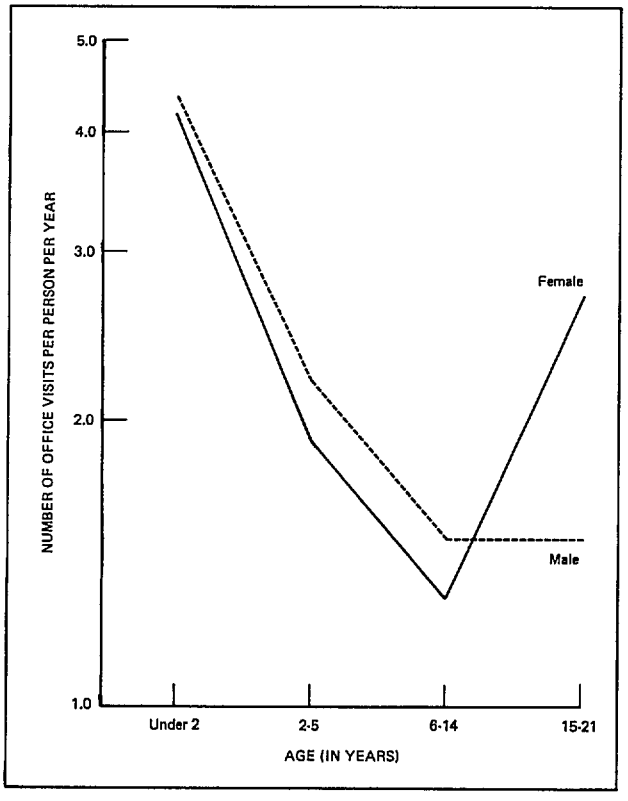

Figure 2. Annual office visit rates for children and young adults, by sex and age: United States, 1975

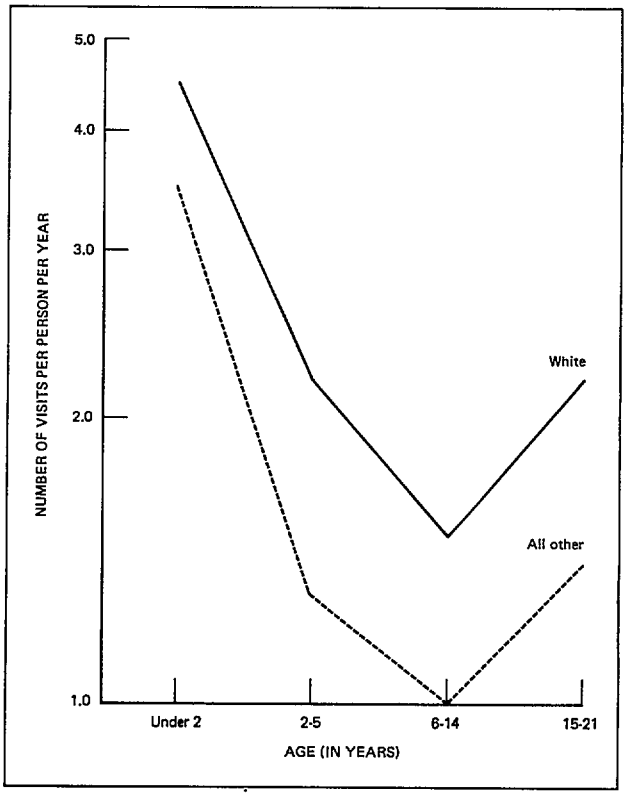

Figure 3. Annual office visit rates for children and young adults, by race and age: United States, 1975.

Annual visit rates for CYA's according to the sex of the patient are shown in figure 2 and table 1. The visit rate for males slightly exceeded that for females for children under 15 years of age. However, for young adults aged 15-21 years, the annual visit rate for females exceeded that for males. The latter finding may be a reflection of the large volume of prenatal examinations occurring for young women.

The visit rate for white CYA's (2.1) was higher than the rate for other races (1.3) for each age interval (figure 3 and table 1).

PHYSICIAN UTILIZATION PATTERNS

Visits made by CYA's to general and family practitioners accounted for approximately two-thirds of the 157 million office visits made by this group during 1975 (figure 4 and table 2). Office visits to obstetrician-gynecologists accounted for about one-fifth of the visits to other

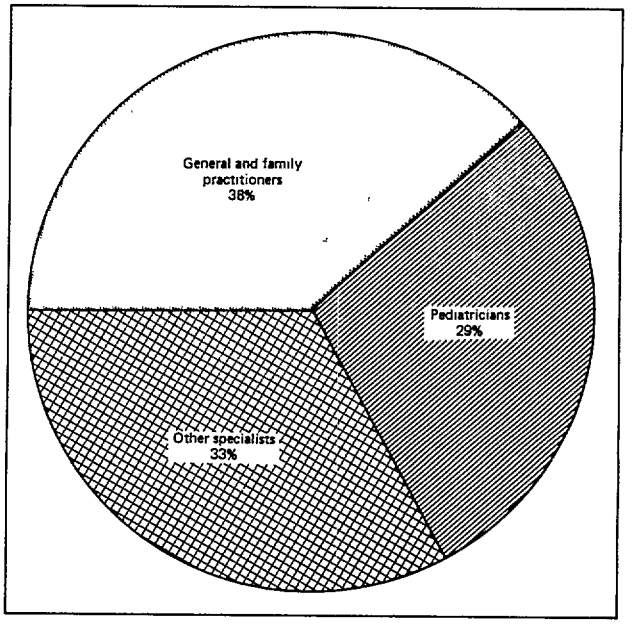

Figure 4. Percent distribution of office visits made by children and young adults, by physician specialty: United States, 1975.

specialists. Visits to the pediatrician accounted for approximately 44 percent of the office visits made by persons under 15 years, but for only 5 percent of those made by young adults (table B). Visits to general and family practitioners, on the other hand, accounted for 45 percent of the office contacts by young adults and approximately 34 percent of the visits made by the younger group. Characteristics of office visits to pediatricians, general and family practitioners, and obstetrician-gynecologists have been previously published.[2-4]

Further graphing of physician utilization patterns for each age category (figure 5) reveals that the proportion of visits to pediatricians decreased as the age of the CYA visitor increased, and the proportion of visits to other specialists increased as the age of the CYA visitor increased. For young adults aged 15-21 years, about 15 percent of the total visits were to obstetrician-gynecologists.

Ambulatory CYA visits according to physician specialty by type and location of practice are shown in table 3. There were more office visits by CYA's to general and family practice physicians engaged in solo practice than to those practicing in a group or partnership arrangement. The reverse was true for those visits to specialists in pediatrics and obstetrics-gynecology where visits to physicians in multiple-member practices exceeded those to solo practitioners.

Table B. Number and percent distribution of office visits made by children and young adults by selected physician specialties: United States, 1975

Physician specialty	All ages	Under 15 years	15-21 years
	Number of visits in thousands		
All specialties	157,431	99,010	58,421
	Percent distribution		
Total	100.0	100.0	100.0
General and family practice	38.3	34.1	45.5
Pediatrics	29.3	43.7	4.9
Obstetrics-gynecology	6.1	1.1	14.6
General surgery	3.9	2.6	6.0
Internal medicine	3.6	2.1	6.3
Orthopedic surgery	3.6	3.4	4.0
Ophthalmology	3.6	3.4	3.8
Otolaryngology	3.5	4.0	2.7
Dermatology	2.7	1.3	5.1
Psychiatry	1.4	1.0	2.4
Other	4.0	3.3	4.7

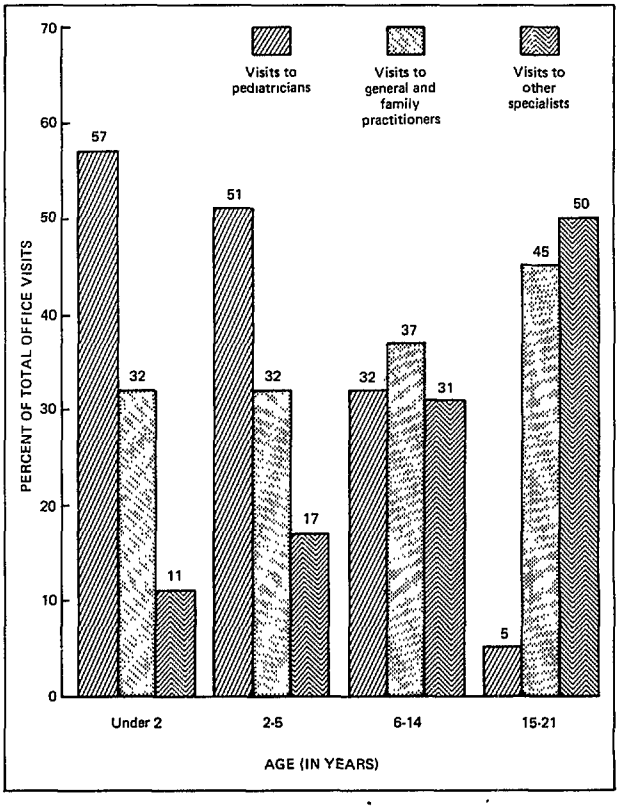

Figure 5. Percent distribution of office visits made by children and young adults, by physician specialty and age: United States, 1975.

Visits within standard metropolitan statistical areas (SMSA's) (73 percent) outnumbered nonmetropolitan visits (27 percent) for all visits made by CYA's to physicians' offices.

UTILIZATION BY VISIT CHARACTERISTICS

General Visit Utilization Patterns

Information abstracted from the Patient Record (see appendix III) concerning the patient's prior-visit status reveals that the majority of visits (82 percent) made by CYA's were return visits (table C).

Proportionately, there were more new patient visits by children under 6 years of age than by CYA's 6 years and older (table 4).

Survey results show that ambulatory pediatric care included a large proportion of problems considered not serious and slightly serious

Table C. Percent distribution of office visits made by children and young adults by patient's prior-visit status: United States, 1975

Patient's prior-visit status	Percent distribution
Total	100.0
New patient	17.9
Return patient:	
New problem	33.0
Old problem	49.1

Table D. Percent distribution of office visits made by children and young adults by seriousness of patient's problem: United States, 1975

Degree of seriousness	Percent distribution
Total	100.0
Serious or very serious	11.3
Slightly serious	30.0
Not serious	58.7

(table D); seriousness of problem is defined as the physician's judgment of the extent of impairment that might result if no care were obtained (see appendix II). Data (table D) on the physician's judgment of the seriousness of the patient's problem, complaint, or symptom show that over one-half of the problems presented by CYA's were considered "not serious," a reflection of the large volume of well-person examinations and acute, self-limiting problems characteristic of CYA's. The statistics in table E show that an acute condition[a] (55 percent) was the major categorical reason for visit. Chronic problems,[b] on the other hand, accounted for 17 percent of the CYA visits. The ratio of acute problems to chronic problems tended to decrease with age (table E). In other words, the proportion of visits at which a chronic problem was involved tended to increase as the age of the patient increased. The percents in table E also show the proportion of visits involving routine well-person examinations decreasing as the patient's age increases.

For CYA's, a limited history or examination characterized approximately 50 percent of the visits (table 5). General history or examination and clinical laboratory tests each accounted for about 20 percent of the visits. Proportionately more clinical laboratory tests were performed for young adults aged 15-21 years than for children of any other age. It may be further noted that the proportion of visits in each age category involving a blood pressure check increased with age. Data in table 5 show that prescription of drugs (42 percent) was the most common therapeutic-type service.

Followup care of some type was advised at the majority of CYA visits. At about 47 percent of the visits, the patient was advised to return at a specified time; about one-fifth of the visits entailed no followup plans (table 5).

Duration of visit represents the amount of time spent by the patient in face-to-face contact with the physician. The average encounter time for all CYA visits was about 13 minutes. Table F shows the mean duration of visit for the four CYA age groups and for the five most frequently visited specialists.

Table E. Percent of office visits made by children and young adults, by selected categorical reason for visit and age of patient, with ratios of acute to chronic problems: United States, 1975

Categorical reason for visit	All ages	Age of patient			
		Under 2 years	2-5 years	6-14 years	15-21 years
Acute problem	54.5	48.7	65.3	58.3	49.0
Chronic problem	17.4	8.7	13.4	20.7	20.4
Well-adult and well-child examinations	17.6	40.6	17.4	13.0	11.3
Ratio of acute to chronic problems	3.1	5.6	4.9	2.8	2.4

[a] An *acute condition* is defined as a condition or illness having a relatively sudden or recent onset (i.e., within 3 months of the visit).

[b] A *chronic problem* is defined as a condition or illness with an onset 3 months before the present visit.

Table F. Mean contact duration for children and young adults, by age of patient and selected physician specialties: United States, 1975

Age of patient and physician specialty	Mean contact duration (in minutes)[1]
Total	12.6
Age	
Under 2 years	11.2
2-5 years	11.3
6-14 years	12.9
15-21 years	13.5
Specialty	
General and family practice	10.8
Pediatrics	12.1
Obstetrics-gynecology	12.4
General surgery	11.5
Internal medicine	15.6

[1]Time spent in face-to-face contact between physician and patient.

Utilization by Patient's Presenting Symptom

One unique aspect of NAMCS is the attempt to measure the major reason for visit as reported in the patient's own words (question 5 of the Patient Record). However, the reliability of these data may be somewhat limited for children, for whom the reason for visit may frequently be reported in the words of the parent or accompanying adult(s). The patient's problems, complaints, or symptoms are coded according to a special classification developed for use in NAMCS.[5]

A rank ordering of the 54 most frequent problems, complaints, or symptoms as presented in the words of the CYA visitor (or in the case of children, in the words of the accompanying parent or adult) is shown in table 6. These symptom data represent the problems, complaints, or symptoms listed first in item 5 of the Patient Record (see appendix III). Because of sampling variability, this ranking of problems does not represent true statistical difference

Table G. Number of office visits by selected diagnoses and percent distribution of office visits made by children and young adults by physician specialties, according to selected diagnoses: United States, 1975

10 most frequent diagnoses of illness-related conditions and ICDA code[1]	Number of office visits in thousands	Total	Physician specialty		
			General or family practice	Pediatrics	All other
		Percent distribution			
All diagnoses	157,431	100.0	38.3	29.3	32.4
Acute upper respiratory infection 465	8,220	100.0	53.1	35.6	11.3
Otitis media 381	7,597	100.0	30.0	49.9	20.1
Acute pharyngitis 462	4,597	100.0	51.6	39.5	*8.9
Acute tonsillitis 463	4,543	100.0	54.3	32.5	13.2
Other eczema and dermatitis 692	4,158	100.0	49.0	36.2	14.8
Bronchitis, unqualified 490	3,280	100.0	40.7	52.7	*6.6
Hay fever 507	2,968	100.0	33.8	32.0	34.2
Other viral diseases 079	2,620	100.0	33.4	28.8	37.8
Asthma 493	1,753	100.0	28.9	38.9	32.2
Streptococcal sore throat and scarlet fever 034	1,706	100.0	47.9	44.9	*7.2

[1]Based on *Eighth Revision International Classification of Diseases, Adapted for Use in the United States, 1965* (ICDA) (see reference 6).

among the estimates. These symptom data show that among the 157 million total CYA visits, sore throat and well-baby examination each accounted for about 5 percent of the total.

Examination of table 7 reveals a difference in the spectrum of presenting symptoms among the various age groups. As might be predicted, the well-baby examination was the most common reason for visit for the youngest age group (1,387 per 1,000 persons) and pregnancy examination was the most common reason for office visits made by persons aged 15-21 years (210 per 1,000 persons).

Utilization by Physician's Diagnosis

Information concerning principal diagnoses for CYA's (table 8) reveals that diagnoses rendered by physicians most frequently fell into the category of "special conditions and examinations"[c] (25 percent) or diseases of the respiratory system (22 percent).

The most frequent individual ICDA diagnoses for CYA visitors are ranked according to their frequency of occurrence in table 9.

Visit rates by age for selected CYA diagnoses (table 10) show that for otitis media and for conditions associated with the respiratory system, the annual visit rate tended to decrease with increasing age. Only for acute tonsillitis was this pattern altered—the annual visit rate for children aged 2-5 years exceeded that for children under age 2.

Although the proportion of visits to general and family practice physicians and pediatricians for selected diagnoses (table G) differed, only for acute upper respiratory infection, otitis media, and acute tonsillitis were the differences statistically significant.

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[c]"Special conditions and examinations" is a supplementary classification (codes Y00-Y13) of the *International Classification of Diseases, Adapted for Use in the United States, 1965* (ICDA). Included in this category, for example, are medical or special examination (Y00), persons receiving prophylactic inoculation and vaccination (Y02), and prenatal care (Y06) (see reference 6).

REFERENCES

[1]National Center for Health Statistics: National Ambulatory Medical Care Survey: Background and methodology, United States, 1967-72, by J. B. Tenney and others. *Vital and Health Statistics.* Series 2-No. 61. DHEW Pub. No. (HRA) 74-1335. Health Resources Administration. Washington. U.S. Government Printing Office, Apr. 1974.

[2]National Center for Health Statistics: Ambulatory medical care rendered in pediatricians' offices during 1975, by T. Ezzati. *Advance Data From Vital and Health Statistics,* No. 13. DHEW Pub. No. (HRA) 77-1250. Health Resources Administration. Hyattsville, Md. Oct. 13, 1977.

[3]National Center for Health Statistics: National Ambulatory Medical Care Survey of visits to general and family practitioners, January-December 1975, by B. K. Cypress. *Advance Data From Vital and Health Statistics,* No. 15. DHEW Pub. No. (HRA) 78-1250. Health Resources Administration. Hyattsville, Md. Dec. 14, 1977.

[4]National Center for Health Statistics: Office visits to obstetrician-gynecologists: National Ambulatory Medical Care Survey, United States, 1975, by T. Ezzati. *Advance Data From Vital and Health Statistics,* No. 20. DHEW Pub. No. (HRA) 78-1250. Health Resources Administration. Hyattsville, Md. Mar. 13, 1978.

[5]National Center for Health Statistics: The National Ambulatory Medical Care Survey: Symptom classification, by S. Meads and T. McLemore. *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.

[6]National Center for Health Statistics: *Eighth Revision International Classification of Diseases, Adapted for Use in the United States.* PHS Pub. No. 1693. Public Health Service. Washington. U.S. Government Printing Office, 1967.

[7]National Center for Health Statistics: Replication: An approach to the analysis of data from complex surveys, by P. J. McCarthy. *Vital and Health Statistics.* Series 2-No. 14. DHEW Pub. No. (HSM) 73-1269. Health Services and Mental Health Administration. Washington. U.S. Government Printing Office, Apr. 1966.

[8]National Center for Health Statistics: Pseudoreplication: Further evaluation and application of the balanced half-sample technique, by P. J. McCarthy. *Vital and Health Statistics.* Series 2-No. 31. DHEW Pub. No. (HSM) 73-1270. Health Services and Mental Health Administration. Washington. U.S. Government Printing Office, Jan. 1969.

LIST OF DETAILED TABLES

Table 1. Number and percent distribution of office visits and visit rates for children and young adults by age, sex, and race of patient: United States, 1975

Patient characteristic	Number of visits in thousands	Percent distribution of visits	Number of visits per person per year[1]
All visits	157,431	100.0	2.0
Age			
Under 2 years	25,598	16.3	4.3
2-5 years	26,784	17.0	2.1
6-14 years	46,628	29.6	1.4
15-21 years	58,421	37.1	2.1
Sex and age			
Female	83,254	52.9	2.1
Under 2 years	12,255	7.8	4.2
2-5 years	11,993	7.6	1.9
6-14 years	21,893	13.9	1.3
15-21 years	37,113	23.6	2.7
Male	74,177	47.1	1.8
Under 2 years	13,343	8.5	4.4
2-5 years	14,792	9.4	2.2
6-14 years	24,735	15.7	1.5
15-21 years	21,307	13.5	1.5
Race and age			
White	140,742	89.4	2.1
Under 2 years	22,026	14.0	4.5
2-5 years	23,874	15.2	2.2
6-14 years	42,266	26.8	1.5
15-21 years	52,576	33.4	2.2
All other	16,689	10.6	1.3
Under 2 years	3,572	2.3	3.5
2-5 years	2,910	1.8	1.3
6-14 years	4,362	2.8	1.0
15-21 years	5,845	3.7	1.4

[1]Rates are based on population estimates for July 1, 1975, furnished by the U.S. Bureau of the Census (see appendix I).

Table 2. Number and percent distribution of office visits made by children and young adults by selected physician specialties, according to age of patient: United States, 1975

Physician specialty	All ages	Age of patient			
		Under 2 years	2-5 years	6-14 years	15-21 years
	Number of visits in thousands				
All specialties	157,431	25,598	26,784	46,628	58,421
	Percent distribution				
Total	100.0	100.0	100.0	100.0	100.0
General and family practice	38.3	31.7	31.9	36.7	45.5
Pediatrics	29.3	56.5	51.1	32.4	4.9
Obstetrics-gynecology	6.1	*1.9	*0.6	*0.9	14.6
General surgery	3.9	*1.4	*1.7	3.8	6.0
Internal medicine	3.6	*0.8	*1.4	3.1	6.3
Orthopedic surgery	3.6	3.4	2.3	4.0	4.0
Ophthalmology	3.6	*1.0	1.9	5.6	3.8
Otolaryngology	3.5	*1.3	4.6	5.1	2.7
Dermatology	2.7	*0.5	*0.5	2.2	5.1
Psychiatry	1.4	*0.0	*0.3	1.4	2.4
Other	4.0	*1.5	3.7	4.8	4.7

Table 3. Number and percent distribution of office visits made by children and young adults by selected physician specialties, according to type, region, and location of practice: United States, 1975

Physician specialty	Number of visits in thousands	Total	Type of practice		Region				Location of practice	
			Solo	Other[1]	Northeast	North Central	South	West	Metropolitan[2]	Nonmetropolitan
		Percent distribution								
All specialties	157,431	100.0	54.2	45.8	22.2	28.5	32.3	17.1	73.4	26.6
General and family practice	60,338	100.0	67.9	32.1	15.1	36.0	31.7	17.2	57.6	42.4
Pediatrics	46,112	100.0	41.6	58.4	31.0	25.7	27.9	15.4	89.1	10.9
Obstetrics-gynecology	9,631	100.0	36.7	63.3	16.5	24.4	41.7	17.3	74.8	25.2
General surgery	6,135	100.0	58.7	41.3	20.6	23.3	44.7	11.4	65.4	34.6
Internal medicine	5,707	100.0	56.7	43.3	32.5	31.9	23.1	12.4	80.3	19.7
Orthopedic surgery	5,697	100.0	42.5	57.5	22.2	16.1	42.8	18.8	82.5	17.5
Ophthalmology	5,603	100.0	70.3	29.7	29.1	21.3	29.7	19.9	83.5	16.5
Otolaryngology	5,522	100.0	15.7	84.3	10.3	26.0	37.8	25.9	64.8	35.2
Dermatology	4,247	100.0	57.6	42.4	15.3	*4.5	58.8	21.5	78.6	21.4
Psychiatry	2,132	100.0	83.6	*16.4	46.3	*11.5	26.5	*15.6	97.8	*2.2

[1]Includes group and partnership.
[2]Located within the standard metropolitan statistical areas (SMSA's).

Table 4. Number and percent distribution of office visits made by children and young adults by prior-visit status, seriousness of problem, and selected major reasons for visit, according to age of patient: United States, 1975

Visit characteristic	All ages	Age of patient			
		Under 2 years	2-5 years	6-14 years	15-21 years
	Number of visits in thousands				
All visits	157,431	25,598	26,784	46,628	58,421
	Percent distribution				
Total	100.0	100.0	100.0	100.0	100.0
Prior-visit status					
New patient	17.9	13.7	13.3	18.6	21.3
Old patient, new problem	33.0	35.2	37.0	34.9	28.8
Old patient, old problem	49.1	51.1	49.7	46.5	49.8
Seriousness of problem					
Serious or very serious	11.3	8.9	12.9	11.6	11.4
Slightly serious	30.0	23.1	33.7	33.5	28.5
Not serious	58.7	67.9	53.5	54.9	60.1
Major reason for visit (selected reasons)					
Acute problem	43.3	39.6	53.9	47.0	37.1
Acute problem, followup	11.2	9.1	11.4	11.3	11.9
Chronic problem, routine	11.9	5.5	8.8	14.8	13.7
Chronic problem, flareup	5.5	3.2	4.6	5.9	6.7
Well-adult and well-child examinations	17.6	40.6	17.4	13.0	11.3

Table 5. Number and percent of office visits made by children and young adults by selected visit characteristics and age of patient: United States, 1975

Selected visit characteristic	All ages	Age of patient			
		Under 2 years	2-5 years	6-14 years	15-21 years
	Number of visits in thousands				
All visits	157,431	25,598	26,784	46,628	58,421
Services ordered or provided	Percent of visits[1]				
No services	3.4	3.8	3.7	3.2	3.3
Diagnostic service:					
Limited history, examination	49.8	43.5	51.0	49.9	52.0
General history, examination	20.3	33.2	20.2	17.7	16.8
Clinical lab test	19.9	12.7	18.9	16.7	26.1
Blood pressure check	15.3	2.9	6.0	10.6	28.8
X-ray	5.7	2.2	4.0	7.7	6.3
Vision test	5.2	*0.9	5.0	7.3	5.5
Hearing test	2.0	*0.4	3.3	2.7	1.6
Therapeutic service:					
Drug prescribed or dispensed	42.0	37.8	47.8	41.2	41.9
Immunization or desensitization	10.3	24.7	12.9	10.4	2.8
Medical counseling	12.0	16.2	11.0	10.9	11.6
Injection	10.8	11.7	12.6	10.1	10.2
Office surgery	6.9	2.2	5.0	8.6	8.6
Disposition					
No followup planned	21.3	14.0	24.4	25.0	20.1
Return at specified time	47.3	60.1	39.0	40.6	50.9
Return, if needed, P.R.N.	24.9	20.7	29.3	26.8	23.3
Telephone followup planned	5.1	4.5	7.2	6.5	3.4
Referred to other physician/agency	2.5	*1.5	2.6	2.7	2.8

[1]Percents may total more than 100.0 since more than one treatment or more than one disposition could be given at a single visit.

Table 6. Number, percent distribution, and cumulative percent of office visits made by children and young adults, by the 54 most frequent patient problems, complaints, or symptoms: United States, 1975

Problems, complaints, or symptoms and NAMCS code[1]	Number of visits in thousands	Percent distribution of visits	Cumulative percent
All visits	157,431	100.0	100.0
1. Sore throat 520	8,503	5.4	5.4
2. Well-baby examination 906	8,291	5.3	10.7
3. Cough 311	6,564	4.2	14.9
4. Pregnancy examination, routine 905	6,398	4.1	19.0
5. General medical examination 900	6,248	4.0	23.0
6. Fever 002	5,820	3.7	26.7
7. Physical examination 901	5,740	3.7	30.4
8. Surgical aftercare 986	5,450	3.5	33.9
9. Visit for therapy, medication 910	5,255	3.3	37.2
10. Earache 735	5,187	3.3	40.5
11. Allergic skin reactions 112	4,671	3.0	43.5
12. Cold 312	4,373	2.8	46.3
13. Problem, lower extremity 400	4,361	2.8	49.1
14. Abdominal pain 540	3,391	2.2	51.3
15. Wounds of skin 116	3,342	2.1	53.4
16. Problem, upper extremity 405	3,122	2.0	55.4
17. None 997	2,293	1.5	56.9
18. Headache 056	2,017	1.3	58.2
19. Eye examination 908	1,975	1.3	59.5
20. Acne or pimples 100	1,908	1.2	60.7
21. Nausea and vomiting 572	1,788	1.1	61.8
22. Gynecological examination 904	1,694	1.1	62.9
23. Other symptoms—ears 740	1,670	1.1	64.0
24. Problem, face and neck region 410	1,574	1.0	65.0
25. Nasal congestion 301	1,568	1.0	66.0
26. Swelling or mass of skin 115	1,521	1.0	67.0
27. Warts 111	1,458	0.9	67.9
28. Other vision dysfunction 701	1,428	0.9	68.8
29. Pain, back region 415	1,402	0.9	69.7
30. Other symptoms referable to the respiratory system 330	1,348	0.9	70.6
31. Skin irritations, NEC 113	1,072	0.7	71.3
32. Vaginal discharge 662	1,056	0.7	72.0
33. Hay fever 329	989	0.6	72.6
34. Other specific symptoms referable to skin 120	980	0.6	73.2
35. Menstrual disorders 653	959	0.6	73.8
36. Problems, NEC 990	906	0.6	74.4
37. Visit for laboratory test 920	890	0.6	75.0
38. Diarrhea 555	875	0.6	75.6
39. Fatigue 004	863	0.6	76.2
40. Eye pain and irritation 705	722	0.5	76.7
41. Other hearing dysfunctions 731	700	0.4	77.1
42. Pain in chest 322	657	0.4	77.5
43. Weight gain 010	647	0.4	77.9
44. Asthma 328	630	0.4	78.3
45. Symptoms referable to tonsils 527	609	0.4	78.7
46. Visit for advice, situational problems 941	607	0.4	79.1
47. Visit for family planning services—medication 931	602	0.4	79.5
48. Swollen lymph glands 232	576	0.4	79.9
49. Painful urination 604	563	0.4	80.3
50. Other disorders of respiratory rhythm and sound 307	552	0.4	80.7
51. Other symptoms, mental health 830	552	0.4	81.1
52. Abdominal swelling or mass 542	547	0.4	81.5
53. Visit for advice and instructions 940	542	0.3	81.8
54. Other symptoms, limb and joint 422	506	0.3	82.1
55. Other	29,469	18.7	100.0

[1]Problems and codes based on a symptom classification developed for use in the NAMCS (see reference 5).
NOTES: Percents may not total 100.0 due to rounding. NEC—not elsewhere classified.

Table 7. Number and percent distribution of office visits and visit rates for children and young adults, by age of patient and the most frequent patient problems, complaints, or symptoms: United States, 1975

Age and problems, complaints, or symptoms and NAMCS code[1]	Number of visits in thousands	Percent distribution of visits	Visit rate per 1,000 persons per year[2]
All ages	157,431	100.0	1,954
Under 2 years			
Total	25,598	100.0	4,318
Well-baby examination .906	8,225	32.1	1,387
Fever .002	1,850	7.2	312
Cough .311	1,479	5.8	249
Cold .312	1,197	4.7	202
Allergic skin reactions .112	1,080	4.2	182
Visit for therapy, medication .910	994	3.9	168
Earache .735	596	2.3	101
Diarrhea .555	532	2.1	90
Nausea and vomiting .572	*442	1.7	75
Nasal congestion .301	*437	1.7	74
Other	8,766	34.2	1,478
2-5 years			
Total	26,784	100.0	2,064
General medical examination .900	2,499	9.3	193
Fever .002	2,241	8.4	173
Cough .311	2,115	7.9	163
Earache .735	1,643	6.1	127
Sore throat .520	1,446	5.4	111
Visit for therapy, medication .910	1,215	4.5	94
Cold .312	1,147	4.3	88
Allergic skin reactions .112	1,030	3.8	79
Surgical aftercare .986	939	3.5	72
Physical examination .901	906	3.4	70
Wounds of skin .116	793	3.0	61
Nausea and vomiting .572	*465	1.7	36
Other symptoms—ears .740	*401	1.5	31
Other	9,944	37.1	766
6-14 years			
Total	46,628	100.0	1,396
Sore throat .520	3,851	8.3	115
Visit for therapy, medication .910	2,375	5.1	71
General medical examination .900	2,197	4.7	66
Earache .735	2,059	4.4	62
Surgical aftercare .986	2,039	4.4	61
Cough .311	1,912	4.1	57
Physical examination .901	1,812	3.9	54
Problem, lower extremity .400	1,634	3.5	49
Fever .002	1,443	3.1	43
Wounds of skin .116	1,410	3.0	42
Problem, upper extremity .405	1,407	3.0	42

See footnotes at end of table.

Table 7. Number and percent distribution of office visits and visit rates for children and young adults, by age of patient and the most frequent patient problems, complaints, or symptoms: United States, 1975—Con.

Age and problems, complaints, or symptoms and NAMCS code[1]	Number of visits in thousands	Percent distribution of visits	Visit rate per 1,000 persons per year[2]
6-14 years—Con.			
Allergic skin reactions .112	1,261	2.7	38
Abdominal pain .540	1,237	2.7	37
Cold .312	959	2.1	29
Eye examination .908	871	1.9	26
Headache .056	848	1.8	25
Other vision dysfunction .701	845	1.8	25
Warts .111	642	1.4	19
Other symptoms—ears .740	559	1.2	17
Hay fever .329	536	1.1	16
Problem, face and neck region .410	529	1.1	16
Nausea and vomiting .572	508	1.1	15
Other	15,694	33.7	470
15-21 years			
Total	58,421	100.0	2,068
Pregnancy examination, routine .905	5,941	10.2	210
Sore throat .520	2,963	5.1	105
Physical examination .901	2,892	5.0	102
Problem, lower extremity .400	2,122	3.6	75
Surgical aftercare .986	2,080	3.6	74
Abdominal pain .540	1,735	3.0	61
Gynecological examination .904	1,625	2.8	58
Acne or pimples .100	1,518	2.6	54
Problem, upper extremity .405	1,364	2.3	48
Allergic skin reactions .112	1,300	2.2	46
General medical examination .900	1,165	2.0	41
Pain, back region .415	1,075	1.8	38
Cold .312	1,070	1.8	38
Cough .311	1,058	1.8	37
Wounds of skin .116	1,004	1.7	36
Eye examination .908	985	1.7	35
Vaginal discharge .662	932	1.6	33
Earache .735	889	1.5	31
Menstrual disorders .653	888	1.5	31
Swelling or mass of skin .115	771	1.3	27
Problem, face and neck region .410	749	1.3	27
Warts .111	705	1.2	25
Visit for therapy, medication .910	672	1.2	24
Fatigue .004	623	1.1	22
Visit for laboratory test .920	608	1.0	22
Visit for family planning services—medication .931	600	1.0	21
Other vision dysfunction .701	501	0.9	18
Other	20,586	35.2	729

[1]Problems and codes based on a symptom classification developed for use in the NAMCS (see reference 5).
[2]Rates are based on population estimates for July 1, 1975, furnished by the U.S. Bureau of the Census (see appendix I).

Table 8. Number and percent distribution of office visits made by children and young adults by sex, race, and age of patient, according to principal diagnosis: United States, 1975

Principal diagnosis classified by ICDA category[1]	Number of visits in thousands	Total	Sex		Race		Age			
			Female	Male	White	All other	Under 2 years	2-5 years	6-14 years	15-21 years
		Percent distribution								
All diagnoses	157,431	100.0	52.9	47.1	89.4	10.6	16.3	17.0	29.6	37.1
Infective and parasitic diseases 001-136	10,466	100.0	57.5	42.5	89.0	11.0	15.5	16.8	35.2	32.5
Neoplasms 140-239	1,246	100.0	72.3	27.7	91.9	8.1	*13.6	*9.3	*15.9	61.2
Endocrine, nutritional, and metabolic diseases 240-279	2,309	100.0	65.5	34.5	89.8	10.3	*8.5	*7.0	22.7	61.8
Mental disorders 290-315	3,671	100.0	48.5	51.5	92.2	*7.8	*2.9	*4.0	34.6	58.4
Diseases of nervous system and sense organs 320-389	15,341	100.0	51.1	48.9	92.4	7.6	15.8	23.9	35.7	24.6
Diseases of circulatory system 390-458	1,142	100.0	47.4	52.7	79.7	20.3	*7.3	*10.4	*22.7	59.6
Diseases of respiratory system 460-519	35,238	100.0	48.6	51.4	89.2	10.8	16.8	25.1	33.8	24.3
Diseases of digestive system 520-577	3,376	100.0	52.2	47.9	89.5	*10.5	*13.4	*11.6	28.1	46.9
Diseases of genitourinary system 580-629	6,079	100.0	79.4	20.6	83.0	17.0	*2.8	10.0	16.3	70.9
Diseases of skin and subcutaneous tissue 680-709	11,252	100.0	53.3	46.7	89.4	10.6	10.3	12.2	33.3	44.2
Diseases of musculoskeletal system 710-738	3,021	100.0	42.8	57.2	93.2	*6.8	*14.2	*11.0	29.6	45.2
Symptoms and ill-defined conditions 780-796	6,772	100.0	52.5	47.5	88.3	11.7	10.3	17.1	34.8	37.8
Accidents, poisonings, and violence 800-999	13,395	100.0	35.5	64.5	89.1	11.0	4.8	14.8	36.4	44.1
Special conditions and examinations without sickness Y00-Y13	39,888	100.0	57.8	42.2	89.4	10.6	26.8	13.9	20.6	38.6
Other diagnoses[2]	2,611	100.0	57.4	42.6	87.5	*12.5	24.4	*16.0	30.1	29.5
Diagnoses given as "None"	825	100.0	*47.5	*52.5	93.0	*7.0	*18.0	*11.3	*27.0	*43.7
Diagnoses unknown[3]	801	100.0	*50.5	*49.5	90.7	*9.3	*8.6	*0.6	*33.1	*57.7

[1]Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States, 1965* (ICDA) (see reference 6).
[2]280-289, Diseases of the blood and blood-forming organs; 630-678, Complications of pregnancy, childbirth, and the puerperium; 740-759, Congenital anomalies; 760-779, Certain causes of perinatal morbidity and mortality.
[3]Blank diagnosis; noncodable diagnosis; illegible diagnosis.

Table 9. Number, percent distribution, and cumulative percent of office visits made by children and young adults, by the 54 most common physician diagnoses: United States, 1975

Principal diagnosis and ICDA code[1]	Number of visits in thousands	Percent distribution of visits	Cumulative percent
All visits	157,431	100.0	100.0
1. Medical or special examination Y00	23,457	14.9	14.9
2. Acute upper respiratory infection 465	8,220	5.2	20.1
3. Otitis media 381	7,597	4.8	24.9
4. Prenatal care Y06	6,050	3.8	28.7
5. Medical and surgical aftercare Y10	5,867	3.7	32.4
6. Acute pharyngitis 462	4,597	2.9	35.3
7. Acute tonsillitis 463	4,543	2.9	38.2
8. Other eczema and dermatitis 692	4,158	2.6	40.8
9. Bronchitis, unqualified 490	3,280	2.1	42.9
10. Hay fever 507	2,968	1.9	44.8
11. Diseases of sebaceous glands 706	2,894	1.8	46.6
12. Other viral diseases 079	2,620	1.7	48.3
13. Inoculation and vaccination Y02	2,611	1.7	50.0
14. Refractive errors 370	2,459	1.6	51.6
15. Observation, without need for further medical care 793	2,022	1.3	52.9
16. Asthma 493	1,753	1.1	54.0
17. Streptococcal sore throat and scarlet fever 034	1,706	1.1	55.1
18. Diarrheal disease 009	1,494	0.9	56.0
19. Influenza, unqualified 470	1,411	0.9	56.9
20. Cystitis 595	1,187	0.8	57.7
21. Neuroses 300	1,184	0.8	58.5
22. Otitis externa 380	1,127	0.7	59.2
23. Hypertrophy of tonsils and adenoids 500	1,089	0.7	59.9
24. Obesity 277	1,028	0.7	60.6
25. Acute nasopharyngitis (common cold) 460	1,015	0.6	61.2
26. Chronic sinusitis 503	985	0.6	61.8
27. Disorders of menstruation 626	985	0.6	62.4
28. Other and unspecified laceration of head 873	975	0.6	63.0
29. Acute bronchitis and bronchiolitis 466	973	0.6	63.6
30. Other ill-defined and unknown causes of morbidity and mortality 796	912	0.6	64.2
31. Other diseases of ear and mastoid process 387	883	0.6	64.8
32. Other person without complaint or illness Y09	871	0.6	65.4
33. Pneumonia, unspecified 486	870	0.6	66.0
34. Acute laryngitis and tracheitis 464	804	0.5	66.5
35. Infective diseases of uterus (except cervix), vagina, and vulva 622	795	0.5	67.0
36. Postpartum observation Y07	794	0.5	67.5
37. Conjunctivitis and ophthalmia 360	788	0.5	68.0
38. Impetigo 684	657	0.4	68.4
39. Sprains and strains of other and unspecified parts of back 847	625	0.4	68.8
40. Synovitis, bursitis, and tenosynovitis 731	623	0.4	69.2
41. Symptoms referable to abdomen and lower gastrointestinal tract 785	622	0.4	69.6
42. Other diseases of urinary tract 599	611	0.4	70.0
43. Other diseases of upper respiratory tract 508	593	0.4	70.4
44. Special symptoms not elsewhere classified 306	587	0.4	70.8
45. Other general symptoms 788	587	0.4	71.2
46. Infectious mononucleosis 075	582	0.4	71.6
47. Sprains and strains of ankle and foot 845	581	0.4	72.0
48. Chronic pharyngitis and nasopharyngitis 502	566	0.4	72.4
49. Transient situational disturbances 307	545	0.3	72.7
50. Behavior disorders of childhood 308	545	0.3	73.0
51. Strabismus 373	522	0.3	73.3
52. Gastritis and duodenitis 535	519	0.3	73.6
53. Other deformities 738	514	0.3	73.9
54. Symptoms referable to respiratory system 783	502	0.3	74.2
55. All other	40,678	25.8	100.0

[1]Based on *Eighth Revision International Classification of Diseases, Adapted for Use in the United States, 1965* (ICDA) (see reference 6).

Table 10. Number of office visits and visit rates for selected diagnoses for children and young adults, by age of patient: United States, 1975

Principal diagnosis, ICDA code,[1] and age of patient	Number of visits in thousands	Number of visits per 1,000 persons per year[2]
Medical or special examination (Y00)		
Under 2 years	9,174	1,548
2-5 years	3,914	302
6-14 years	4,738	142
15-21 years	5,631	199
Acute upper respiratory infection (465)		
Under 2 years	2,003	338
2-5 years	2,384	184
6-14 years	2,156	65
15-21 years	1,679	59
Otitis media (381)		
Under 2 years	1,860	314
2-5 years	2,796	215
6-14 years	2,335	70
15-21 years	606	21
Medical and surgical aftercare (Y10)		
Under 2 years	*435	73
2-5 years	973	75
6-14 years	2,208	66
15-21 years	2,251	80
Acute pharyngitis (462)		
Under 2 years	653	110
2-5 years	995	77
6-14 years	1,739	52
15-21 years	1,210	43
Acute tonsillitis (463)		
Under 2 years	502	85
2-5 years	1,489	115
6-14 years	1,620	49
15-21 years	932	33
Other eczema and dermatitis (692)		
Under 2 years	576	97
2-5 years	709	55
6-14 years	1,829	55
15-21 years	1,045	37
Bronchitis, unqualified (490)		
Under 2 years	780	132
2-5 years	985	76
6-14 years	974	29
15-21 years	541	19

See footnotes at end of table.

Table 10. Number of office visits and visit rates for selected diagnoses for children and young adults, by age of patient: United States, 1975—Con.

Principal diagnosis, ICDA code,[1] and age of patient	Number of visits in thousands	Number of visits per 1,000 persons per year[2]
Hay fever (507)		
Under 2 years	*139	23
2-5 years	*355	27
6-14 years	1,579	47
15-21 years	895	32
Other viral diseases (079)		
Under 2 years	*288	49
2-5 years	*323	25
6-14 years	1,028	31
15-21 years	981	35
Inoculation and vaccination (Y02)		
Under 2 years	711	120
2-5 years	547	42
6-14 years	1,050	31
15-21 years	*303	11
Asthma (493)		
Under 2 years	*236	40
2-5 years	*488	38
6-14 years	630	19
15-21 years	*399	14

[1]Based on *Eighth International Classification of Diseases, Adapted for Use in the United States, 1965* (ICDA) (see reference 6).
[2]Rates are based on population estimates for July 1, 1975, furnished by the U.S. Bureau of the Census (see appendix I).

APPENDIXES

CONTENTS

LIST OF APPENDIX FIGURES

LIST OF APPENDIX TABLES

APPENDIX I

TECHNICAL NOTES

Statistical Design

Scope of the survey.—The target population of the National Ambulatory Medical Care Survey (NAMCS) encompasses office visits within the coterminous United States made by ambulatory patients to nonfederally employed physicians who are principally engaged in office practice, but not in the specialties of anesthesiology, pathology, and radiology. Telephone contacts and nonoffice visits are excluded.

Sampling frame and sample size.—The sampling frame for the NAMCS is composed of all physicians contained in the master files maintained by the American Medical Association (AMA) and American Osteopathic Association (AOA) as of December 31, 1974, who met the following criteria:

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

Principally engaged in patient care activities.

Nonfederally employed.

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

The 1975 physician universe included 180,125 doctors of medicine and 9,696 doctors of osteopathy.

The 1975 NAMCS sample included 3,507 physicians. Sample physicians were screened at the time of the survey to assure that they met the above-mentioned criteria; 438 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 3,069 in-scope (eligible) physicians, 2,472 (80.5 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, 391 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 1975 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, the organization responsible for field operations under contract to the National Center for Health Statistics (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 Physician files maintained by the AMA and 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

Table I. Distribution of physicians in the universe (American Medical Association and American Osteopathic Association) and in the National Ambulatory Medical Care Survey sample, by physician's specialty: United States, January-December 1975

Physician's specialty	Universe	Gross total	Out of scope	Net total	Non-respondents	Respondents	Response rate
	Number of physicians						
All specialties	189,821	3,507	438	3,069	597	2,472	80.5
General and family practice	53,069	911	122	789	179	610	77.3
Medical specialties	49,801	942	121	821	165	656	79.9
Internal medicine	26,125	505	59	446	99	347	77.8
Pediatrics	12,229	239	39	200	28	172	86.0
Other medical specialties	11,447	198	23	175	38	137	78.3
Surgical specialties	65,434	1,255	89	1,166	214	952	81.6
General surgery	19,606	371	22	349	63	286	81.9
Obstetrics and gynecology	15,124	311	25	286	53	233	81.5
Other surgical specialties	30,704	573	42	531	98	433	81.5
Other specialties	21,517	399	106	293	39	254	86.7
Psychiatry	12,993	242	32	210	20	190	90.5
Other specialties	8,524	157	74	83	19	64	77.1

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 the Induction Interview form displayed in appendix III.

Data Collection and Processing

Field procedures.—Both mail and telephone contacts were used to enlist sample physicians into the NAMCS. Physicians received introductory letters from the NCHS (see appendix III) and the AMA or AOA. When appropriate, a letter from the physician's specialty organization, endorsing the survey and urging his participation, was enclosed with the NCHS letter. A few days later, a field representative telephoned the sample physician to briefly explain the study and arrange an appointment for a personal interview. An initially nonresponding physician was generally recontacted via a telephone call or special explanatory letter and requested to reconsider participation in the study.

During the personal interview, the field representative determined the sample physician's eligibility, ascertained his cooperation, delivered survey materials with verbal and printed instructions, and assigned a predetermined Monday through Sunday reporting period. A short interview concerning basic practice characteristics, such as type of practice and expected number of office visits, was administered. Office staff who were to assist with data collection were invited to attend the instruction session or were offered separate instruction sessions.

Before the beginning of and again during the week assigned for data collection, the interviewer telephoned the sample physician to answer possible questions and to insure that procedures were going smoothly. At the end of the survey week, the participating physician mailed finished survey materials to the interviewer who edited the forms for completeness before transmitting them for central data processing. Problems or missing data at this stage were resolved by interviewer telephone followup to the sample physician; if there were no problems, field procedures were complete with respect to the sample physician's participation in the NAMCS. After the end of the survey year each sample physician was sent a thank-you letter from the NCHS along with one of the survey's statistical reports.

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 (appendix III). 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.—In addition to 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.[3] 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).[4] 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.

Estimation Procedures

Statistics produced from the 1975 NAMCS 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.—Because 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 Physician files, and the denominator was based on data from the sample.

Reliability of Estimates

Since the statistics presented in this report are based on a sample, they will differ somewhat from the figures that would be obtained if a complete census had been taken using the same forms, instructions, and procedures. However, the probability design of the NAMCS permits the calculation of sampling errors. The standard error is primarily a measure of sampling variability that occurs by chance because only a sample rather than the entire population is surveyed. As calculated in this report, the standard error also reflects part of the variation that arises in the measurement process. It does not include estimates of any systematic biases that may be in the data. The chances are about 68 out of 100 that an estimate from the sample would differ from a complete census by less than the standard error. The chances are about 95 out of 100 that the difference would be less than twice the standard error and about 99 out of 100 that it would be less than 2½ times as large.

The relative standard error of an estimate is obtained by dividing the standard by the estimate itself and is expressed as a percentage of the estimate. For this report, asterisks (*) are presented along with the estimate for any estimate with more than a 30-percent relative standard error.

Estimates of sampling variability were calculated using the method of half-sample replication. This method yields overall variability through observation of variability among random subsamples of the total sample. A description of the development and evaluation of the replication technique for error estimation has been previously published.[7,8]

Approximate relative standard errors for aggregates and percentages are presented in figures I and II. In order to derive error estimates that would be applicable to a wide variety of statistics and that could be prepared at moderate cost, several approximations were required. As a result, the relative standard errors shown in figures I and II should be interpreted as approximate rather than exact for any specific estimate. Directions for determining approximate relative standard errors from the figures follow.

1. *Estimates of aggregates:* Approximate relative standard errors (in percent) for aggregate statistics, such as the number of office visits with a given characteristic, are obtained from the curve in figure I, or calculated by the formula

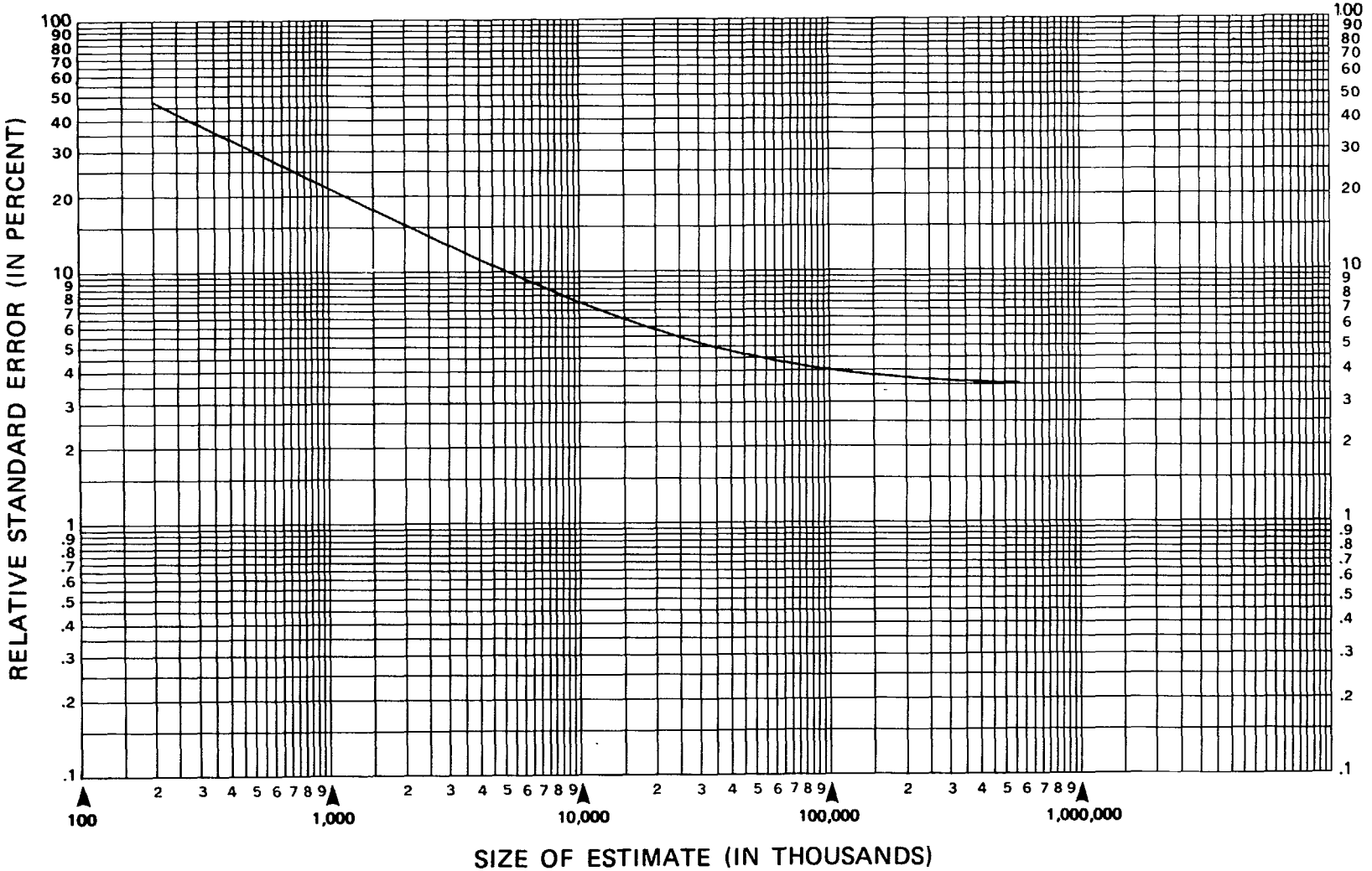
$$\text{RSE}\,(x) = \sqrt{.001160252 + \frac{44.6697}{x}} \cdot 100$$

where x is the aggregate of interest in thousands.

2. *Estimates of percentages:* Approximate relative standard errors (in percent) for estimates of this type can be calculated from the curve in figure I as follows. Obtain the relative standard error of the numerator and denominator. Square each of the relative standard errors, subtract the resulting value for the denominator from the resulting value for

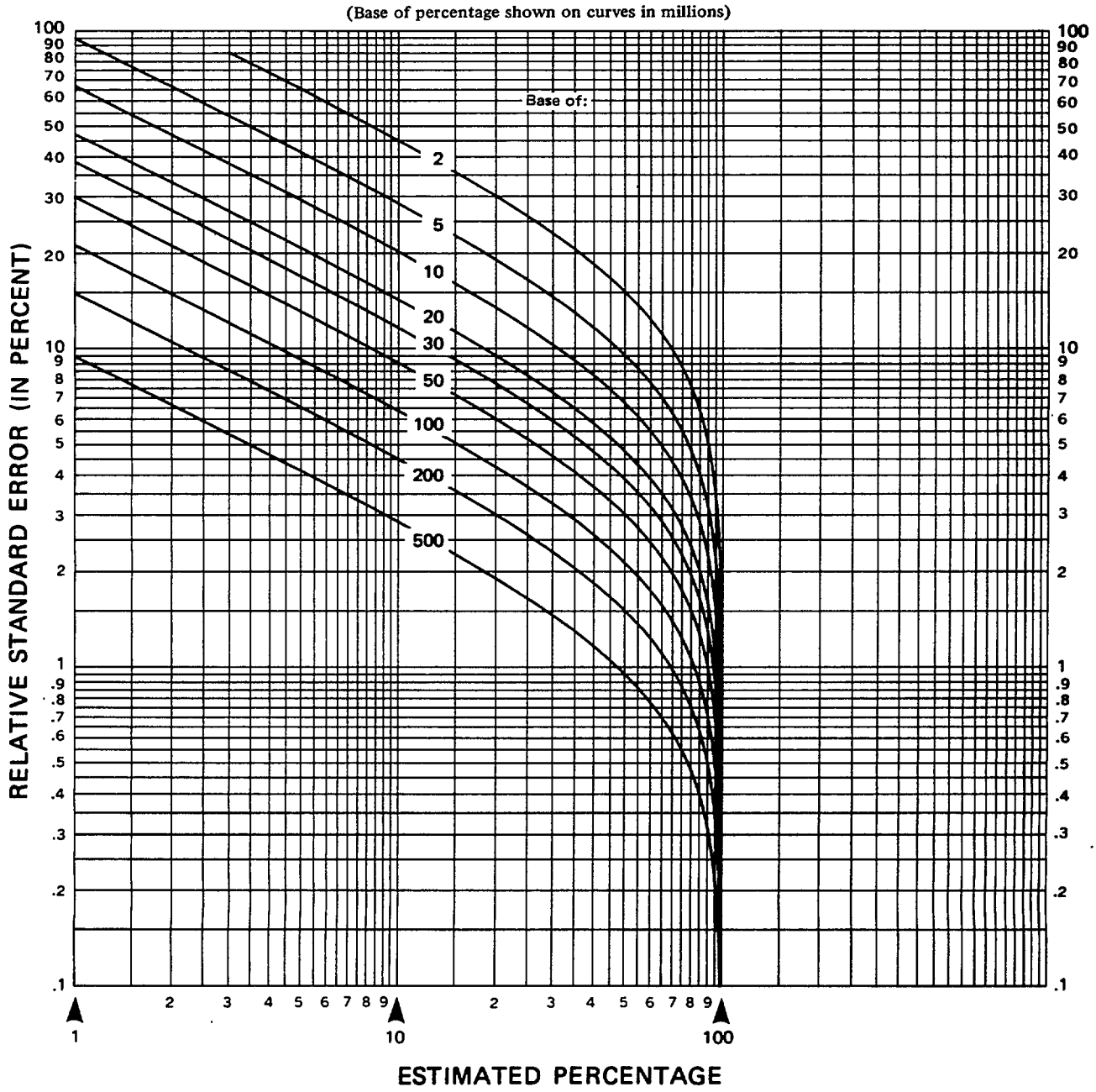
NOTE: A list of references follows the text.

Figure I. Approximate relative standard errors for estimated numbers of office visits, 1975 National Ambulatory Medical Care Survey



Example of use of this chart: An estimate of 10 million office visits (read from scale at bottom of chart) has a relative standard error of 7.5 percent (read from scale at left side of chart) or a standard error of 750,000 office visits (7.5 percent of 10 million visits).

Figure II. Approximate relative standard errors for percentages of estimated numbers of office visits, 1975 National Ambulatory Medical Care Survey



Example of use of this chart: An estimate of 20 percent (read at bottom of chart) based on an estimate of 10 million office visits has a relative standard error of 13.4 percent (read from scale at left of chart) or a standard error of 2.7 percentage points (13.4 percent of 20 percent).

the numerator, and extract the square root. This calculation has been made for several percentages and bases and is presented in figure II. Alternatively, the formula

$$\text{RSE}\ (p) = \sqrt{\frac{44.6697 \cdot (1 - p)}{p \cdot x}} \cdot 100$$

can be used to calculate RSE for any percentage (p) and base (x, in thousands).

3. *Estimates of rates where the numerator is not a subclass of the denominator:* Approximate relative standard errors for rates where the denominator is the total U.S. population or one or more of the age-sex-race groups of the total population are equivalent to the relative standard error of the numerator that can be obtained from figure I.

4. *Estimates of differences between two statistics:* The relative standard errors shown in this appendix are not directly applicable to differences between two sample estimates. The standard error of a difference is approximately the square root of the sum of the squares of each standard error considered separately. This formula will represent the standard error quite accurately for the difference between separate and uncorrelated characteristics, although it is only a rough approximation in most other cases.

In addition to sampling error, survey results are subject to reporting and processing errors and biases due to nonresponse or incomplete response. There is no way to compute the magnitude of these errors. However, these types of errors were kept to a minimum by methods built into the survey procedures. Extensive pretesting was done and careful attention was given to phrasing of the questions and the terms employed and their definitions in order to eliminate ambiguities and encourage uniformity. Steps taken to reduce nonresponse bias are discussed in the sections on field procedures and data collection. Errors in coding and processing were reduced by verification and consistency checks.

Tests of Significance

In this report, the determinaton of statistical inference is based on the t-test with a critical value of 1.96 (0.05 level of significance). Terms relating to differences, such as "higher," "less," etc., indicate that the differences were statistically significant. Terms such as "similar," "no difference,"etc., mean that no statistical significance exists between the statistics being compared. Lack of comment regarding the difference between any two statistics does not mean the difference was tested and found to be not significant.

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, 1975, 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.

Systematic Bias

There have been no attempts to determine systematic bias in the data reported here or to measure the impact of any biases. There are several factors, however, that the user of these data should understand, all of which indicate that these data underrepresent the total number of office visits to office-based physicians. These factors are:

1. The sampling universe for the 1975 NAMCS was the files of "office-based, patient-care" physicians maintained by the AMA and AOA. There are certainly physicians not so classified who, at the time of the survey, would have met the

Table II. Estimates of the civilian noninstitutionalized population of the United States,[1] by age, sex, and race, July 1, 1975

[Used in the calculation of rates]

Sex and race	Age				
	All ages	Under 2 years	2-5 years	6-14 years	15-21 years
	Numbers in thousands				
Total	80,556	5,928	12,976	33,401	28,251
Sex					
Female	39,614	2,900	6,350	16,376	13,988
Male	40,942	3,028	6,626	17,025	14,263
Race					
White	67,733	4,907	10,748	28,030	24,048
All other	12,823	1,021	2,228	5,371	4,203

[1]Excludes Alaska and Hawaii.

criteria for that classification. Visits to these physicians are not represented in these data.

2. A frequent reason for not participating in the NAMCS was given as "too busy" or "too busy right now." This is an indication that the busier physician was not as likely to participate as the less busy physician.

3. Physicians who participated in the NAMCS did a thorough and conscientious job in keeping the Patient Log; however, the probability that a patient was accidentally omitted from the survey is much greater than the probability that a patient was included who did not make a visit. This factor could also introduce a slight bias.

APPENDIX II

DEFINITIONS OF CERTAIN TERMS USED IN THIS REPORT

Terms Relating to the Survey

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 Veterans Administration, 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 (in-

cluding 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:

Region	*States included*
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 that 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 that 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.

Terms Relating to the Patient Record Form

Age.—The age calculated from date of birth was the age at last birthday on the date of visit.

Color or race.—On the Patient Record, color or race includes four categories: white, Negro/black, other, and unknown. The physician was instructed to mark the category which in his judgment was most appropriate for the patient based upon observation and/or prior knowledge of the patient. "Other" was restricted to Orientals, American Indians, and other races neither Negro nor white.

Patient's principal problem(s), complaint(s), or symptom(s) (in patient's own words).—The patient's principal problem, complaint, symptom, or reason for the visit as expressed by the patient. Physicians were instructed to record key words or phrases *verbatim* to the extent possible, listing that problem first which in the physician's judgment was most responsible for the patient's visit.

Seriousness of problem in item 5a.—This item includes four categories: very serious, serious, slightly serious, and not serious. The physician was instructed to check one of the four categories according to his own evaluation of the seriousness of the patient's problem causing this visit. Seriousness refers to physician's clinical judgment as to the extent of the patient's impairment that might result if no care were given.

Major reason(s) for this visit.—The patient's major reason(s) for the visit were classified by the physician into one or more of the following categories:

Acute problem: A condition or illness having a relatively sudden or recent onset (i.e., within 3 months of the visit).

Acute problem, followup: A return visit primarily for continued medical care of a previously treated acute problem.

Chronic problem, routine: A visit primarily to receive regular care or examination for a preexisting chronic condition or illness (onset of condition was 3 months or more before this visit).

Chronic problem, flareup: A visit primarily due to a sudden exacerbation of a preexisting chronic condition.

Prenatal care: Routine obstetrical care provided prior to delivery.

Postnatal care: Routine obstetrical care or examination provided following delivery or termination of pregnancy.

Postoperative care: A visit primarily for care required following surgical treatment. Includes changing dressing, removing sutures or cast, advising on restriction of activities or routine after surgery checkup.

Well adult/child exam: General health maintenance examinations and routine maintenance examinations and routine periodic examinations of presumably healthy persons, both children and adults. Includes annual physical examinations, well-child checkups, school, camp, and insurance examinations.

Family planning: Services or advice that enable patients to determine the number and spacing of their children. Includes both contraception and infertility services.

Counseling/advice: Information of a health nature which would enable the patient to maintain or improve his physical or mental well-being. Included would be advice regarding diet, changing habits or behavior, and general information regarding a specific problem.

Immunization: Administration of any inoculation of specific substances to produce a desired immunity; this includes oral vaccines. (Allergy shots are not included in this category, but are entered in "other.")

Referred by another physician/agency: Medical attention prompted by advice or referral for consultation or treatment from another physician, hospital, clinic, health center, school nurse, minister, pharmacist, etc. *Does not* include self-referral or referral by family or friends.

Administrative purpose: Reasons such as completing insurance forms, school forms, work permits, or discussion of patient's bill.

Other: The reason for this visit is not covered in the preceding list.

Principal diagnosis.—The physician's diagnosis of the patient's principal problem or complaint. In the event of multiple diagnoses, the physician was instructed to list them in order of decreasing importance; "principal" refers to the first-listed diagnosis. The diagnosis represents the physician's best judgment at the time of the visit and may be tentative, provisional, or definitive.

Other significant current diagnosis.—The diagnosis of any other condition known to exist for the patient at the time of the visit. Other diagnoses may or may not be related to the reason for that visit.

Treatments and services ordered or provided.—These include the following:

Limited history/exam: History and/or physical examination which is limited to a specific body site or system, or which is concerned primarily with the patient's chief complaint, for example, pelvic exam or eye exam.

General history/exam: History and/or physical examination of a comprehensive nature, including all or most body systems.

Clinical lab test: One or more laboratory procedures or tests including examination of blood, urine, sputum, smears, exudates, transudates, feces, and gastric content, and including chemistry, serology, bacteriology, and pregnancy test.

Blood pressure check: Self-explanatory.

EKG: Electrocardiogram.

Hearing test: Auditory acuity test.

Vision test: Visual acuity test.

Endoscopy: Examination of the interior of any body cavity, except ear, nose, and throat, by means of an endoscope.

Office surgery: Any surgical procedure performed in the office this visit, including

suture of wounds, reduction of fractures, application/removal of casts, incision and draining of abscesses, application of supportive materials for fractures and sprains, and all irrigations, aspirations, dilatations, and excisions.

Drug prescribed: Drugs, vitamins, hormones, ointments, suppositories, or other medications ordered or provided, except injections and immunizations.

X-ray: Any single or multiple X-ray examination for diagnostic or screening purposes. Radiation therapy is *not* included in this category.

Injection: Administration of any substance by syringe and needle subcutaneously, intravenously, or intramuscularly. This category does not include immunizations, enemas, or douches.

Immunization/desensitization: Administration of any immunizing, vaccinating, or desensitizing agent or substance by any route, for example, syringe, needle, orally, gun, or scarification.

Physiotherapy: Any form of physical therapy ordered or provided, including any treatment using heat, light, sound, or physical pressure or movement, for example, ultrasonic, ultraviolet, infrared, whirlpool, diathermy, cold therapy, and manipulative therapy.

Medical counseling: Instructions and recommendations regarding any health problem, including advice or counsel about diet, change of habit, or behavior. Physicians are instructed to check this category only if the medical counseling is a *significant* part of the treatment.

Psychotherapy/therapeutic listening: All treatments designed to produce a mental or emotional response through suggestion, persuasion, reeducation, reassurance, or support, including psychological counseling, hypnosis, psychoanalysis, and transactional therapy.

Other: Treatments or services rendered which are not listed in the preceding categories.

Disposition.—Eight categories are provided to describe the physician's disposition of the case as follows:

No followup planned: No return visit or telephone contact was scheduled for the patient's problem on this visit.

Return at specified time: The patient was told to schedule an appointment or was instructed to return at a particular time.

Return if needed, P.R.N.: No future appointment was made, but the patient was instructed to make an appointment with the physician if the patient considers it necessary.

Telephone followup planned: The patient was instructed to telephone the physician on a particular day to report on his progress, or if the need arises.

Referred to other physician/agency: The patient was instructed to consult or seek care from another physician or agency. The patient may or may not return to this physician at a later date.

Returned to referring physician: Patient was referred to this physician and was now instructed to consult again with the physician or agency which referred him.

Admit to hospital: Patient was instructed that further care or treatment will be provided in a hospital. No further office visits were expected prior to that admission.

Other: Any other disposition of the case not included in the above categories.

Duration of visit.—Time the physician spent with the patient, but does not include the time patient spent waiting to see the physician, time patient spent receiving care from someone other than the doctor without the presence of the physician, and time spent reviewing records, tests results, and so forth. In the event a patient was provided care by a member of physician's staff but did not see the physician during the visit, "duration of visit" was recorded as zero minutes.

APPENDIX III

SURVEY INSTRUMENTS

INTRODUCTORY LETTER FROM DIRECTOR, NATIONAL CENTER FOR HEALTH STATISTICS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
ROCKVILLE, MARYLAND 20852

NATIONAL CENTER FOR
HEALTH STATISTICS

Endorsing Organizations

American Medical Association
James H. Sammons, M.D.
Executive Vice President

National Medical Association
Alfred F. Fisher
Executive Director

American Academy of Dermatology
John M. Shaw, M.D.
Secretary-Treasurer

American Academy of Family Physicians
Roger Tusken
Executive Director

American Academy of Neurology
Stanley A. Nelson
Executive Director

American Academy of Orthopaedic Surgeons
Charles V. Heck, M.D.
Executive Director

American Academy of Pediatrics
Robert G. Frazier, M.D.
Executive Director

American College of Obstetricians and Gynecologists
Warren H. Pearse, M.D.
Director

American College of Physicians
Edward C. Rosenow, Jr., M.D.
Executive Vice President

American College of Preventive Medicine
Ward Bentley
Executive Director

American College of Surgeons
C. Rollins Hanlon, M.D.
Executive Director

American Osteopathic Association
Edward P. Crowell, D. O.
Executive Director

American Proctologic Society
Alejandro F. Castro, M.D.
Secretary

American Psychiatric Association
Melvin Sabshin, M.D.
Medical Director

American Society of Internal Medicine
William R. Ramsey
Executive Director

American Society of Plastic and Reconstructive Surgeons, Inc.
Dallas F. Whaley
Executive Vice President

American Urologic Association
Hal B. Jennings, Jr., M.D.
Executive Director

Association of American Medical Colleges
John A. D. Cooper, M.D., Ph.D.
President

Dear Dr.

The National Center for Health Statistics, as part of its continuing program to provide information on the health status of the American people, is conducting a National Ambulatory Medical Care Survey (NAMCS).

The purpose of this survey is to collect information about ambulatory patients, their problems, and the resources used for their care. The resulting published statistics will help your profession plan for more effective health services, determine health manpower requirements, and improve medical education.

Since practicing physicians are the only reliable source of this information, we need your assistance in the NAMCS. As one of the physicians selected in our national sample, your participation is essential to the success of the survey. Of course, all information that you provide is held in strict confidence.

Many organizations and leaders in the medical profession have expressed their support for this survey, including those shown to the left. They join me in urging your cooperation in this important research.

Within a few days, a survey representative will telephone you for an appointment to discuss the details of your participation. We greatly appreciate your cooperation.

Sincerely yours,

Dorothy P. Rice
Director

PATIENT RECORD AND PATIENT LOG

B Nº 881078

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 purposes of the survey and will not be disclosed or released to other persons or used for any other purpose.

B Nº 881078

PATIENT LOG

As each patient arrives, record name and time of visit on the log below. For the patient entered on line #2, also complete the patient record to the right.

PATIENT'S NAME	TIME OF VISIT
1	a.m. / p.m.
2	a m / p m

Record items 1-12 for this patient

CONTINUE LISTING PATIENTS ON NEXT PAGE

PATIENT RECORD
NATIONAL AMBULATORY MEDICAL CARE SURVEY

1. DATE OF VISIT Mo / Day / Yr

2. DATE OF BIRTH Mo / Day / Yr

3. SEX
1 ☐ FEMALE
2 ☐ MALE

4. COLOR OR RACE
1 ☐ WHITE
2 ☐ NEGRO/BLACK
3 ☐ OTHER
4 ☐ UNKNOWN

5. PATIENT'S PRINCIPAL PROBLEM(S) COMPLAINT(S), OR SYMPTOM(S) THIS VISIT *(In patient's own words)*
a. MOST IMPORTANT_____
b. OTHER_____

6. SERIOUSNESS OF PROBLEM IN ITEM 5a *(Check one)*
1 ☐ VERY SERIOUS
2 ☐ SERIOUS
3 ☐ SLIGHTLY SERIOUS
4 ☐ NOT SERIOUS

7. HAVE YOU EVER SEEN THIS PATIENT BEFORE?
1 ☐ YES 2 ☐ NO
If YES, for the problem indicated in ITEM 5a?
1 ☐ YES 2 ☐ NO

8. MAJOR REASON(S) FOR THIS VISIT *(Check all major reasons)*
01 ☐ ACUTE PROBLEM
02 ☐ ACUTE PROBLEM, FOLLOW-UP
03 ☐ CHRONIC PROBLEM, ROUTINE
04 ☐ CHRONIC PROBLEM, FLARE-UP
05 ☐ PRENATAL CARE
06 ☐ POSTNATAL CARE
07 ☐ POSTOPERATIVE CARE
(Operative procedure)
08 ☐ WELL ADULT/CHILD EXAM
09 ☐ FAMILY PLANNING
10 ☐ COUNSELING/ADVICE
11 ☐ IMMUNIZATION
12 ☐ REFERRED BY OTHER PHYS/AGENCY
13 ☐ ADMINISTRATIVE PURPOSE
14 ☐ OTHER (*Specify*)

9. PHYSICIAN'S PRINCIPAL DIAGNOSIS THIS VISIT
a. DIAGNOSIS ASSOCIATED WITH ITEM 5a ENTRY
b. OTHER SIGNIFICANT CURRENT DIAGNOSES *(In order of importance)*

10. DIAGNOSTIC/THERAPEUTIC SERVICES ORDERED/PROVIDED THIS VISIT *(Check all that apply)*
01 ☐ NONE
02 ☐ LIMITED HISTORY/EXAM
03 ☐ GENERAL HISTORY/EXAM
04 ☐ CLINICAL LAB. TEST
05 ☐ BLOOD PRESSURE CHECK
06 ☐ EKG
07 ☐ HEARING TEST
08 ☐ VISION TEST
09 ☐ ENDOSCOPY
10 ☐ OFFICE SURGERY
11 ☐ DRUG PRESCRIBED OR DISPENSED
12 ☐ X-RAY
13 ☐ INJECTION
14 ☐ IMMUNIZATION/DESENSITIZATION
15 ☐ PHYSIOTHERAPY
16 ☐ MEDICAL COUNSELING
17 ☐ PSYCHOTHERAPY/THERAPEUTIC LISTENING
18 ☐ OTHER (Specify)_____

11. DISPOSITION THIS VISIT *(Check all that apply)*
1 ☐ NO FOLLOW-UP PLANNED
2 ☐ RETURN AT SPECIFIED TIME
3 ☐ RETURN IF NEEDED, P.R.N.
4 ☐ TELEPHONE FOLLOW-UP PLANNED
5 ☐ REFERRED TO OTHER PHYSICIAN/AGENCY
6 ☐ RETURNED TO REFERRING PHYSICIAN
7 ☐ ADMIT TO HOSPITAL
8 ☐ OTHER (*Specify*)_____

12. DURATION OF THIS VISIT *(Time actually spent with physician)*
_____MINUTES

HRA-34-3
REV. 2-76

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

O.M.B. #68-R1498

INDUCTION INTERVIEW FORM

CONFIDENTIAL*
NORC-4211

Form Approved.
OMB No. 068-S72106
Expires: June 30, 1976

NATIONAL AMBULATORY MEDICAL CARE SURVEY

TIME BEGAN: _____ AM PM

INDUCTION INTERVIEW

(Phys. ID Number)

BEFORE STARTING INTERVIEW

1. ENTER PHYSICIAN I.D. NUMBER IN BOX TO RIGHT, ABOVE

2. ENTER DATES OF ASSIGNED REPORTING WEEK IN Q. 2, P.2

Doctor, before I begin, let me take a minute to give you a little background about this survey.

Although ambulatory medical care accounts for nearly 90 per cent of all medical care received in the United States, there is no systematic information about the characteristics and problems of people who consult physicians in their offices. This kind of information has been badly needed by medical educators and others concerned with the medical manpower situation.

In response to increasing demands for this kind of information, the National Center for Health Statistics, in close consultation with representatives of the medical profession, has developed the National Ambulatory Medical Care Survey.

Your own task in the survey is simple, carefully designed, and should not take much of your time. Essentially, it consists of your participation during a specified 7-day period. During this period, you simply check off a minimal amount of information concerning some of the patients you see.

Now, before we get into the actual procedures, I have a few questions to ask about your practice. The answers you give me will be used only for classification and analysis, and of course all information you provide is held in strict confidence.*

1. First, you are a _____. Is that right?
(ENTER SPECIALTY FROM CODE ON FACE SHEET LABEL.)

Yes 1
No . (ASK A) . . 2

A. IF NO: What is your specialty, (including general practice)?

_____
(Name of Specialty)

*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.

2. Now, doctor, this study will be concerned with the ambulatory patients you will see in your office during the week of (READ REPORTING DATES ENTERED BELOW.)

_____/_____ (that's a Monday) through _____/_____ (that's a Sunday)
month date month date

Are you likely to see any ambulatory patients in your office during that week?

Yes . . . (GO TO Q. 3) . . . 1

No . . . . . (ASK A) . . . 2

A. IF NO: Why is that? RECORD VERBATIM, THEN READ PARAGRAPH BELOW

Since it's very important, doctor, that we include any ambulatory patients that you do happen to see in your office during that week, I'd like to leave these forms with you anyway--just in case your plans change. I'll plan to check back with your office just before (STARTING DATE) to make sure, and I can explain them in detail then, if necessary.

GIVE DOCTOR THE A PATIENT RECORD FORMS AND GO TO Q. 9, P. 6.

3. A. At what office location will you be seeing ambulatory patients during that 7-day period? RECORD UNDER A BELOW AND ASK B WHEN INDICATED.

B. IF HOSPITAL EMERGENCY ROOM OR HOSPITAL OUTPATIENT DEPARTMENT, OR OTHER INSTITUTIONAL LOCATION IN A: Thinking about the ambulatory patients you see in (PLACE IN A), do you, yourself, have principal responsibility for their care over time, or does (INSTITUTION IN A) have primary responsibility for their care over time? CODE UNDER B BELOW.

C. Is that all of the office locations at which you expect to see ambulatory patients during that week?

Yes 1
No 2

IF NO: OBTAIN ADDITIONAL OFFICE LOCATION(S), ENTER IN "A" BELOW, AND REPEAT.

A. Office Location	B. Principal Responsibility?		D. In Scope?	
	Physician	Institution	Yes	No
(1) _____	1	2	1	2
(2) _____	1	2	1	2
(3) _____	1	2	1	2
(4) _____	1	2	1	2

D. FOR EACH OFFICE LOCATION ENTERED IN A, CODE YES OR NO TO "IN SCOPE" ABOVE.

IN SCOPE (Yes)	OUT OF SCOPE (No)
Private offices	Hospital emergency rooms
Free-standing clinics (non-hospital based)	Hospital outpatient departments
Groups, partnerships	College or university infirmaries
Kaiser, HIP, Mayo Clinic	Industrial outpatient facilities
Neighborhood Health Centers	Family planning clinics
Privately operated clinics (except family planning)	Government-operated clinics (VD, maternal & child health, etc.)

IN CASE OF DOUBT, ASK: Is that (clinic/facility/institution) hospital based?

Is that (clinic/facility/institution) government operated?

IF ALL LOCATIONS ARE OUT OF SCOPE, THANK THE DOCTOR AND LEAVE.

PATIENT RECORDS MUST BE COLLECTED FROM ALL IN-SCOPE LOCATIONS REGARDLESS OF ANSWER TO B -- PRINCIPAL RESPONSIBILITY.

4. A. During that week (REPEAT DATES), how many ambulatory patients do you expect to see in your office practice? (DO NOT COUNT PATIENTS SEEN AT [OUT-OF-SCOPE LOCATIONS] CODED IN 3-B.)

ENTER TOTAL UNDER "A" BELOW AND CIRCLE ON APPROPRIATE LINE.

B. And during those seven days (REPEAT DATES IF NECESSARY), on how many days do you expect to see any ambulatory patients? COUNT EACH DAY IN WHICH DOCTOR EXPECTS TO SEE ANY PATIENTS AT AN IN-SCOPE OFFICE LOCATION.

ENTER TOTAL UNDER "B" BELOW AND CIRCLE NUMBER IN APPROPRIATE COLUMN.

DETERMINE PROPER PATIENT LOG FORM FROM CHART BELOW. READ ACROSS ON "TOTAL PATIENTS" LINE UNDER "A" AND CIRCLE LETTER IN APPROPRIATE "DAYS" COLUMN UNDER "B."

THIS LETTER TELLS YOU WHICH OF THE FOUR PATIENT LOG FORMS (A, B, C, D) SHOULD BE USED BY THIS DOCTOR.

LOG FORM DESCRIPTION	A. Expected total patients during survey week. ENTER TOTAL FROM Q. 4-A. _____	B. Total days in practice during week. ENTER TOTAL FROM Q. 4-B. _____ DAYS						
		1	2	3	4	5	6	7
A--Patient Record is to be completed for ALL patients listed on Log.	1- 12 PATIENTS	A	A	A	A	A	A	A
	13- 25 "	B	A	A	A	A	A	A
B--Patient Record is to be completed for every SECOND patient listed on Log.	26- 39 "	C	B	A	A	A	A	A
	40- 52 "	C	B	B	A	A	A	A
	53- 65 "	D	C	B	B	A	A	A
	66- 79 "	D	C	B	B	B	A	A
C--Patient Record is to be completed for every THIRD patient listed on Log.	80- 92 "	D	D	C	B	B	B	B
	93-105 "	D	D	C	B	B	B	B
	106-118 "	D	D	C	C	B	B	B
	119-131 "	D	D	C	C	B	B	B
	132-145 "	D	D	D	C	C	B	B
*D--Patient Record is to be completed for every FIFTH patient listed on Log.	146-158 "	D	D	D	C	C	B	B
	159-171 "	D	D	D	C	C	C	C
	172-184 "	D	D	D	C	C	C	C
	185-197 "	D	D	D	D	D	D	D
	198-210 "	D	D	D	D	D	D	D
	211+ "	D	D	D	D	D	D	D

*In the rare instance the physician will see more than 500 patients during his assigned reporting week, give him two D Patient Log Folios and instruct him to complete a patient record form for only every tenth patient. Then you are to draw an X or line on line 5 on every other page of the two folio pads, starting with page 1 of the pad.

5. FIND PATIENT LOG FOLIO WITH APPROPRIATE LETTER AND ENTER LETTER AND NUMBER OF THIS FORM HERE.

_____
(Folio Number)

6. HAND DOCTOR HIS FOLIO AND EXPLAIN HOW FORMS ARE TO BE FILLED OUT. SHOW DOCTOR THE INSTRUCTIONS ON POCKET OF FOLIO AND ITEM 10 DEFINITIONS ON CARD IN FOLIO, TO WHICH HE CAN REFER AFTER YOU LEAVE.

RECORD VERBATIM BELOW ANY CONCERN, PROBLEMS OR QUESTIONS THE DOCTOR RAISES.

7. IF DOCTOR EXPECTS TO SEE AMBULATORY PATIENTS AT MORE THAN ONE IN-SCOPE LOCATION DURING ASSIGNED WEEK, TELL HIM YOU WILL DELIVER THE FORMS TO THE OTHER LOCATION(S). ENTER THE FORM LETTER AND NUMBER(S) FOR THOSE LOCATIONS BELOW, BEFORE DELIVERING FORM(S).

Location	Patient Record Form Letter & Number

8. During the survey week (REPEAT EXACT DATES), will anyone be available to help you in filling out these records (at each IN-SCOPE location)?

Yes . . . (ASK A) . . 1
No 2

A. IF YES: Who would that be?

RECORD NAME, POSITION AND LOCATION.

NAME	POSITION	LOCATION	B. *INTERVIEWER: WAS PERSON BRIEFED BY YOU? Yes	No
			1	2
			1	2
			1	2
			1	2

*INTERVIEWER SHOULD BRIEF SUCH PERSON IF POSSIBLE.

9. Do you have a solo practice, or are you associated with other physicians in a partnership, in a group practice, or in some other way?

Solo 1
Partnership . . . (ASK A-C). 2
Group . . . . . (ASK A-C). 3
_____ <--- Other (SPECIFY AND ASK A-C). 4

IF PARTNERSHIP, GROUP, OR OTHER:

A. Is this a prepaid group practice? Yes . (ASK [1]) . .. 1
No 2

[1] IF YES TO A: What per cent of patients are prepaid? _____ per cent

B. How many other physicians are associated with you? NUMBER OF PHYSICIANS: _____

C. What are the specialties of the other physicians associated with you?

	Specialty	Number of Physicians
(1)	_____	_____
(2)	_____	_____
(3)	_____	_____
(4)	_____	_____
(5)	_____	_____

10. Now I have just one more question about your practice. (NOTE: IF DOCTOR PRACTICES IN LARGE GROUP, THE FOLLOWING INFORMATION CAN BE OBTAINED FROM SOMEONE ELSE.)

A. What is the total number of full-time (35 hours or more per week) employees of your (partnership/group) practice? Include persons regularly employed who are now on vacation, temporarily ill, etc. Do not include other physicians. RECORD ON TOP LINE OF COLUMN A BELOW.
(1) How many of these full-time employees are a ... (READ CATEGORIES BELOW AS NECESSARY AND RECORD NUMBER OF EACH IN COLUMN A.)

B. And what is the total number of part-time (less than 35 hours per week) employees of your (partnership/group) practice? Again, include persons regularly employed who are now on vacation, ill, etc. Do not include other physicians. RECORD ON TOP LINE OF COLUMN B BELOW.)
(1) How many of these part-time employees are a ... (READ CATEGORIES BELOW AS NECESSARY AND RECORD NUMBER OF EACH IN COLUMN B.)

Employees	A. Full-time (35 or more hours/week)	B. Part-time (Less than 35 hours/week)
	TOTAL: _____	TOTAL: _____
(1) Registered Nurse	_____	_____
(2) Licensed Practical Nurse	_____	_____
(3) Nursing Aide	_____	_____
(4) Physician Assistant*	_____	_____
(5) Technician	_____	_____
(6) Secretary or Receptionist	_____	_____
(7) Other (SPECIFY) _____	_____	_____

*Physician Assistant must be a graduate of an accredited training program for Physician Assistants (Physician Extenders, Medex, etc.) or certified by the National Board of Medical Examiners through the Certification Exam for Assistant to the Primary Care Physician.

11. During the past seven (7) days, about how many house calls did you make?

NUMBER OF HOUSE CALLS: _____

12. During the past seven (7) days, how many times did you provide to patients advice or consultation by telephone?

None 1
1-9 2
10-24 3
25-49 4
50 or more 5

BEFORE YOU LEAVE, STRESS THAT EACH AMBULATORY PATIENT SEEN BY THE DOCTOR DURING THE 7-DAY PERIOD AT ALL IN-SCOPE OFFICE LOCATIONS (REPEAT THEM) IS TO BE INCLUDED IN THE SURVEY, THAT EACH PATIENT IS TO BE RECORDED ON THE LOG, AND ONLY THE APPROPRIATE NUMBER OF PATIENT RECORDS COMPLETED.

Thank you for your time, Dr. _____. If you have any (more) questions, please feel free to call me. My phone number is written in the folio. I'll call you on Monday morning of your survey week just to remind you.

13. TIME INTERVIEW ENDED . . . . . _____ AM / PM

14. DATE OF INTERVIEW . . . . . | | | | | | | |
(Month) (Day) (Year)

COMPLETE ITEMS I AND II ON THE LAST PAGE IMMEDIATELY AFTER THE INTERVIEW.

I. How much interest do you think the doctor has in the survey?

- Great interest 1
- Some interest 2
- Little interest 3
- No interest 4
- Can't tell 5

II. How confident are you that the doctor will complete the forms?

- Definitely will 1
- Probably will 2
- Doubtful 3

INTERVIEWER NUMBER

INTERVIEWER'S SIGNATURE

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