NAMCS MICRO-DATA TAPE DOCUMENTATION

1973

ABSTRACT

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

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I.   DESCRIPTION OF THE NATIONAL AMBULATORY MEDICAL CARE SURVEY

INTRODUCTION.--These Micro-Data Tapes comprise the data collected by the National Ambulatory Medical Care Survey (NAMCS) in 1973, conducted by the National Center for Health Statistics (NCHS). The National Ambulatory Medical Care Survey provides continuous data from samples of patient records selected from a national sample of office-based physicians. These national estimates describe the utilization of ambulatory medical care services in the coterminous United States. In 1973 there were approximately 29,000 patient records sampled from the 1,103 doctors that participated in the survey. For a description of the survey design and data collection procedures, see below. For a more detailed description of the survey design, data collection procedures, and the estimation process see reference 1.

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

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

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

SCOPE OF THE SURVEY.--The basic sampling unit for the NAMCS is the physician-patient encounter or visit. Only visits in the offices of nonfederally employed physicians classified by the American Medical Association (AMA) or the American Osteopathic Association (AOA) as "office-based, patient care" were included in the 1973 NAMCS. In addition, physicians in the specialties of anesthesiology,

pathology, and radiology were excluded from the physician universe. Major
types of ambulatory encounters not included in the 1973 NAMCS were those made
by telephone, those made outside of the physician's office, and those made in
hospital or institutional settings. It is planned to extend the NAMCS to
include these encounters in the future, though some complex methodological and
sampling problems must be resolved first.

SAMPLING FRAME AND SIZE OF SAMPLE. The sampling frame for the NAMCS is
composed of all physicians contained in the master files maintained by the
AMA and AOA as of December 31, 1972, who met the following criteria:

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

Principally engaged in patient care activities;

Nonfederally employed;

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

The 1973 NAMCS sample included 1,695 physicians: 1,629 MD's and 66
doctors of osteopathy. Sample physicians were screened at the time of the
survey to assure that they met the above-mentioned criteria; 254 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 1,441 in-scope (eligible) physicians,
1,103 (76.5 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, 146 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 1973 NAMCS utilized a multistage probability design
that involved probability samples of primary sampling units (PSU's), physician
practices within PSU's, and patient visits within practices. The first-stage
sample of 87 PSU's was selected by the National Opinion Research Center (NORC),
the organization responsible for field operations under contract to the NCHS.
A PSU is a county, a group of adjacent counties, or a standard metropolitan
statistical area (SMSA). A modified probability proportional-to-size procedure
using separate sampling frames for SMSA's and for nonmetropolitan counties was
employed. After sorting and stratifying by size, region, and demographic
characteristics, each frame was divided into sequential zones of 1 million
residents, and a random number was drawn to determine which PSU came into the
sample from each zone.

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

The final stage was the selection of patient visits within the annual
practices of sample physicians. This involved two steps. First, the total
physician sample was divided into 52 random subsamples of approximately equal
size, and each subsample was randomly assigned to 1 of the 52 weeks in the
survey year. Second, a systematic random sample of visits was selected by
the physician during the assigned week. The sampling rate varied for this
final step from a 100-percent sample for very small practices to a 20-percent
sample for very large practices as determined in a presurvey interview. The
method by which the sampling rate was determined is described in reference 12.

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

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

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

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

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

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

Population Figures.--The base population used in computing annual visit rates is presented in table II. These figures are based on provisional estimates for the civilian noninstitutionalized population as of July 1, 1973, provided by the U.S. Bureau of the Census. Because the NAMCS includes data for only the coterminous United States, the original census estimates were modified to account for the exclusion of Alaska and Hawaii from the study. For this reason the population estimates should not be considered as official population estimates and are presented here solely for the purpose of providing denominators for rate computations.

Estimation Procedures.--Statistics produced from the 1973 National Ambulatory Medical Care Survey were derived by a multistage estimating procedure. The procedure produces essentially unbiased national estimates and has basically three components: (1) inflation by reciprocals of the probabilities of selection, (2) adjustment for nonresponse, and (3) a ratio adjustment to fixed totals. Each of these components is described briefly below.

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

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

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

Sampling Errors.--Procedures for calculating sampling errors as well as estimates of standard errors of statistics derived from the NAMCS are described in Appendix I of reference 4.

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

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

References

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

1.--National Center for Health Statistics: National Ambulatory Medical Care Survey: Background and Methodology, United States. VITAL AND HEALTH STATISTICS. Series 2-No. 61. DHEW Pub. No. (HRA) 74-1335. Health Resources Administration. Washington. U.S. Government Printing Office. March 1974.

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

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

4.--National Center for Health Statistics: The National Ambulatory Medical Care Survey: 1973 Summary, United States, May 1973-April 1974. VITAL AND HEALTH STATISTICS. Series 13, No. 21. DHEW Pub. No. (HRA) 76-1772. Public Health Service. Washington. U.S. Government Printing Office, October 1975.

5.--National Center for Health Statistics: National Ambulatory Medical Care Survey: May 1973-April 1974. Monthly Vital Statistics Report, Vol. 24, No. 4. DHEW Pub. No. (HRA) 76-1120. Public Health Service. Rockville, Maryland. July 14, 1975.

6.--Induction Interview Form. National Ambulatory Medical Care Survey. National Opinion Research Center. University of Chicago. OMB No. 068-S72106.

II.   Technical Description of Tapes

     Date Set Name: NAMC1973

     Number of Reels: 1

     Number of Recording Tracks: 9

     Density (bpi):   1600

     Language: EBEDIC

     Parity: ODD

     Record Length: ~~92~~ 85

     Blocksize: ~~4,600~~ 3400

     Number of Records: 29,102

III.   TAPE RECORD FORMAT

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

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

Item No.	Field Length	Tape Location	Item Description and Codes	
8	14	25-38	Major reason for this visit	
	1	25	Acute problem	(1=yes and 2=no)
	1	26	Acute problem, follow-up	"
	1	27	Chronic problem, routine	"
	1	28	Chronic problem, flare-up	"
	1	29	Prenatal care	"
	1	30	Postnatal care	"
	1	31	Postoperative care	"
	1	32	Well adult/child exam	"
	1	33	Family planning	"
	1	34	Counseling or advice	"
	1	35	Immunization	"
	1	36	Referral	"
	1	37	Administrative	"
	1	38	Other	"
9	12	39-50	Physician's principal diagnosis (see reference 3 for codes	
9.1	4	39-42	First diagnosis associated with item 5A	
9.2	4	43-46	Second diagnosis associated with item 5A	
9.3	4	47-50	Other significant current diagnoses	
10	11	51-61	Treatment/Service ordered or provided	
10.1	1	51	None ordered	(1=yes and 2=no)
10.2	1	52	History/Exam	"
10.3	1	53	Lab Procedure/Test	"
10.4	1	54	X-rays	"
10.5	1	55	Injection or Immunization	"
10.6	1	56	Office Surgery	"
10.7	1	57	Prescription Drug	"
10.8	1	58	Nonprescription Drug	"
10.9	1	59	Psychotherapy or Therapeutic Listening	"
10.10	1	60	Counseling or Advice	"
10.11	1	61	Other	"

Item No.	Field Length	Tape Location	Item Description and Codes	
11	8	62-69	Disposition of visit	
11.1	1	62	No follow-up planned	(1=yes and 2=no)
11.2	1	63	Return at specified time	"
11.3	1	64	Return if needed	"
11.4	1	65	Telephone follow-up	"
11.5	1	66	Referral	"
11.6	1	67	Return to referring physician	"
11.7	1	68	Admit to hospital	"
11.8	1	69	Other	"
12	1	70	Duration of visit 1=0 minutes 2=1-5 minutes 3=6-10 minutes 4=11-15 minutes 5=16-30 minutes 6=31-60 minutes 7=60+ minutes	
13	10	71-80	Patient Weight A right justified, alphanumeric integer developed by the NAMCS staff for the purpose of producing national estimates from sample estimates. See section on "Estimation Procedures" on page 47 of reference 4, and also notes on page 6 of these documentation.	
14	1	81	Geographic Region (Based on actual location of physician's practice. 1=Northeast 2=North Central 3=South 4=West	
15	2	82-83	Metropolitan/Nonmetropolitan (Based on actual location in conjunction with the Bureau of the Census definition.) 01=Standard Metropolitan Statistical Area (SMSA) 02=Non-SMSA	

Item No.	Field Length	Tape Location	Item Description and Codes
16	1	84	Physician Specialty Group (Derived from Induction Interview—see reference 6.)

       1-General/Family Practice

        MEDICAL SPECIALTIES

       2-Internal Medicine
       3-Pediatrics
       4-Other

        SURGICAL SPECIALTIES

       5-General Surgery
       6-Obstetrics and Gynecology
       7-Other

        OTHER SPECIALTIES

       8-Psychiatry
       9-Other

Item No.	Field Length	Tape Location	Item Description and Codes
17		85	Type of practice (Derived from Induction Interview—see reference 6.)

       1-Solo
       2-Partnership
       3-Group
       4-Other

APPENDIX

Definitions of Certain Terms Used in this Document.

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

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

Physician.--Can be classified as either:

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

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

   physicians in military service

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

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

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

Patients.--Can be classified as either:

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

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

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

patients who telephone and receive advice from the physician

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

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

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

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

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

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 which constitute the central city and identify the county in which it is located as the central county; second, economic and social relationships with "contiguous" counties which are metropolitan in character, so that the periphery of the specific metropolitan area may be determined. SMSA's may cross State lines. In New England SMSA's consist of cities and towns, rather than counties.

Table I. Distribution of physicians in the universe (AMA and AOA) and in the 1973 National
          Ambulatory Medical Care Survey sample by physician specialty, United States,
          May 1973-April 1974

Physician specialty	Universe	Gross total	Out of Scope	Net Total	Non-Response	Response	Response Rate
All specialties	184,386	1695	254	1441	338	1103	76.5
General and family practice	55,530	507	82	425	114	311	73.2
Medical specialties	47,036	439	68	371	82	289	77.9
Internal medicine	24,817	223	30	193	48	145	75.1
Pediatrics	11,634	103	23	80	15	65	81.3
Other	10,585	113	15	98	19	79	80.6
Surgical specialties	63,498	579	61	518	125	393	75.9
General surgery	19,406	178	15	163	42	121	74.2
Obstetrics and gynecology	14,672	140	15	125	32	93	74.4
Other	29,420	261	31	230	51	179	77.8
Other specialties	18,322	170	43	127	17	110	86.6
Psychiatry	12,243	106	16	90	44	76	84.4
Other	6,079	64	27	37	3	34	91.9

Table II. Estimates of the civilian noninstitutional population of
the United States by geographic region, metropolitan
and nonmetropolitan area, and sex and age,
as of November 1, 1973

Geographic region, metropolitan and nonmetropolitan area, and sex	Age					
	All ages	Under 15 years	15-24 years	25-44 years	45-64 years	65 years and over
	Number in thousands					
All regions	206,422	55,347	37,643	50,407	42,631	20,395
Northeast	48,862	12,521	8,395	11,866	10,949	5,131
North central	56,658	15,480	10,414	13,566	11,516	5,682
South	64,926	17,718	12,095	15,790	12,949	6,374
West	35,977	9,628	6,738	9,186	7,217	3,209
Metropolitan area	141,620	37,814	25,891	35,687	29,194	13,085
Male	67,976	19,254	12,515	17,187	13,774	5,266
Female	73,650	18,560	13,379	18,501	15,421	7,823
Nonmetropolitan area . . .	64,803	17,533	11,751	14,720	13,438	7,310
Male	31,570	8,934	5,870	7,138	6,427	3,160
Female	33,227	3,579	5,878	7,581	7,009	4,146

TABLE III. ` Estimates of the civilian noninstitutional
population of the United States by age,
color and sex, as of November 1, 1973

Color and sex	Age					
	All ages	Under 15 years	15-24 years	25-44 years	45-64 years	65 years and over
All colors . . .	206,422	55,347	37,643	50,407	42,631	20,395
Male	99,546	28,208	18,385	24,326	20,201	8,426
Female	106,877	27,139	19,257	26,081	22,430	11,969
White	180,222	46,592	32,357	44,260	38,402	18,591
Male	87,224	23,815	15,886	21,598	18,278	7,647
Female	92,998	22,776	16,472	22,662	20,124	10,943
All other	26,201	8,755	5,285	6,127	4,229	1,804
Male	12,322	4,393	2,500	2,728	1,923	778
Female	13,879	4,362	2,786	3,399	2,306	1,026

D650459

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. TREATMENT/SERVICE ORDERED OR PROVIDED THIS VISIT *(Check all that apply)*

01 ☐ NONE ORDERED/PROVIDED

02 ☐ GENERAL HISTORY/EXAM

03 ☐ LAB PROCEDURE/TEST

04 ☐ X-RAYS

05 ☐ INJECTION/IMMUNIZATION

06 ☐ OFFICE SURGICAL TREATMENT

(Specify)_____

07 ☐ PRESCRIPTION DRUG

08 ☐ NON-PRESCRIPTION DRUG

09 ☐ PSYCHOTHERAPY/THERAPETUIC LISTENING

10 ☐ MEDICAL COUNSELING/ADVICE

11 ☐ 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

HSM 686 5
REV. 4-73

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

O.M.B. #68 S72106
EXPIRATION DATE 6/30/75

1973 NAMCS USER QUESTIONNAIRE

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

Name: _____

Title: _____

Organization: _____

Address: _____

_____

Date of tape purchase: _____

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

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

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

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

4. What output was produced using the tape?

5. How was this output used?

6. How was the overall quality of the documentation?

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

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

9. Do you have any other comments or complaints?

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

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