

SAMPLE

NATIONAL AMBULATORY MEDICAL CARE SURVEY 2013 LOOKBACK MODULE

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LOOKBACK MODULE

Collect the following data for each prior visit in the previous 12 months.
Collect up to 10 prior visits, starting with the oldest. (Exclude telephone calls, emails and faxes).

VISITS

Month	Day	Year	Does the patient now have — <i>Mark (X) all that apply.</i> 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> Cerebrovascular disease/ History of stroke or transient ischemic attack (TIA) 3 <input type="checkbox"/> Congestive heart failure (CHF) 4 <input type="checkbox"/> Diabetes 5 <input type="checkbox"/> Hypertension 6 <input type="checkbox"/> Hyperlipidemia 7 <input type="checkbox"/> Ischemic heart disease	Does the patient have a family history of premature coronary heart disease (CHD), coronary artery disease (CAD), or ischemic heart disease (IHD), in a father, son, or brother less than age 55? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown Does the patient have a family history of premature coronary heart disease (CHD), coronary artery disease (CAD), or ischemic heart disease (IHD), in a mother, daughter, or sister less than age 65? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown
		201		
Was the patient pregnant at the time of visit? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
Smoke cigarettes? 1 <input type="checkbox"/> Not current 2 <input type="checkbox"/> Current 3 <input type="checkbox"/> Unknown				

Height	Weight	Blood pressure
ft in OR cm	lb oz OR kg gm	Systolic / Diastolic

Blood tests – Enter all blood tests ORDERED or PROVIDED at this visit. – Mark (X) all that apply. 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> Lipids/Cholesterol 3 <input type="checkbox"/> HbA1c (Glycohemoglobin) 4 <input type="checkbox"/> Fasting blood glucose (FBG) 5 <input type="checkbox"/> BUN/Creatinine 6 <input type="checkbox"/> Potassium 7 <input type="checkbox"/> Sodium 8 <input type="checkbox"/> AST/ALT 9 <input type="checkbox"/> Basic metabolic panel 10 <input type="checkbox"/> Comprehensive metabolic panel (CMP)	Health education/Counseling – Enter all health education or counseling ORDERED or PROVIDED at this visit. Mark (X) all that apply. 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> Diet/Nutrition-Reduce fat/cholesterol 3 <input type="checkbox"/> Diet/Nutrition-Reduce salt/sodium 4 <input type="checkbox"/> Weight or caloric reduction 5 <input type="checkbox"/> Exercise 6 <input type="checkbox"/> Smoking cessation	Assessment and plan – Mark (X) all that apply. 1 <input type="checkbox"/> NONE 2 <input type="checkbox"/> Blood pressure assessment and plan 3 <input type="checkbox"/> Cholesterol assessment and plan 4 <input type="checkbox"/> Blood glucose assessment and plan 5 <input type="checkbox"/> Referral
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Assessment and plan – Blood pressure 1 <input type="checkbox"/> Controlled 2 <input type="checkbox"/> Elevated or uncontrolled 3 <input type="checkbox"/> Medication being titrated 4 <input type="checkbox"/> Ambulatory/home blood pressure monitoring normal 5 <input type="checkbox"/> Patient nonadherence	Assessment and plan – Cholesterol 1 <input type="checkbox"/> Controlled 2 <input type="checkbox"/> Elevated or uncontrolled 3 <input type="checkbox"/> Medication being titrated 4 <input type="checkbox"/> Patient nonadherence	Assessment and plan – Blood glucose 1 <input type="checkbox"/> Controlled 2 <input type="checkbox"/> Elevated or uncontrolled 3 <input type="checkbox"/> Medication being titrated 4 <input type="checkbox"/> Patient nonadherence	Assessment and plan – Referral <i>Mark (X) all that apply.</i> 1 <input type="checkbox"/> Nurse management 2 <input type="checkbox"/> Nutritionist 3 <input type="checkbox"/> Smoking-cessation program 4 <input type="checkbox"/> Weight loss program 5 <input type="checkbox"/> Other physician, including primary care provider
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Is patient allergic to any medications? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No or no known allergies 3 <input type="checkbox"/> Unknown	Has the patient had any adverse reactions to any medications e.g., bleeding from aspirin? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No or no known adverse reactions 3 <input type="checkbox"/> Unknown
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Enter medication(s) patient is allergic to (Up to 8) _____ _____ _____ _____ _____ _____	Enter medication(s) patient had adverse reactions(s) to (Up to 8) _____ _____ _____ _____ _____ _____
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Enter drugs that were ordered, supplied, administered or continued during this visit. Include Rx and OTC drugs, immunizations, allergy shots, oxygen, anesthetics, chemotherapy, and dietary supplements (Up to 30).

	New	Continued	Same dose	Dose increased	Dose decreased
(1)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
(30)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

TEST RESULTS

Was blood for the following laboratory tests drawn on the day of the sampled visit or during the 15 months prior to the visit? Collect up to 50 results for each type of test, starting with the oldest.

Item no.	Type of Test	Test Results	Date of test (mm/dd/yyyy)	Test Results	Date of test (mm/dd/yyyy)	Test Results	Date of test (mm/dd/yyyy)
1	Total Cholesterol 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
2	High density lipoprotein (HDL) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
3	Low density lipoprotein (LDL) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
4	Triglycerides (TGs) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
5	HbA1c (Glycohemoglobin) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	%	/ /	%	/ /	%	/ /
		%	/ /	%	/ /	%	/ /
		%	/ /	%	/ /	%	/ /
		%	/ /	%	/ /	%	/ /
		%	/ /	%	/ /	%	/ /
6	Fasting blood glucose (FBG) 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
7	Serum creatinine 1 <input type="checkbox"/> Yes → 2 <input type="checkbox"/> None found	mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /
		mg/dL	/ /	mg/dL	/ /	mg/dL	/ /