NATIONAL AMBULATORY MEDICAL CARE SURVEY
LIST OF DATA ITEMS, 1973-2002

For survey years 1973-91, there are two public use files--one for patient visit data where each record contains information on a sampled patient visit and a second for drug mention data where each record represents a single drug mention along with its associated visit data. The second file is limited to those visits with mention of medication therapy. For the 1991 data, it is possible to link information on the drug file with information on the patient visit file. Beginning with the 1992 survey year, only one data file is produced annually that contains both patient visit and drug information.

Patient visit data

Data on the patient visit file reflect the NAMCS instrument or Patient Record form. Each file record contains all of the items in the following summary, including an inflation factor or patient visit weight. This weight must be used to obtain national estimates of health care utilization from the sample data

Items without dates are available on the public use files for all survey years.

Patient visit file

Date of visit
Patient's age
Patient's sex
If female, is patient pregnant? (1997-2000)
Patient's race (revised in 1979 and 1999)
Patient's ethnicity (1979-present)
Does patient smoke cigarettes? (1991-96)
Does patient use tobacco? (2001-present)
Expected source(s) of payment (1985-present) (revised in 1995 and 1997)
Was authorization required for care? (1997-2000)
Are you the patient's primary care physician? (1997-present)
Does patient belong to an HMO? (1997-2000)
Is this a capitated visit? (1997-2000)
Was patient referred by another physician? (1977-present)
Has the physician seen patient before?
If yes, for same condition as this visit? (1973-1996)
How many past visits in the last 12 months? (2001-present)
Episode of care (2001-present)
Do other physicians share patient's care for this problem? (2001-present)
Major reason for the visit (1973-76, 1979-81, 1997-present)
Patient's reason(s) for the visit (up to three) (classification revised in 1979)
Is visit injury related? (1991-present)
Place of occurrence of injury (1995-2000)
Is injury work related? (1995-2000)
Is injury intentional? (1997-2000)
Cause of injury verbatim text (1997-present)
Cause of injury (up to three) (ICD-9-CM E codes) (1995-2002)
Physician's diagnoses (up to three) (ICD-9-CM used from 1979-present)
Is diagnosis probable, questionable, or ruleout? (1997-present)
Does patient now have:
  depression (1991-92, 1995-96)

- hypertension (1991-92, 1995-96)
- hypercholesterolemia (1991-92)
- obesity (1991-96)
- asthma (1993-94)
- diabetes (1993-96)
- HIV (1993-96)
- osteoporosis (1993-94)
- arthritis (1995-96)
- COPD (1995-96)
- chronic renal failure (1995-96)
- hyperactivity/ADD (1995-96)

Ambulatory surgical procedures (1991-present) (ICD-9-CM procedure codes)
(reported under "Tests, Surgical and Non-Surgical Procedures and Therapies" in 1993-94)
Diagnostic/screening services[1]
Counseling/advice[1]
Selected types of therapy[1]
Medications provided or prescribed (up to 8 in 1980; up to 5 in 1985-1994; up to 6 in 1995-2002)
Is this a new medication for the patient? (1985-1992)
Were any drugs from formulary list? (1997)
Additional drug characteristics for each medication coded (1992-present):

- Generic name code
- Prescription status code
- Controlled substance status code
- Composition status code
- Drug class (from National Drug Code Directory)
- Ingredient codes (up to 5)

Providers seen this visit (1995-present)
Disposition of the visit (1973-1996, 1999-present)
Duration of the visit
Patient visit weight (an inflation factor assigned to the visit)
Geographic region of the visit
Metropolitan statistical area (MSA) or non-MSA location of the visit
Seriousness of the problem (1973-78)
Time since onset of the complaint (1977-78)
Accidental injury or product-related illness (1979)
Patient-physician linking code (1991-present)
Physician specialty
Type of doctor (doctor of medicine or osteopathy)
Type of practice (solo, partnership, group) (1973-85)
Type of office setting for this visit (1997-present)
Solo practice? (1997-present)
Employment status of physician (1997-present)
Who owns this office? (1997-present)
Is lab testing performed at this office? (1997-present)
Does physician make home visits? (2001-present)
Does physician make hospital visits? (2001-present)
Does physician do telephone consults? (2001-present)
Does physician do email consults? (2001-present)
Who completed the Patient Record forms? (1998-present)
Setting type (2001-present)

Intentionality of injury recode (based on E code) (1997-present)
Race recode (1993-present)
Physician specialty recode (1993-present)
Age recode (1995-present)
Age in days for patients less than one year (1995-present)
Masked sample design variables (1993-present)

Drug mentions

The drug file concerns only those office visits at which one or more medications were ordered, administered, or provided. There is one record for each drug mentioned or entered on the Patient Record form. A single office visit in 1985 could have up to five drugs mentioned on the form, resulting in five separate records on the file. On the other hand, if there were no drugs mentioned for a particular office visit, there would be no records on the drug file for that visit. Each file record contains all of the items in the following summary, including an inflation factor or drug weight. This weight must be used to obtain national estimates of drug utilization from the sample data.

Drug mention file (1980-81, 1985, and 1989-91)

Items without dates are available on the public use files for all survey years.

Medication/drug entry code
Medication/drug entry name
Generic name code
Generic name
Brand name (1980-81)
Entry status code
Prescription status code
Controlled substance status code
Composition status code
Ingredient codes (up to 5)
Number of drugs coded on encounter form
Drug weight (an inflation factor assigned to each drug record)
Date of visit
Patient's age
Patient's sex
Patient's race (revised in 1979)
Patient's ethnicity
Expected source(s) of payment (1985 to the present)
Was patient referred by another physician?
Patient's reason(s) for the visit (up to three)
Physician's diagnoses (up to three)
(ICD-9-CM)
Has the physician seen patient before?
If yes, for same condition as this visit?
Diagnostic/screening services[1]
Counseling/advice[1]
Selected types of therapy[1]
Disposition of the visit (revised in 1995)
Duration of the visit
Geographic region of the visit

Metropolitan statistical area (MSA) or non-MSA location of the visit
Major reason for the visit (1980-81)
Is visit injury related? (1991)
Does patient smoke cigarettes? (1991)
Ambulatory surgical procedures (ICD-9-CM procedure codes) (1991)
Does patient now have:
  depression (1991)
  hypertension (1991)
  hypercholesterolemia (1991)
  obesity (1991)
Patient-physician linking code (1991)
Physician specialty
Type of doctor (doctor of medicine or osteopathy
Type of practice (solo, partnership, group) (1980-85)

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[1]Updated and/or reformatted periodically in order to keep pace with the current spectrum of physician services being provided.

9/28/04