Data from the
NATIONAL HEALTH SURVEY

Series 13
Number 42

Office Visits for Diseases of the Respiratory System

The National Ambulatory Medical Care Survey

United States, 1975-76

Based on data obtained from a national sample of office-based physicians, statistics are presented which describe ambulatory medical care during visits for treatment of diseases of the respiratory system. Utilization patterns of visits which included diagnoses of acute and chronic respiratory conditions are presented in terms of demographic and clinical characteristics. Highlighted diagnoses include acute upper respiratory infections, influenza, pneumonia, emphysema, asthma, hay fever, and other chronic respiratory conditions. Data regarding influenza visits for 1974, 1975, and 1976 are also presented.

DHEW Publication No. (PHS) 79-1793

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Office of Health Research, Statistics, and Technology
National Center for Health Statistics
Hyattsville, Md. July 1979

Library of Congress Cataloging in Publication Data

Cypress, Beulah K.

Office visits for diseases of the respiratory system.

(Vital and health statistics: Series 13, Data from the National Health Survey; No. 42) (DHEW publication (PHS) 79-1793)

Includes bibliographical references.

1. Respiratory organs—Diseases—United States—Statistics. 2. Physician services utilization—United States—Statistics. 3. Health surveys—United States. I. Title. II. 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. 42. III. Series: United States. Dept. of Health, Education, and Welfare. DHEW publication; (PHS) 79-1793.

RA407.3.A349 no. 42 [RA645.R4] 362.1'1'0973s

ISBN 0-8406-0160-3 [362.1'9'6200973] 79-11339

NATIONAL CENTER FOR HEALTH STATISTICS

DIVISION OF HEALTH RESOURCES UTILIZATION STATISTICS

Vital and Health Statistics-Series 13-No. 42

DHEW Publication No. (PHS) 79-1793
Library of Congress Catalog Card Number 79-11339

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OFFICE VISITS FOR DISEASES OF THE RESPIRATORY SYSTEM

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INTRODUCTION

From January 1975 through December 1976 an estimated 163.4 million visits to office-based physicians in the conterminous United States were attributed to diseases of the respiratory system. These visits comprised 14 percent of all office visits during that period. Respiratory conditions led all other morbid conditions in volume of visits.[a] This report describes certain demographic and clinical characteristics associated with these visits and amplifies *Advance Data* report No. 41, "Office Visits for Respiratory Conditions."[1] It is the second series report with a focus on diagnoses based on 1975-76 data. An earlier report published in Series 13[2] dealt with characteristics of visits for circulatory diseases.

The data were collected in the National Ambulatory Medical Care Survey (NAMCS), a continuous sample survey conducted by the Division of Health Resources Utilization Statistics of the National Center for Health Statistics. Detailed information regarding the background and methodology of the survey was published in *Vital and Health Statistics,* Series 2, No. 61.[3]

The scope of the survey and limitations of the data are described briefly to assist in interpreting the estimates. A detailed description of the 1975-76 survey, including technical details, definitions, and survey instruments, appears in the appendixes. The 1975 and 1976 surveys were conducted identically using the same instruments, definitions, and procedures. The two years of data were combined to provide greater reliability of estimates. Therefore, estimates of numbers of visits in this report are for a 2-year period, but ratios and rates represent *average annual estimates.*

SCOPE OF THE SURVEY

The basic sampling unit for NAMCS is the physician-patient encounter or visit. "Encounter" and "visit" are used interchangeably in this report.[b] Only visits in the conterminous United States 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 1975-76 NAMCS. In addition, physicians in the specialties of anesthesiology, pathology, and radiology were excluded from the physician universe.

[a] For this report the data classified as "morbid" apply to those visits where the principal diagnosis fell in certain illness categories based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA). These categories are included in ICDA codes 000-279, 290-629, 680-738, and 780-796. Diseases of the respiratory system are included in the ICDA group code 460-519.

[b] The term "contact" applies only to that part of the visit or encounter that involved a face-to-face interchange between physician and patient.

Major types of ambulatory encounters not included in the 1975-76 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 as resources permit.

The definitions of "office," "physician," "patient," and "visit" as they determine eligibility for NAMCS are presented in appendix II.

SOURCE AND LIMITATIONS OF THE DATA

The data presented in this report were derived from information provided by a national probability sample of office-based physicians. A sample of 6,529 physicians was contacted during 1975-76. Of the 5,604 physicians who were eligible for the study, 4,476 (79.9 percent) participated, providing data on a random sample of some 114,000 patient visits.

Specially trained interviewers visited the physicians prior to a designated reporting week, provided survey materials, and informed each physician and staff member of the methods and definitions to be used. During a randomly assigned 7-day reporting period, the sample physician maintained a listing of all office visits. For a systematic random sample of those visits, data were recorded on an encounter form provided for that purpose (see appendix III).

The three appendixes to this report provide information necessary for proper understanding and 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. Imputation methods, estimation techniques, and estimates of sampling variation are also presented. Since 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." Examples of relative standard errors and instructions for their use are also 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, including letters, Patient Record forms, and Induction Interview forms, are in appendix III.

Data on the utilization of physicians' services are also collected for the Health Interview Survey (HIS), another program of NCHS, but from a different universe. Estimates provided by HIS may differ from those in NAMCS because of differences in definitions, populations sampled, and collection procedures. Data from HIS are published in Series 10 of *Vital and Health Statistics.*

Information about a maximum of three diagnoses for each sampled visit was collected during the survey. Each participating physician was requested to list on the data collection form the *principal* diagnosis which was his evaluation of the patient's condition related to the chief complaint or other reason for visit. Up to two additional significant diagnoses known to exist for the patient at that time could also be listed, but these were not necessarily related to the current visit. Diagnoses were classified and coded according to the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).[4] The principal, or first-listed, diagnosis is the primary emphasis of this report. However, patterns of coexisting diagnoses are often revealing, and additional data regarding second- and third-listed diagnoses are given when they are relevant.

The data used in this report encompass the major ICDA category diseases of the respiratory system (code 460-519). This report provides detailed information about characteristics of visits for selected most frequent, well-defined diseases within the category, e.g., influenza (ICDA code 470-474) and asthma (ICDA code 493).

This report is divided into two sections. Section I describes visits for selected acute diseases of the respiratory system; section II includes selected chronic diseases of the respiratory system.

In NAMCS 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. A "chronic" condition is a preexisting condition that began 3 months or more before the visit (see appendix II). However, the acute-chronic dichotomy used in this report is based on the tradition that certain diseases, such as asthma, are always considered chronic regardless of the time of onset.

Since this report is an expansion of a prior report,[1] the basic estimates of numbers of visits are the same. However, one change from the earlier report should be noted. When the physician enters a diagnosis on the Patient Record as "bronchitis" (without a qualification of "acute" or "chronic"), it is coded in the survey as "bronchitis, unqualified" (ICDA code 490). Since the description of code 490 in the ICDA reads in part "*excludes acute* bronchitis" (italics added), this group of visits was added to the group of visits for "chronic bronchitis" (code 491) in the first report. Later, when the data were explored further for the current report, it was observed that almost all of the visits in the "bronchitis, unqualified" group were described as "acute" in item 8 of the Patient Record (see appendix III).[c] Therefore, it was assumed that when the physician did not precede "bronchitis" with a descriptive term, he meant "acute bronchitis." Because of this change in interpretation, the numbers of visits used in this report for the two diseases, "acute bronchitis" and "chronic bronchitis," are different from those shown in *Advance Data* No. 41.[1]

Prevalence of a disease cannot be deduced from the number of physician visits. These visits do not necessarily reflect the degree to which a condition is present in the population even though visits to the physician's office may be motivated by a pathological condition or the visit may result in the detection of the condition. NAMCS was designed to provide information about the provision and use of certain ambulatory medical care services and is therefore a rich source of data concerning utilization of physicians' services when visits are characterized by specific diseases. Prevalence data may be obtained from other surveys conducted by NCHS.[d]

ALL DISEASES OF THE RESPIRATORY SYSTEM

Visits for respiratory conditions were more common among patients less than 15 years old than among older patients. Table A shows that about 28 percent of all office visits by patients

Table A. Number and percent of office visits for all diagnostic classes and for diseases of the respiratory system, by patient sex, race, and age: United States, 1975-76

Sex, race, and age	All ICDA diagnostic classes[1]		Diseases of the respiratory system[1]	
	Number of visits in thousands	Percent of visits	Number of visits in thousands	Percent of visits
All visits...	1,155,900	100.0	163,401	14.1
Sex and race				
Female	697,727	100.0	87,464	12.5
White	625,201	100.0	76,850	12.3
Black and all other races	72,525	100.0	10,614	14.6
Male	458,174	100.0	75,937	16.6
White	413,320	100.0	67,947	16.4
Black and all other races	44,853	100.0	7,990	17.8
Age				
Under 15 years	209,005	100.0	58,036	27.8
15-24 years	174,974	100.0	21,833	12.5
25-34 years	171,827	100.0	20,532	12.0
35-44 years	122,805	100.0	15,001	12.2
45-54 years	147,082	100.0	16,552	11.3
55-64 years	143,060	100.0	16,362	11.4
65 years and over	187,148	100.0	15,086	8.1

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

[c]Item 8, major reason(s) for visit, was not used as a source of data for the less detailed advance report.

[d]For example, see publications of HIS (Series 10) and the Health and Nutrition Examination Survey (Series 11).

Table B. Number and percent distribution of office visits for acute and chronic diseases of the respiratory system, by diagnosis: United States, 1975-76

Diagnosis and ICDA Code[1]	Number of visits in thousands	Percent distribution
All respiratory disease diagnoses ... 460-519	163,401	100.0
Acute upper respiratory infections, except influenza ... 460-466,490	92,705	56.7
Acute nasopharyngitis (common cold) ... 460	4,445	2.7
Acute sinusitis ... 461	2,598	1.6
Acute pharyngitis ... 462	17,414	10.7
Acute tonsillitis ... 463	12,573	7.7
Acute laryngitis and tracheitis ... 464	2,982	1.8
Acute upper respiratory infection of multiple or unspecified sites ... 465	33,248	20.3
Acute bronchitis and bronchiolitis, and bronchitis unqualified ... 466, 490	19,446	11.9
Influenza ... 470-474	10,312	6.3
Pneumonia ... 480-486	5,194	3.2
Chronic diseases of the respiratory system ... 491-493, 502-503, 507	45,602	27.9
Chronic bronchitis ... 491	1,646	1.0
Emphysema ... 492	5,223	3.2
Asthma ... 493	10,591	6.7
Chronic pharyngitis and nasopharyngitis ... 502	2,486	1.5
Chronic sinusitis ... 503	8,284	5.1
Hay fever ... 507	17,012	10.4
Other acute and chronic diseases of the respiratory system ... 500-501, 504-506, 508, 510-519	9,589	5.9

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

less than 15 years old were for treatment of a respiratory disease, but only from 8 to 13 percent of visits by patients 15 years or older were for similar conditions. The respiratory disease category comprised the highest proportion of visits by patients under 15 years old of all ICDA groups. There was some variation in the age distribution of visits, however, when specific acute and chronic diseases were considered separately. Age statistics for specific diseases are presented in Sections I and II and in the detailed tables associated with each section.

Table B shows that more than half of the patients in the respiratory disease group who visited physicians had acute upper respiratory infections. Approximately 10 percent of the visits were made for influenza and pneumonia, and 28 percent of the office visits were made for six chronic respiratory problems.

Section 1 of this report presents estimates of visits for specific acute respiratory diseases in terms of physician specialty, patient characteristics, and clinical characteristics—presenting symptoms, associated diagnoses, and patient management. A similar description is provided for chronic respiratory diseases in Section II. Section I also includes a discussion of influenza visits for the 3-year period 1974-76.

SECTION I. ACUTE DISEASES OF THE RESPIRATORY SYSTEM

PATIENT CHARACTERISTICS

Estimates of visits for the six diseases which comprise the acute upper respiratory infections group, as well as for influenza and pneumonia, are detailed by patient sex, race, and age in table

1. The median visit age for these conditions varied from 10.7 years for acute tonsillitis to 39.9 years for acute sinusitis.[e]

As a basis of comparison for the median visit ages shown in table 1, it should be noted that the median age of the civilian population of the United States in 1976 was 29.1 years,[5] and the median visit age for all NAMCS visits in 1976 was about 37 years.

Figure 1 illustrates average annual visit rates for acute upper respiratory infections (acute URI's). The plot highlights the large difference between the visit rate of patients less than 15 years old and those of older age groups. The visit rate curve for pneumonia, shown in figure 2, is flatter than the URI curve in figure 1, and the differences in pneumonia rates among the age groups are not statistically significant.

[e]Median *visit* age should not be confused with median *patient* age. The calculation of median visit age includes all visits and the same patient may be counted more than once.

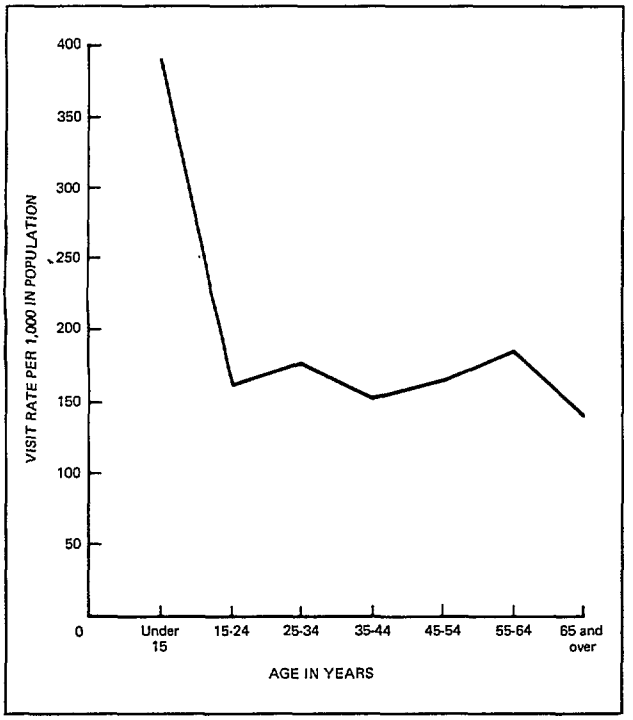

Figure 1. Average annual rate of office visits for acute upper respiratory infections, except influenza (460-466, 490), by patient age: United States, 1975-76

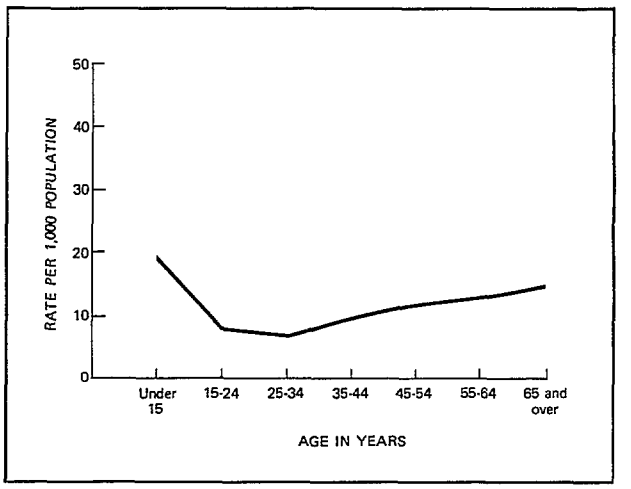

Figure 2. Average annual rate of office visits for pneumonia (460-466), by patient age: United States, 1975-76

INFLUENZA

There has been heightened interest in influenza data in recent years due to outbreaks of various strains of influenza virus throughout the country. Influenza surveillance data, collected and published by the Center for Disease Control (CDC),[6, 7] provide information on influenza gathered from, among, other sources, State epidemiologists reporting on emergency room visits and from about 191 "physician reporting units."[f] A series of special weekly reports on flu-like illnesses, issued by NCHS, was based on information collected from a national sample of households queried in HIS.[8] However, NAMCS is the only source of national data on the utilization of office-based medical care as a result of an illness diagnosed by the physician as influenza. Therefore, this report includes separate influenza estimates for 1974, 1975, and 1976 (rather than estimates for combined years 1975 and 1976 as with other diagnoses described in this report).

Table C shows the number and annual rate of influenza visits and visit rates by four geographic regions for each of the three years. The year 1975 ranked first in visit volume and rate, with 1976 second and 1974 last. Visit rates

[f]CDC Report No. 91 describes "physician reporting units" as "sentinel physician reporters or routine county or State morbidity reporting."

Table C. Number of office visits for influenza (470-474) and annual rate of office visits, by geographic region and year: United States, 1974-76

Geographic region	Year		
	1974	1975	1976
	Number in thousands		
All visits	3,755	6,123	4,189
	Visit rate per 1,000 in population		
All regions	18.2	29.4	20.0
Northeast	9.7	16.3	14.7
North Central	19.8	58.6	15.2
South	22.4	17.1	23.3
West	19.8	25.0	28.4

were adjusted for changing yearly regional populations and are, therefore, comparable across years and regions. For example, the Northeast Region rate in 1974 of 9.7 visits per thousand persons is the lowest rate shown in the table. In contrast, the North Central Region rate in 1975 of 58.6 exceeds all others.

Influenza rates by patient age for 1974, 1975, and 1976 are plotted separately in figure 3. Visit rates in 1975 for patients 25-54 years old were higher than they were for that age span in the other two years. For patients aged 55 years and older, 1975 rates exceeded those of 1974 but were not statistically different from those of 1976. Differences in visit rates for patients less than 25 years old were also not statistically significant. Therefore, most of the increased visit rate in 1975 may be attributed to visits by patients 25-54 years old. Furthermore, other NAMCS data indicate that the number of influenza visits in 1975 by patients in that age group in the North Central Region were more than double the 1974 and 1976 volume in the same area.

The data seem to indicate a high concentration of influenza visits by patients 25-54 years of age in the North Central Region during 1975. However, it is difficult to be certain, from NAMCS data alone, that this was not a statistical

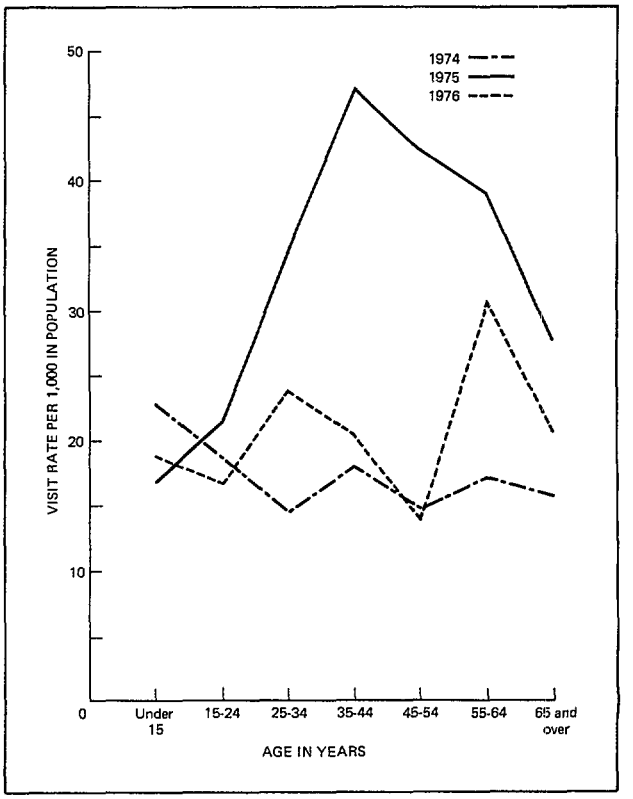

Figure 3. Average rate of office visits for influenza (470-474) for 1974, 1975, and 1976, by patient age: United States

quirk. There is no precise way to validate these data. Furthermore, office visits may or may not be a real index of increased incidence of disease because of the many other factors which affect office visits. On the other hand, there is some evidence reported by CDC of "high influenza activity" in 1975 which affected some of the States in the North Central Region.[6] This outbreak was less related to older persons than the 1976 outbreak was.[g] Figure 3 shows that in 1975 the highest visit rate was in the age group 35-44 years, while in 1976 patients 55-64 years old made office visits more frequently. To some degree these findings support CDC data.

However, it should be noted that many factors motivate physician visits. For example, the outbreak of swine flu in early 1975[7] might have precipitated the upsurge in office visits by

[g]Personal communication with CDC representative.

patients with febrile upper respiratory illnesses during the balance of the year.

Reports from CDC and HIS indicate that influenza epidemics typically occur in the fourth calendar quarter of a year and in the first quarter of the succeeding year.[6,8] It is instructive, therefore, to examine office visit data during the four quarters of each of the three years of interest for their degree of consistency with HIS and CDC data. The NAMCS quarterly visit estimates for 1974-76, charted in figure 4, appear to support these epidemiological findings since the highest proportions of visits for each year are in the first and fourth quarters. The beginning of 1975 appears to have had the most influenza visit activity.

CLINICAL CHARACTERISTICS

Coexisting Diagnoses

Over 92 million visits in 1975-76 were due primarily to an acute upper respiratory infection other than influenza. Since patients who suffer from acute respiratory problems often also have other acute and chronic conditions, data on second- or third-listed diagnoses should be examined. The most frequent second or third diagnoses noted by physicians when patients visited for acute URI are shown in table D. Since all but three of the diagnoses listed are among the top 25 ranking conditions seen by physicians in 1975-76, it is not unusual to find them associated with the over 92 million visits for acute URI. However, visits for chronic sinusitis, diarrheal disease, and other diseases of the blood and blood-forming organs (chiefly lymphadenitis), which are not as highly represented in the total NAMCS visit count, appeared frequently with acute URI.

Patient Problems, Complaints, or Symptoms

Patients' principal problems, complaints, or symptoms—the reasons for visit—have been identified and coded according to a taxonomy developed for NAMCS.[9] The reason for visit as expressed by the patient that the physician

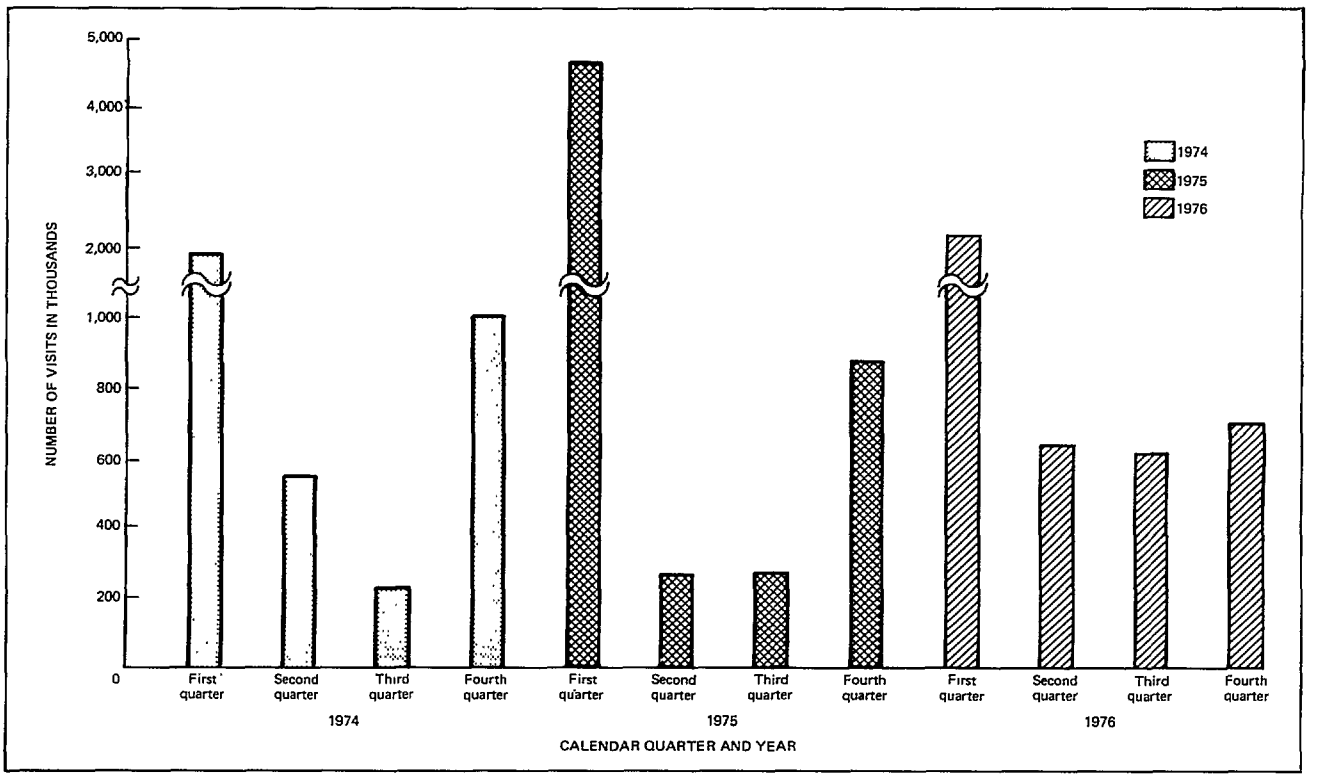

Figure 4. Number of office visits for influenza (470-474) by calendar quarter and year: United States, 1974-76

Table D. Number and percent of office visits for acute upper respiratory infections except influenza (460-466, 490) by most frequent second- or third-listed diagnosis in rank order: United States, 1975-76

Rank	Second- or third-listed diagnosis[1] and ICDA code[2]	Number of visits in thousands	Percent[3]
	All visits 460-466, 490	92,705	100.0
1	Otitis media 381	2,768	3.0
2	Essential benign hypertension 401	1,298	1.4
3	Heart disease 410-429	1,044	1.1
4	Chronic sinusitis 503	912	1.0
5	Hay fever 507	849	0.9
6	Asthma 493	808	0.9
7	Other diseases of blood and blood-forming organs[4] 289	780	0.9
8	Obesity, not specified as of endocrine origin 277	773	0.8
9	Diabetes mellitus 250	760	0.8
10	Diarrheal disease 009	679	0.7
11	Other eczema and dermatitis[5] 692	635	0.7

[1]Number of visits for different second or third diagnoses are not additive since more than one disease may have been diagnosed during the same visit.

[2]Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).

[3]Percents will not add to 100.0 because only the most frequent second or third diagnoses are listed in the table.

[4]Includes lymphadenitis, unspecified, except mesenteric.

[5]Includes allergy or allergic reaction, not elsewhere classified.

judged most responsible for the patient making the visit was entered on the Patient Record. In NAMCS this is considered the *principal* problem, complaint, symptom, or reason for visit.[h] The physician may also list other significant problems in order of their importance at that visit.

Patients with respiratory illnesses rarely present a solitary symptom; a complex of symptoms, or syndrome, is more likely to be present during a visit. Therefore, the problems listed in rank order of number of visits (table 2) should be interpreted from this perspective. In this table each acute respiratory disease diagnosis is listed with its most frequently associated reasons for visit. These latter are presented in the table as principal and secondary or tertiary symptoms. Since order may not be a distinguishing characteristic of symptomatology, it is logical to add the number of visits for a given principal problem to the number of visits listed second or third. The extent of pervasiveness of a problem in a given diagnosis may then be gauged. For example, "cough" was the principal symptom causing about 8.4 million visits for acute bronchitis, but there were an additional 2.7 million visits for acute bronchitis in which cough was listed second or third, making a total of about 11.1 million visits in which cough was part of the bronchitis syndrome.

Cough, cold, sore throat, and fever were symptoms commonly presented during visits for most acute respiratory conditions. The problem of chest pain was prominent only with a diagnosis of bronchitis.

Seriousness and Status of the Problem

Physicians were requested to judge the seriousness of the patients' problem based on the extent of impairment that might result if no care were available. A four-point scale ranging from "not serious" to "very serious" was used in the survey. Although a definition of "seriousness" was provided to all participants, it is difficult to estimate the degree of adherence to it. Such evaluation is often highly subjective. The data should be viewed in this context. Additionally, "not serious" cannot be equated with "unnecessary." For example, while the physician may consider a mild sore throat "not serious," the physician's clinical judgment is needed to make that decision.

Table 3 shows the results of evaluating the severity of principal problems associated with acute respiratory diseases. Except for pneumonia, most diagnosed problems for which visits were made were judged "not serious" or "slightly serious." Table 3 also provides information on problem status, i.e., whether the problem was presented by a patient for the first time or whether the problem was presented for continuing care. Patients making an office visit to their physician for acute respiratory diseases except pneumonia were likely to present new rather than continuing problems. Since most acute respiratory problems are

[h]The terms "problem," "complaint," or "symptom" and "reason for visit" are used interchangeably in this report.

usually short-duration, self-limiting conditions, these outcomes were not unexpected.

Diagnostic and Therapeutic Services

Table 4 shows data on the number of types of diagnostic and therapeutic services rendered during visits for various acute respiratory diseases. Table 5 presents proportions of visits which included selected diagnostic and therapeutic services. Tables 6, 7, and 8 show data on selected services rendered when patients visited for acute URI, influenza, and pneumonia in terms of patient age and sex and problem status.

Two or more services were provided for almost all visits (table 4), and these services were most likely to be a limited examination and/or history and drug therapy. For all diagnoses listed in table 5, except bronchitis and pneumonia, the proportion of visits including X-rays was lower than the average for all NAMCS visits. Like visits for most conditions other than circulatory, proportions of visits in which blood pressure was measured were lower than average.

Visit Disposition and Duration

Other aspects of patient management included in NAMCS concern the disposition and duration of the visit.

For most of the acute respiratory conditions shown in table 9, patients were told to "return if needed" more often than they were given other instructions. When pneumonia was diagnosed, however, patients were more likely to be instructed to return at a specified time. The visit disposition selected by the physician appears to reflect the seriousness he attached to the problem. Only in the case of visits for pneumonia, which was more likely than other diagnoses to be judged serious or very serious, was the "return at a specified time" instruction given more frequently than other instructions. Physicians were more likely to plan no followup when respiratory diseases were diagnosed than when visits were due to other morbidity-related disease categories. This reflects the many visits for self-limiting conditions.

Visit duration is the physician's estimate of the amount of time spent in direct encounter with the patient. Contact duration when only staff personnel see the patient is included in the survey but excluded from the calculation of mean contact duration. Table E shows the average number of minutes per visit for visits that included a contact with the physician. The mean contact duration of all NAMCS visits was about 15.3 minutes. The mean duration of bronchitis, influenza, and pneumonia visits did not differ significantly from this average, but visits for other acute conditions lasted less than the average time. Proportions of visits are categorized by time intervals in table 9.

These statistics do not reflect the time physicians spend in patient care which is not necessarily in the presence of the patient, such as evaluating test results, reviewing histories, and reading X-rays.

Table E. Mean contact duration in minutes of office visits and standard error of the mean, by selected acute diseases of the respiratory system: United States, 1975-76

Diagnosis and ICDA code[1]	Contact duration in minutes	
	Mean[2]	Standard error of the mean
Acute nasopharyngitis and acute upper respiratory infection of multiple or unspecified sites 460, 465	10.9	0.27
Acute sinusitis 461	10.3	2.10
Acute pharyngitis 462	10.8	0.26
Acute tonsillitis 463	10.4	0.32
Acute laryngitis and tracheitis 464	12.0	0.69
Acute bronchitis and bronchiolitis and bronchitis unqualified 466, 490	12.5	0.27
Influenza 470-474	14.0	1.68
Pneumonia 480-486	13.4	0.47

[1]Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).
[2]Time spent in face-to-face encounter between patient and physician.

Physician Specialty

Table 10 shows the distribution of visits for selected acute respiratory conditions according to physician specialty. The highest proportions of visits for these respiratory diagnoses, except

for acute laryngitis and tracheitis, were to the offices of general and family practitioners (GFP's). This was not an unexpected result since GFP's constitute the highest proportion of office-based physicians in the United States.[10]

Tables 11 and 12 show the proportions of visits to various specialists for acute URI, influenza, and pneumonia by patient age, problem status, and selected services.

The large proportions of visits to pediatricians reflect the young age which is characteristic of visits for respiratory problems. A further age breakdown of visits to pediatricians is provided in table 13.

SECTION II. CHRONIC DISEASES OF THE RESPIRATORY SYSTEM

The six chronic diseases highlighted in this section are listed in table B. These conditions accounted for about 28 percent of the visits in the respiratory disease category; the greater share of this number were due to hay fever (10 percent) and asthma (7 percent).

PATIENT CHARACTERISTICS

Patients visiting physicians for these six chronic conditions were generally older than those visiting for the acute conditions described in Section I. Table 14 shows that the median visit age ranged from 27.3 years for hay fever to 64.7 years for emphysema. (Almost all visits for emphysema were by patients 45 years of age and older.)

Figure 5 illustrates the visit rates for hay fever and asthma. The asthma curve has a drop in visit rate at age group 15-24 years, with a subsequent rise until age 64 years. According to a recent report from the National Institutes of Health's National Heart, Lung, and Blood Institute (NHLBI), asthmatic children may go through a disease-free period during puberty but may have recurrences later in life.[11] The NHLBI can offer no reason for this phenomenon which appears to be reflected in the office visit rates illustrated in figure 5. There is a drop in the rate of hay fever visits after age 34 years which may be related to the fact that immunotherapy over time is known to reduce the severity of the problem. (Data on the major reason for visit obtained from item 8 of the Patient Record indicate that the purpose of 23 percent of all visits by patients with hay fever was immunization or desensitization.)

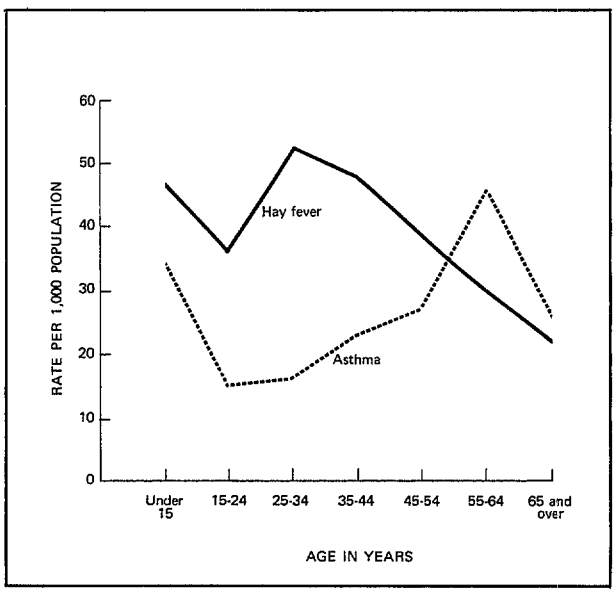

Figure 5. Average annual rate of office visits for hay fever and asthma, by patient age: United States, 1975-76

As with most NAMCS visits, proportions of females visiting for most respiratory illnesses exceeded those of males. However, male visits clearly exceeded female visits when the diagnosis was emphysema.

CLINICAL CHARACTERISTICS

Coexisting Diagnoses

Patients with chronic respiratory diseases are known to have frequent episodes of acute respiratory and other infections. When such episodes occur, the current problem is usually indicated on the Patient Record as the principal

diagnosis. Section I showed that many patients visiting physicians for treatment of acute URI also had chronic sinusitis, hay fever, and asthma (table D). Therefore, two factors should be examined—the number of visits in which the chronic problems were listed as second or third diagnoses (as an aid to estimating their total visit incidence) and the frequency of other types of diagnoses when the chronic respiratory conditions were the principal diagnoses. *Principal* diagnoses alone tend to underrepresent the number of times a given diagnosis is a recognized condition of the patient.

By adding the number of visits for each disease shown in table F to the number of visits in which each was a principal diagnosis (table B), more realistic estimates of visit incidence may be obtained for these diagnoses. For example, asthma was the principal diagnosis in about 10.6 million visits but was also a listed diagnosis in an additional 4.5 million visits, making a total of approximately 15.1 million visits in which the patient was identified as having the condition. Similarly, 22.9 million visits included hay fever patients.

Diseases that most frequently coexisted with the principal diagnoses of emphysema, asthma, and hay fever are shown in table G. Asthma and hay fever were highly concomitant. Heart disease was the most frequent second or third diagnosis when emphysema patients visited, not a surprising finding in view of the similar age range for both conditions. Another NCHS report on diseases of the circulatory system also pointed out the frequent coincidence of emphysema with coronary heart disease during physician visits.[2]

Table F. Number of office visits by selected chronic diseases of the respiratory system listed as second or third diagnosis: United States, 1975-76

Diagnosis and ICDA code[1]	Number of visits in thousands
Emphysema 492	4,592
Asthma 493	4,503
Chronic pharyngitis and nasopharyngitis 502	1,367
Chronic sinusitis 503	4,599
Hay fever 507	5,919

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

Patient Problems, Complaints, or Symptoms

Table 15 lists the symptoms most frequently associated with visits for chronic respiratory diseases. Proportions of visits in which patients presented certain symptoms are listed according to the symptoms' assignment to primary status and to that of lesser importance at that visit in the physician's judgment. The order of given symptoms may not be realistic for respiratory illnesses because of accompanying multiple symptoms.

The reason "visit for medication" was given in 12 percent of asthma visits and 17 percent of hay fever visits. This reason category includes therapeutic measures such as allergy shots and immunizations.

Table G. Number and percent of office visits by principal diagnosis and most frequent second- or third-listed diagnosis: United States, 1976-77

Principal diagnosis and ICDA code[1]	Number of visits in thousands	Total	Second- or third-listed diagnosis and ICDA code[1,2]	Number of visits in thousands	Percent
Emphysema 492	5,223	100.0	Heart disease 410-429	814	15.6
Asthma 493	10,951	100.0	Hay fever 507	1,361	12.4
Hay fever 507	17,012	100.0	Asthma 493	1,330	7.8

[1]Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).
[2]Number of visits for different second- or third-listed diagnoses are not additive since more than one disease may have been diagnosed during the same visit.

Shortness of breath was cited as the principal problem during 13 percent of asthma visits and about 42 percent of emphysema visits.

Seriousness and Status of the Problem

By their nature, chronic respiratory diseases were more often continuing problems than they were new problems. Of those diseases shown in table 16, visits for emphysema were proportionately more often judged serious or very serious than were the other diagnoses. While more than half of the visits for pharyngitis, sinusitis, and hay fever were evaluated as "not serious," this does not preclude the necessity for care and surveillance of these conditions.

Diagnostic and Therapeutic Services

Tables 17 and 18 provide information on the number and types of diagnostic and therapeutic services rendered. Typical of most visits, the limited examination and/or history and drug therapy were widely used. The percents of visits which included blood pressure checks were higher than average for visits including diagnoses of chronic bronchitis and emphysema. It has been shown that blood pressure measurement during physician visits is more related to patient age than to the presentation of problems associated with hypertension, with use of the procedure increasing as patients age.[12] The frequent use of the sphygmomanometer during bronchitis and emphysema visits may be due to the nature of the problem or to the older median visit age related to these two diseases.

A high degree of immunotherapy was used during visits for asthma (41 percent) and hay fever (53 percent).

Table 19 gives additional data on services by patient age and sex and problem status for asthma visits, and table 20 gives the same information for hay fever visits.

Visit Disposition and Duration

Table 21 shows that the most frequent instruction given patients with chronic respiratory diseases (except sinusitis) was to return at a specified time. No followup was planned in only a small proportion of visits. The findings are in contrast to those for acute respiratory disease visits, at which physicians more often made no plans for followup or told the patient to return if needed.

Table H shows that there was little variation in mean contact duration among the chronic respiratory diseases. Visits for chronic problems lasted longer than did those for acute URI (table E), reflecting the more intensive care required in treating chronic illness. However, the mean duration of these visits was close to the average for all NAMCS visits.

Table H. Mean contact duration in minutes of office visits and standard error of the mean, by selected chronic diseases of the respiratory system: United States, 1975-76

Diagnosis and ICDA Code[1]	Contact duration in minutes[2]	
	Mean	Standard error of the mean
Chronic bronchitis 491	17.5	1.22
Emphysema 492	17.1	.71
Asthma 493	15.2	.76
Chronic pharyngitis and nasopharyngitis 502	13.1	1.30
Chronic sinusitis 503	13.1	.93
Hay fever 507	13.7	.75

[1] Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).
[2] Time spent in face-to-face encounter between patient and physician.

Additional details on proportions of visits by time intervals may be found in table 21.

Physican Specialty

Table 22 shows that the majority of visits for chronic bronchitis, emphysema, and chronic sinusitis were to GFP's.

Internists treated a higher proportion of patients visiting for emphysema than they did those with other respiratory diseases and were responsible for the second highest proportion of visits to all physicians for that problem. Since about two-thirds of all visits to internists were by patients 45 years of age and older, internists

saw more respiratory problems related to the elderly, such as emphysema, than those related to the young, such as acute URI.[13]

The highest proportions of asthma (32 percent) and hay fever (31 percent) visits were to allergists and to general and family practitioners, who treated 30 percent and 26 percent, respectively. Pediatricians saw about 22 percent of all patients visiting for asthma and 18 percent of those visiting for hay fever. The pediatrician's caseload accounted for 58 percent of asthma visits to specialists by patients under 15 years old and 49 percent of all hay fever visits. Table 23 shows the number and percent of office visits to pediatricians for asthma and hay fever by patient's age group.

Data are listed in table 24 on the distribution of asthma and hay fever visits to various specialties according to patient age, problem status and diagnostic and therapeutic services.

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LIST OF DETAILED TABLES

Table I. Number, percent distribution, and average annual rate of office visits for selected acute diseases of the respiratory system and percent distribution for all other morbidity-related groups, by selected patient characteristics: United States, 1975-76

Patient sex, race, and age	Diagnosis and ICDA code[1]								
	Acute naso-pharyngitis and acute upper respir-atory infection of multiple or unspecified sites (460, 465)	Acute sinusitis (461)	Acute pharyngitis (462)	Acute tonsillitis (463)	Acute laryngitis and tracheitis (464)	Acute bronchitis and bronchiolitis, and bronchitis unqualified (466, 490)	Influenza (470-474)	Pneumonia (480-486)	All other morbidity-related ICDA[2] groups (000-458, 520-629, 680-738, 780-796)
	Number of visits in thousands								
All visits	37,693	2,598	17,414	12,573	2,982	19,446	10,312	5,194	667,261
	Percent distribution								
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Sex									
Female	54.2	57.3	55.2	52.3	58.3	57.0	47.0	50.8	61.5
Male	45.8	42.7	44.8	47.7	41.7	43.0	53.0	49.2	38.5
Race									
White	82.9	74.4	90.4	87.8	93.6	88.0	94.0	89.2	90.3
Black and all other	17.1	25.6	9.6	12.2	*6.4	12.0	6.0	10.8	9.7
Age									
Under 15 years	45.0	*11.2	45.2	61.5	54.0	35.2	18.1	37.7	11.7
15-24 years	13.3	*16.6	16.9	17.1	*4.9	9.8	14.3	12.4	12.1
25-44 years	19.3	29.9	21.6	12.4	*16.0	19.8	31.7	17.1	24.4
45-64 years	15.4	35.9	12.1	7.6	21.5	23.6	25.9	20.3	30.2
65 years and over	7.0	*6.6	4.2	*1.3	*3.7	11.8	10.0	12.5	21.7
Median visit age	18.6	39.9	17.8	10.7	11.1	29.9	35.3	24.9	---
Standard error of median visit age	1.3	5.1	2.6	1.1	4.8	2.7	1.8	4.7	---
	Visit rate per 1,000 in population								
All visits	90.3	6.2	41.7	30.1	7.1	46.6	24.7	12.4	---
Sex									
Female	94.5	6.9	44.5	30.5	8.0	51.4	22.5	12.2	---
Male	85.8	5.5	38.7	29.8	6.2	41.5	27.1	12.7	---
Race									
White	86.2	5.3	43.4	30.4	7.7	47.2	26.7	12.8	---
Black and all other	117.7	12.2	30.5	28.1	*3.5	42.6	11.3	10.3	---
Age									
Under 15 years	160.7	*2.7	74.6	73.3	15.3	64.8	17.7	18.6	---
15-24 years	64.8	*5.6	38.0	27.8	*1.9	24.6	19.0	8.3	---
25-44 years	68.9	7.4	35.7	14.8	*4.5	36.4	31.0	8.4	---
45-64 years	67.7	10.8	24.6	11.1	7.5	53.3	31.1	12.3	---
65 years and over	61.4	*4.0	17.0	*3.9	*2.6	53.2	24.1	15.1	---

[1]Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).
[2]For this report excludes categories relating to special conditions and examinations without sickness; complications of pregnancy, childbirth, and the puerperium; congenital anomalies; certain causes of perinatal morbidity and mortality; accidents, poisonings, and violence; diagnosis "none" and "unknown."

Table 2. Number and percents of office visits for selected acute diseases of the respiratory system by principal diagnosis and by patient principal and second- or third-listed problem: United States, 1975-76

Principal diagnosis and patient's problem, complaint, or symptom, and NAMCS code[1]	Principal diagnosis and principal problem[2]		Principal diagnosis and second- or third-listed problem	
	Number of visits in thousands	Percent of visits[3]	Number of visits in thousands	Percent of visits
Acute nasopharyngitis and acute upper respiratory infection of multiple or unspecified sites	37,693	100.0	37,693	100.0
Cold 312	10,646	28.3	1,735	2.3
Cough 311	6,318	16.8	5,531	7.3
Throat soreness 520	5,268	14.0	2,268	3.0
Fever 002	3,173	8.4	2,244	3.0
Nasal congestion 301	1,904	5.1	1,833	2.4
Earache 735	691	1.8	716	1.0
Headache 056	*326	*0.9	580	0.8
Acute sinusitis	2,598	100.0	2,598	100.0
Sinus problems 304	1,208	46.5	*	*
Acute pharyngitis	17,414	100.0	17,414	100.0
Throat soreness 520	10,509	60.4	1,273	
Fever 002	1,782	10.2	1,179	3.4
Cold 312	1,057	6.1	*287	*0.8
Cough 311	839	4.8	1,045	3.0
Acute tonsillitis	12,573	100.0	12,573	100.0
Throat soreness 520	6,665	53.0	1,060	4.2
Fever 002	1,969	15.7	1,253	5.0
Symptoms referable to tonsils 527	1,411	11.2	*206	*0.8
Acute laryngitis and tracheitis	2,982	100.0	2,982	100.0
Cough 311	917	30.8	*380	*6.4
Disorders of voice 325	590	19.8	*	*
Acute bronchitis and bronchiolitis, and bronchitis, unqualified	19,446	100.0	19,446	100.0
Cough 311	8,408	43.2	2,747	7.1
Cold 312	2,653	13.6	*434	1.1
Other symptoms referable to the respiratory system 330	1,381	7.1	*558	1.4
Fever 002	1,005	5.2	1,669	4.3
Throat soreness 520	718	3.7	605	1.6
Pain in chest 322	632	3.3	719	1.9
Influenza	10,312	100.0	10,312	100.0
Flu 313	3,133	30.4	*268	1.3
Cough 311	1,201	11.6	652	3.2
Fever 002	1,172	11.4	1,086	5.3
Cold 312	690	6.7	*215	*1.0
Pneumonia	5,194	100.0	5,194	100.0
Cough 311	1,437	27.7	833	8.0
Fever 002	*450	*8.7	750	7.2

[1]Problems are identified and coded according to a symptom classification developed for use in NAMCS (see reference 9).

[2]Within a given diagnosis, visits for different *principal* problems are additive; visits for different *principal* problems may not be added to visits for different *second or third* problems since they may have been presented during the same visit.

[3]Percents will not add to 100.0 because all problems related to each diagnosis are not listed.

Table 3. Number of office visits for selected acute diseases of the respiratory system and percent distribution of visits by problem status and by problem seriousness, according to diagnosis: United States, 1975-76

Diagnosis and ICDA code[1]	Number of visits in thousands	Total	Problem status		Problem seriousness		
			New problem	Continuing problem	Not serious	Slightly serious	Serious or very serious
		Percent distribution					
Acute nasopharyngitis and acute upper respiratory infection of multiple or unspecified sites 460, 465	37,693	100.0	59.4	40.6	57.9	36.4	5.7
Acute sinusitis 461	2,598	100.0	59.7	40.3	29.7	60.5	*9.8
Acute pharyngitis 462	17,414	100.0	63.9	36.1	51.7	40.6	7.7
Acute tonsillitis 463	12,573	100.0	61.1	38.9	34.9	51.2	14.0
Acute laryngitis and tracheitis 464	2,982	100.0	57.6	42.4	46.3	43.7	*10.1
Acute bronchitis and bronchiolitis, and bronchitis, unqualified 466, 490	19,446	100.0	51.8	48.2	35.1	53.0	11.9
Influenza 470-474	10,312	100.0	73.8	26.2	33.2	56.6	10.2
Pneumonia 480-486	5,194	100.0	41.5	58.5	13.2	38.9	48.0

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

Table 4. Number of office visits for selected acute diseases of the respiratory system and percent distribution of visits by number of types of diagnostic and therapeutic services ordered or provided, according to diagnosis: United States, 1975-76

Diagnosis and ICDA code[1]	Number of visits in thousands	Number of types of service				
		Total	None	One	Two	Three or more
		Percent distribution				
Acute nasopharyngitis and acute upper respiratory infection of multiple or unspecified sites 460, 465	37,693	100.0	1.1	17.0	40.3	41.7
Acute sinusitis 461	2,598	100.0	-	4.2	44.7	51.2
Acute pharyngitis 462	17,414	100.0	0.8	15.3	41.1	42.8
Acute tonsillitis 463	12,573	100.0	0.5	18.8	40.8	39.9
Acute laryngitis and tracheitis 464	2,982	100.0	1.0	21.1	39.7	38.3
Acute bronchitis and bronchiolitis, and bronchitis unqualified 466, 490	19,446	100.0	1.0	14.5	36.3	48.1
Influenza 470-474	10,312	100.0	0.3	15.7	40.6	43.4
Pneumonia 480-486	5,194	100.0	1.1	17.3	27.8	53.8

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

Table 5. Number of office visits for selected acute diseases of the respiratory system and for all other morbidity-related groups by diagnostic or therapeutic services ordered or provided, by diagnosis: United States, 1975-76

Diagnostic or therapeutic service	Diagnosis and ICDA code[1]								
	Acute naso-pharyngitis and acute upper respiratory infection of multiple or unspecified sites (460, 465)	Acute sinusitis (461)	Acute pharyngitis (462)	Acute tonsillitis (463)	Acute laryngitis and tracheitis (464)	Acute bronchitis and bronchiolitis, and bronchitis unqualified (466, 490)	Influenza (470-474)	Pneumonia (480-486)	All other morbidity-related ICDA[2] groups (000-458, 520-629, 680-738, 780-796)
	Number of visits in thousands								
All visits	37,693	2,598	17,414	12,573	2,982	19,446	10,312	5,194	667,261
	Percent[3]								
Limited history and/or examination	66.0	82.2	68.8	65.4	68.8	66.2	54.5	64.7	67.7
General history and/or examination	12.8	*6.8	9.7	11.5	*10.4	13.1	9.9	17.8	18.8
Clinical laboratory test	14.3	*9.4	30.8	24.9	*14.8	13.9	14.0	19.3	27.0
X-ray	3.0	*7.4	*1.3	*1.3	*2.1	12.6	*4.7	34.8	8.0
Blood pressure check	25.1	20.6	18.8	10.0	16.3	30.5	26.3	27.2	42.4
Drug prescribed[4]	81.8	90.5	77.4	79.0	77.0	76.9	79.8	63.6	65.5
Injection	26.7	34.0	24.9	31.5	25.2	29.2	45.0	21.9	19.1
Medical counseling	7.8	*3.4	5.6	7.9	*8.9	9.3	7.7	*10.3	16.6
Other diagnostic and therapeutic services[5]	4.9	*13.2	3.5	*2.8	*3.8	8.2	*4.9	*6.1	36.0

[1]Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).
[2]For this report excludes categories relating to special conditions and examinations without sickness, complications of pregnancy, childbirth, and the puerperium; congenital anomalies; certain causes of perinatal morbidity and mortality; accidents, poisonings, and violence; diagnosis "none" and "unknown."
[3]Percents will not add to 100.0 because more than one service may have been provided.
[4]Includes prescription and nonprescription drugs.
[5]Includes electrocardiogram, hearing test, vision test, endoscopy, immunization, office surgery, physiotherapy, psychotherapy and therapeutic listening, and other diagnostic or therapeutic services.

Table 6. Number and percent of office visits for acute upper respiratory infections except influenza (460-466, 490) by selected diagnostic or therapeutic services ordered or provided, by patient age, sex, and problem status: United States, 1975-76

Patient age, sex, and problem status	Number of visits in thousands	Diagnostic or therapeutic service							
		Limited history and/or examination	General history and/or examination	Clinical laboratory test	X-ray	Blood pressure check	Drug prescribed[1]	Injection	Medical counseling
Age		Percent[2]							
Under 3 years	14,566	59.3	18.4	15.1	*1.8	*1.5	77.6	21.9	8.5
3-5 years	10,332	65.1	11.7	21.9	*1.8	*3.3	79.2	21.6	7.9
6-10 years	10,082	67.5	12.3	25.7	*2.9	*4.7	77.5	20.3	8.8
11-14 years	6,298	65.1	11.8	29.5	*2.4	12.0	77.5	22.0	*7.7
15-24 years	12,595	69.5	10.7	20.2	*4.3	28.5	83.3	31.2	5.6
25-44 years	17,689	68.5	9.4	16.7	6.3	34.8	82.4	29.1	7.2
45-64 years	15,036	70.8	10.4	14.0	7.7	42.2	78.7	38.2	7.8
65 years and over	6,106	71.6	*8.9	12.1	*8.6	50.1	77.8	32.4	*8.8
Sex									
Female	50,928	67.7	11.1	19.4	4.7	25.3	80.1	27.1	8.2
Male	41,777	66.3	12.8	17.6	4.4	19.3	79.0	28.4	7.0
Problem status									
New problem	54,548	68.0	13.5	19.0	4.9	22.9	83.1	26.4	7.6
Continuing problem	38,157	65.7	9.5	18.1	4.0	22.1	74.6	29.6	7.7

[1]Includes prescription and nonprescription drugs.
[2]Percents will not add to 100.0 because more than one service may have been provided.

Table 7. Number of office visits for influenza (470-474) and percent of visits by diagnostic or therapeutic services ordered or provided, by patient age, sex, and problem status: United States, 1975-76

Patient age, sex, and problem status	Number of visits in thousands	Diagnostic or therapeutic service							
		Limited history and/or examination	General history and/or examination	Clinical laboratory test	X-ray	Blood pressure check	Drug prescribed[1]	Injection	Medical counseling
		Percent[2]							
Age									
Under 6 years	971	59.6	*12.7	*14.4	-	-	*52.3	*50.9	*20.9
6-14 years	893	51.4	*30.0	*12.5	*2.8	*1.6	76.2	*29.8	*8.9
15-24 years	1,472	67.5	*4.2	*10.1	-	*27.2	85.4	42.8	*6.4
25-44 years	3,267	45.9	*6.6	*12.0	*4.2	29.1	84.0	49.1	*4.1
45-64 years	2,674	55.2	*5.4	*14.0	*10.4	36.1	84.2	44.0	*4.1
65 years and over	1,034	58.9	*20.7	*27.1	*4.0	*36.8	76.5	*45.5	*16.5
Sex									
Female	4,849	56.6	12.0	16.2	*6.4	29.9	79.7	39.3	*5.5
Male	5,463	52.5	*8.1	12.1	*3.2	23.1	79.9	50.1	*9.6
Problem status									
New problem	7,607	55.7	11.1	15.8	*3.8	26.9	82.7	43.6	7.8
Continuing problem	2,705	51.1	*6.8	8.9	*7.1	24.6	71.7	48.9	*7.4

[1]Includes prescription and nonprescription drugs.
[2]Percents will not add to 100.0 because more than one service may have been provided.

Table 8. Number of office visits for pneumonia (480-486) and percent of visits by diagnostic or therapeutic services ordered or provided, by patient age, sex, and problem status: United States, 1975-76

Patient age, sex, and problem status	Number of visits in thousands	Diagnostic or therapeutic service							
		Limited history and/or examination	General history and/or examination	Clinical laboratory test	X-ray	Blood pressure check	Drug prescribed[1]	Injection	Medical counseling
		Percent[2]							
Age									
Under 6 years	1,280	58.3	*28.3	*20.9	*30.3	*6.3	60.4	*16.1	*10.4
6-14 years	676	*51.6	*16.4	*25.1	*30.9	*7.2	*59.3	*7.1	*11.7
15-24 years	643	*79.1	*5.0	*25.9	*33.6	*14.8	*60.2	*40.0	*5.5
25-44 years	890	67.5	*22.0	*20.7	*29.0	*45.4	64.6	*16.4	*11.6
45-64 years	1,056	62.0	*10.7	*11.5	*38.6	*42.1	70.4	*25.7	*13.7
65 years and over	649	*77.5	*17.4	*14.7	*50.8	*52.6	*65.6	*32.3	*6.2
Sex									
Female	2,640	66.2	*14.4	*19.2	36.5	24.7	62.6	26.3	*7.9
Male	2,554	63.2	*21.4	*19.4	33.1	30.0	64.7	*17.4	*12.9
Problem status									
New problem	2,156	56.0	28.8	*23.4	44.7	31.4	70.7	*24.3	*12.1
Continuing problem	3,037	71.0	10.0	*16.3	27.9	24.3	58.6	20.3	*9.0

[1]Includes prescription and nonprescription drugs.
[2]Percents will not add to 100.0 because more than one service may have been provided.

Table 9. Number of office visits for selected acute diseases of the respiratory system and for all other morbidity-related groups and percent distribution by duration and disposition of visits, by diagnosis: United States, 1975-76

Duration and disposition of office visit	Diagnosis and ICDA code[1]								
	Acute nasopharyngitis and acute upper respiratory infection of multiple or unspecified sites (460, 465)	Acute sinusitis (461)	Acute pharyngitis (462)	Acute tonsillitis (463)	Acute laryngitis and tracheitis (464)	Acute bronchitis and bronchiolitis, and bronchitis unqualified (466, 490)	Influenza (470-474)	Pneumonia (480-486)	All other morbidity-related ICDA[2] groups (000-458, 520-629, 680-738, 780-796)
	Number of visits in thousands								
All visits	37,693	2,598	17,414	12,573	2,982	19,446	10,312	5,194	667,261
	Percent distribution								
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Duration[3]									
0-5 minutes	20.1	37.2	21.5	23.8	15.9	13.7	11.2	9.8	13.4
6-10 minutes	46.3	37.2	45.5	44.8	42.2	46.0	36.9	36.8	38.5
11-15 minutes	23.7	15.1	24.0	25.1	25.7	26.0	20.9	36.1	27.5
16-30 minutes	9.4	9.3	8.4	5.7	15.6	13.2	29.8	16.3	21.9
31 minutes or longer	*0.5	*1.1	*0.6	*0.6	*0.6	*1.2	*1.3	*1.0	7.5
Disposition[4]									
No followup	23.0	13.7	22.6	16.9	12.0	13.7	20.0	11.1	8.2
Return at specified time	26.2	21.2	22.2	29.0	27.0	42.0	21.5	64.1	63.7
Return if needed	46.4	61.6	42.7	44.0	52.4	38.6	53.0	16.2	24.9
Telephone followup	5.1	4.4	14.3	9.6	10.2	6.0	5.5	5.4	3.6

[1]Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).
[2]For this report excludes categories relating to special conditions and examinations without sickness; complications of pregnancy, childbirth and the puerperium; congenital anomalies; certain causes of perinatal morbidity and mortality; accidents, poisonings, and violence; diagnosis "none" and "unknown."
[3]Face-to-face encounter between physician and patient.
[4]Percents will not add to 100.0 because more than one disposition may have been possible.

Table 10. Number of office visits for selected acute diseases of the respiratory system and percent distribution of visits by physician specialty, according to diagnosis: United States, 1975-76

Diagnosis and ICDA code[1]	Number of visits in thousands	Physician specialty						
		Total	General and family practice	Internal medicine	Pediatrics	General surgery	Otolaryngology	All other specialties
		Percent distribution						
Acute nasopharyngitis and acute upper respiratory infection of multiple or unspecified sites 460,465	37,693	100.0	60.4	8.2	21.6	3.5	2.0	4.5
Acute sinusitis 461	2,598	100.0	70.1	*7.5	*7.3	*1.0	*7.5	*6.6
Acute pharyngitis 462	17,414	100.0	53.6	7.4	28.4	*2.6	3.9	4.1
Acute tonsillitis 463	12,573	100.0	57.2	*2.4	28.2	*2.4	*4.0	5.8
Acute laryngitis and tracheitis 464	2,982	100.0	36.3	*6.2	40.9	*2.3	*9.1	*5.2
Acute bronchitis and bronchiolitis, and bronchitis unqualified 466, 490	19,446	100.0	57.3	13.6	20.3	*2.8	*0.3	5.7
Influenza 470-474	10,312	100.0	78.5	7.3	8.8	*2.0	*0.3	*3.1
Pneumonia 480-486	5,194	100.0	50.5	14.9	27.0	*3.3	*0.0	*4.3

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

Table 11. Percent distribution of office visits for acute upper respiratory infections except influenza (460-466, 490) by patient age, problem status, and selected services, according to physician specialty: United States, 1975-76

Patient age, problem status, and selected services	Physician specialty			
	General and family practice	Internal medicine	Pediatrics	Otolaryngology
	Percent distribution			
Total	100.0	100.0	100.0	100.0
Patient age				
Under 15 years	32.5	11.6	94.7	*15.0
15-24 years	17.1	14.3	4.2	*13.3
25-44 years	23.4	31.0	*0.6	42.8
45-64 years	19.6	27.9	*0.5	*21.7
65 years and over	7.4	15.3	-	*7.2
Problem status				
New problem	59.9	65.5	56.5	48.7
Continuing problem	40.1	34.5	43.5	51.3
Diagnostic or therapeutic service[1]				
Limited history and/or examination	70.5	71.3	58.9	65.3
General history and/or examination	10.2	14.2	16.4	*10.4
Clinical laboratory test	15.1	22.3	28.4	*6.5
X-ray	3.7	13.6	*2.3	*5.5
Blood pressure check	27.3	46.5	3.7	*1.3
Drug prescribed[2]	82.3	75.4	77.3	74.3
Injection	33.9	15.3	15.5	*14.8
Medical counseling	6.1	10.2	9.7	*10.2

[1]Percents will not add to 100.0 because more than one service may have been provided.
[2]Includes prescription and nonprescription drugs.

Table 12. Percent distribution of office visits for influenza (470-474) and pneumonia (480-486) by patient age, problem status, and selected services ordered or provided, according to physician specialty: United States, 1975-76

Patient age, problem status, and selected services	Influenza			Pneumonia		
	General and family practice	Internal medicine	Pediatrics	General and family practice	Internal medicine	Pediatrics
	Percent distribution					
Total	100.0	100.0	100.0	100.0	100.0	100.0
Patient age						
Under 15 years	11.8	*3.0	93.4	*20.1	*2.7	97.2
15-24 years	16.2	*11.9	*4.0	*16.4	*16.2	*1.9
25-44 years	33.8	*29.9	*2.5	23.5	*22.4	-
45-64 years	28.3	*29.8	-	29.8	*18.2	*0.8
65 years and over	9.9	*25.4	-	*10.1	*40.6	-
Problem status						
New problem	72.7	76.4	73.8	38.0	49.5	43.1
Continuing problem	27.3	23.6	26.2	62.1	50.5	56.9
Diagnostic or therapeutic service[1]						
Limited history and/or examination	53.7	68.6	*41.0	65.3	80.2	51.7
General history and/or examination	*6.4	*17.5	*36.1	*14.7	*14.8	*27.3
Clinical laboratory test	11.5	*33.4	*21.5	*16.4	*19.8	*25.9
X-ray	*3.6	*14.8	*2.0	27.8	*57.3	*29.6
Blood pressure check	25.7	*54.1	*0.6	30.1	*53.5	*0.4
Drug prescribed[2]	83.0	*61.2	65.0	69.6	*51.4	60.0
Injection	50.0	*20.8	*24.1	31.8	*7.0	*10.5
Medical counseling	*5.3	*11.5	*25.5	*7.6	*15.5	*13.3

[1]Percents will not add to 100.0 since more than one service may have been provided.
[2]Includes prescription and nonprescription drugs.

Table 13. Number of office visits to pediatricians and percents of visits made by patients under 15 years of age for selected acute diseases of the respiratory system and percent of visits by age of patient: United States, 1975-76

Diagnosis and ICDA code[1]	Number of visits in thousands	Age			
		Under 3 years	3-5 years	6-10 years	11-14 years
		Percent[2]			
Acute nasopharyngitis and acute upper respiratory infection of multiple or unspecified sites 460, 465	8,149	51.7	22.1	14.2	7.2
Acute pharyngitis 462	4,945	25.5	20.7	29.1	17.7
Acute tonsillitis 463	3,551	25.5	35.3	25.3	*11.3
Acute laryngitis and tracheitis 464	1,220	*43.5	*29.9	*21.2	*3.7
Acute bronchitis and bronchiolitis, and bronchitis unqualified 466,490	3,938	36.6	28.3	20.7	*7.8
Influenza 470-474	904	*27.5	*18.3	*30.4	*17.3
Pneumonia 480-486	1,400	*39.4	*28.5	*19.4	*9.9

[1]Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).
[2]Percents will not add to 100.0 because percents of age groups 15 years and over are not shown.

Table 14. Number, percent distribution, and average annual rate of office visits for selected chronic diseases of the respiratory system and percent distribution for all other morbidity-related groups, by selected patient characteristics: United States, 1975-76

Selected patient characteristics	Diagnosis and ICDA code[1]						
	Chronic bronchitis (491)	Emphysema (492)	Asthma (493)	Chronic pharyngitis and naso-pharyngitis (502)	Chronic sinusitis (503)	Hay fever (507)	All other morbidity-related ICDA[2] groups (000-458, 520-629, 680-738, 780-796)
	Number of visits in thousands						
All visits	1,646	5,223	10,951	2,486	8,284	17,012	667,261
	Percent distribution						
	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Sex							
Female	50.6	29.6	54.9	58.2	58.8	56.3	61.5
Male	49.4	70.4	45.1	41.9	41.2	43.7	38.5
Race							
White	92.4	91.9	87.3	94.8	89.9	94.4	90.3
Black and all other	*7.7	*8.1	12.7	*5.2	10.1	5.6	9.7
Age							
Under 15 years	*1.5	*1.1	32.9	25.5	10.3	29.2	11.7
15-24 years	*6.3	*0.1	10.9	*13.1	14.8	16.6	12.1
25-44 years	*19.3	*4.8	18.1	30.8	35.7	30.9	24.4
45-64 years	45.3	44.9	28.1	*18.8	27.4	17.7	30.2
65 years and over	*27.7	49.0	10.1	*11.9	11.7	5.6	21.7
Median visit age in years	57.4	64.7	32.0	33.0	37.8	27.3	---
Standard error of median visit age in years	3.0	2.2	4.4	5.8	2.7	2.2	---
	Visit rate per 1,000 population						
All visits	4.0	12.5	26.2	6.0	19.9	40.8	---
Sex							
Female	3.9	7.2	27.8	6.7	22.6	44.4	---
Male	4.0	18.3	24.6	5.2	17.0	36.9	---
Race							
White	4.2	13.2	26.4	6.5	20.5	44.3	---
Black and all other	*2.3	*7.7	25.4	*2.4	15.3	17.3	---

Table 14. Number, percent distribution, and average annual rate of office visits for selected chronic diseases of the respiratory system and percent distribution for all other morbidity-related groups, by selected patient characteristics: United States, 1975-76--Con.

Selected patient characteristics	Diagnosis and ICDA code[1]						
	Chronic bronchitis (491)	Emphysema (492)	Asthma (493)	Chronic pharyngitis and naso-pharyngitis (502)	Chronic sinusitis (503)	Hay fever (507)	All other morbidity-related ICDA[2] groups (000-458, 520-629, 680-738, 780-796)
Age	Visit rate per 1,000 population						
Under 15 years	*0.2	*0.1	34.2	6.0	8.1	47.1	---
15-24 years	*1.4	*0.1	15.4	*4.2	15.9	36.4	---
25-44 years	*3.0	*2.4	18.8	7.3	28.1	49.9	---
45-64 years	8.7	27.3	35.8	*5.4	26.4	35.0	---
65 years and over	*10.6	60.3	25.6	*6.9	22.6	22.3	---

[1]Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).
[2]For this report excludes categories relating to special conditions and examinations without sickness; complications of pregnancy, childbirth, and the puerperium; congenital anomalies; certain causes of perinatal morbidity and mortality; accidents, poisonings, and violence; diagnosis "none" and "unknown."

Table 15. Number and percents of office visits for selected chronic diseases of the respiratory system by principal diagnosis and by patient principal and second- or third-listed problem: United States, 1975-76

Principal diagnosis and patient's problem, complaint, or symptom and NAMCS code[1]	Principal diagnosis and principal problem[2]		Principal diagnosis and second- or third-listed problem	
	Number of visits in thousands	Percent of visits[3]	Number of visits in thousands	Percent of visits
Chronic bronchitis	1,646	100.0	1,646	100.0
Cough 311	*499	*30.3	*277	*8.4
Emphysema	5,223	100.0	5,223	100.0
Shortness of breath 306	2,210	42.3	*295	*2.8
Cough 311	*378	*7.2	*431	*4.1
Asthma	10,951	100.0	10,591	100.0
Asthma 328	2,973	27.2	*288	*1.3
Other disorders of respiratory rhythm and sound 307	1,832	16.7	*539	*2.5
Shortness of breath 306	1,421	13.0	*260	*1.2
Cough 311	1,401	12.8	639	2.9
Visit for medication[4] 910	1,337	12.2	*	*
Hay fever[5] 329	*267	*2.4	562	2.6
Chronic pharyngitis and nasopharyngitis	2,486	100.0	2,486	100.0
Nasal congestion 301	615	24.7	*219	*4.4
Chronic sinusitis	8,284	100.0	8,284	100.0
Sinus problems 304	1,741	21.0	*365	*2.2
Headache 056	1,653	20.0	*442	*2.7
Nasal congestion 301	1,156	14.0	603	3.6
Throat soreness 520	608	7.3	*329	*2.0
Cough 311	598	7.2	*384	*2.3
Cold 312	*557	*6.7	*265	*1.6
Hay fever	17,012	100.0	17,012	100.0
Nasal congestion 301	4,791	28.2	992	2.9
Hay fever 329	3,409	20.0	*545	*1.6
Visit for medication[4] 910	2,903	17.1	*216	*0.6
Sneezing 310	649	3.8	*210	*0.6
Cough 311	*551	*3.2	*281	*0.8

[1]Problems are identified and coded according to a symptom classification developed for use in NAMCS (see reference 9).
[2]Within a given diagnosis, visits for different *principal* problems are additive, but visits for different *principal* problems may not be added to visits for different *second or third* problems since they may have been presented during the same visit.
[3]Percents will not add to 100.0 because all problems related to each diagnosis are not listed.
[4]Includes allergy shots, immunizations, routine inoculations, injections of vitamins and hormones; new and renewal prescriptions.
[5]Includes allergy and pollinosis.

Table 16. Number of office visits for selected chronic diseases of the respiratory system and percent distribution of visits by problem status and by problem seriousness, according to diagnosis: United States, 1975-76

Diagnosis and ICDA code[1]	Number of visits in thousands	Total	Problem status		Problem seriousness		
			New problem	Continuing problem	Not serious	Slightly serious	Serious or very serious
		Percent distribution					
Chronic bronchitis 491	1,646	100.0	*27.0	73.0	39.6	40.6	*19.7
Emphysema 492	5,223	100.0	13.1	86.9	10.0	31.8	58.2
Asthma 493	10,951	100.0	9.5	90.6	21.6	46.3	32.1
Chronic pharyngitis and naso-pharyngitis 502	2,486	100.0	38.7	61.3	57.3	33.7	9.0
Chronic sinusitis 503	8,284	100.0	50.7	49.3	54.6	36.3	9.0
Hay fever 507	17,012	100.0	16.7	83.3	57.0	36.8	6.2

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

Table 17. Number of office visits for selected chronic diseases of the respiratory system and percent distribution of visits by number of types of diagnostic and therapeutic services ordered or provided, according to diagnosis: United States, 1975-76

Diagnosis and ICDA code[1]	Number of visits in thousands	Number of types of service				
		Total	None	One	Two	Three or more
		Percent distribution				
Chronic bronchitis 491	1,646	100.0	-	*12.5	*22.3	65.2
Emphysema 492	5,223	100.0	*0.1	10.9	21.0	68.1
Asthma 493	10,951	100.0	*0.5	32.5	27.5	39.5
Chronic pharyngitis and nasopharyngitis 502	2,486	100.0	*2.2	19.7	43.8	34.4
Chronic sinusitis 503	8,284	100.0	*0.7	15.9	32.6	50.9
Hay fever 507	17,012	100.0	*0.3	45.7	28.1	25.9

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

Table 18. Number of office visits for selected chronic diseases of the respiratory system and for all other morbidity-related groups by diagnostic or therapeutic services ordered or provided, by diagnosis: United States, 1975-76

Diagnostic or therapeutic service	Diagnosis and ICDA code[1]						
	Chronic bronchitis (491)	Emphysema (492)	Asthma (493)	Chronic pharyngitis and naso-pharyngitis (502)	Chronic sinusitis (503)	Hay fever (507)	All other morbidity-related ICDA[2] groups (000-458, 520-629, 680-738, 780-796)
	Number of visits in thousands						
All visits	1,646	5,223	10,951	2,486	8,284	17,012	667,261
	Percent of visits[3]						
Limited history and/or examination	53.6	71.7	53.0	57.2	68.5	38.2	67.7
General history and/or examination	*25.8	12.5	10.1	*14.9	7.0	6.9	18.8
Clinical laboratory test	*32.3	17.2	6.0	*7.5	10.3	4.8	27.0
X-ray	*24.1	13.4	5.8	*5.7	*6.7	*2.1	8.0
Blood pressure check	53.3	62.7	19.9	20.0	35.9	9.2	42.4
Electrocardiogram	*14.9	*9.7	*1.3	*0.0	*1.2	*0.7	4.6
Drug prescribed[4]	59.4	63.1	49.4	67.6	79.0	31.9	65.5
Injection	*27.5	22.8	26.4	*14.9	29.5	22.6	19.1
Immunization	*3.2	*4.2	40.7	*14.5	*1.1	52.7	1.6
Medical counseling	*17.8	16.7	11.5	*8.4	9.5	10.3	16.6
Other diagnostic and therapeutic services[5]	*8.6	11.4	7.7	11.6	16.1	10.7	29.9

[1]Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).
[2]For this report excludes categories relating to special conditions and examinations without sickness; complications of pregnancy, childbirth and the puerperium; congenital anomalies; certain causes of perinatal morbidity and mortality; accidents, poisonings, and violence; diagnosis "none" and "unknown."
[3]Percents will not add to 100.0 because more than one service may have been provided.
[4]Includes prescription and nonprescription drugs.
[5]Includes hearing test, vision test, endoscopy, office surgery, physiotherapy, psychotherapy or therapeutic listening, and other diagnostic or therapeutic services.

Table 19. Number and percent of office visits for asthma (493) by patient age, sex, and problem status and percent of visits, by diagnostic or therapeutic services ordered or provided: United States, 1975-76

Patient age, sex, and problem status	Number of visits in thousands	Diagnostic or therapeutic service								
		Limited history and/or examination	General history and/or examination	Clinical laboratory test	X-ray	Blood pressure check	Drug prescribed[1]	Injection	Immunization and/or desensitization	Medical counseling
		Percent[2]								
Patient age										
Under 6 years	1,552	45.7	*10.9	*7.0	*7.4	*3.3	55.2	36.2	*32.0	*12.8
6-14 years	2,049	46.4	*8.4	*5.1	*4.4	*4.1	39.9	26.9	46.9	*6.1
15-24 years	1,195	*47.1	*9.3	*7.4	*3.8	*13.9	*45.8	*16.1	52.2	*12.1
25-44 years	1,977	52.7	*11.6	*4.8	*6.2	*26.5	46.9	*20.7	46.5	*18.6
45-64 years	3,077	62.1	*9.9	*5.7	*6.6	31.4	54.7	27.8	35.4	*9.5
65 years and over	1,101	56.7	*10.6	*7.9	*5.9	*35.0	52.2	*29.2	*33.5	*12.1
Patient sex										
Female	6,007	53.8	11 0	*5.8	*4.9	23.1	50.9	25.2	42.9	13.8
Male	4,944	51.9	*9.0	*6.2	*7.0	15.6	47.4	27.9	38.1	*8.8
Problem status										
New problem	1,034	50.0	*37.5	*19.7	*20.8	*35.3	78.3	26.5	*9.5	*15.7
Continuing problem	9,917	53.3	7.2	*4.5	*4.3	18.3	46.3	26.4	*44.0	11.1

[1]Includes prescription and nonprescription drugs.
[2]Percents will not add to 100.0 because more than one service may have been provided.

Table 20. Number and percent of office visits for hay fever (507) by patient age, sex, and problem status and percent of visits, by diagnostic or therapeutic services ordered or provided: United States, 1975-76

Patient age, sex, and problem status	Number of visits in thousands	Diagnostic or therapeutic service						
		Limited history and/or examination	General history and/or examination	Blood pressure check	Drug prescribed[1]	Injection	Immunization and/or desensitization	Medical counseling
		Percent[2]						
Patient age								
Under 6 years	1,323	*33.3	*13.0	*0.8	*40.6	*12.0	54.2	*15.0
6-14 years	3,642	32.6	*5.8	*1.3	22.7	18.0	59.8	*9.1
15-24 years	2,823	38.6	*9.6	*12.3	35.7	24.9	46.9	*9.0
25-44 years	5,263	39.5	*5.0	*10.4	33.4	27.0	51.8	11.5
45-64 years	3,004	46.5	*5.7	*14.7	32.8	23.3	50.3	*10.6
65 years and over	957	*31.3	*9.4	*18.0	*32.4	*21.8	*53.0	*5.6
Patient sex								
Female	9,579	40.3	6.4	10.5	34.2	22.3	52.5	10.1
Male	7,434	35 4	*7.6	*7.6	29.0	23.0	53.0	10.7
Problem status								
New problem	2,848	54.8	24.1	22.4	73.0	*14.0	11.5	*17.8
Continuing problem	14,164	34.8	*3.5	6.6	23.6	24.3	61.0	8.8

[1]Includes prescription and nonprescription drugs.
[2]Percents will not add to 100 0 because more than one service may have been provided.

Table 21. Number of office visits for selected chronic diseases of the respiratory system and for all other morbidity-related groups and percent distribution by duration and disposition of visits, by diagnosis: United States, 1975-76

Duration and disposition	Diagnosis and ICDA code[1]						
	Chronic bronchitis (491)	Emphysema (492)	Asthma (493)	Chronic pharyngitis and naso-pharyngitis (502)	Chronic sinusitis (503)	Hay fever (507)	All other morbidity-related ICDA[2] groups (000-458, 520-629, 680-738, 780-796)
	Number of visits in thousands						
All visits	1,646	5,223	10,951	2,486	8,284	17,012	667,261
	Percent distribution						
	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Duration[3]							
0-5 minutes	*9.7	6.9	22.6	20.0	20.1	40.1	13.4
6-10 minutes	*29.7	28.0	31.9	40.7	36.1	28.0	38.5
11-15 minutes	37.1	31.8	24.6	23.3	25.7	16.5	27.5
16-30 minutes	*16.8	26.6	14.8	13.2	16.0	10.4	21.9
31 minutes or longer	*6.7	6.7	6.2	2.9	2.1	5.1	7.5
Disposition[4]							
No followup	*5.5	*4.5	*2.9	*16.5	13.4	4.7	8.2
Return at specified time	58.6	74.9	77.3	48.1	38.4	74.5	63.7
Return if needed	*32.9	16.2	17.2	32.8	42.7	19.6	24.9
Telephone followup	*3.6	*2.5	*3.7	*2.9	*6.4	*1.8	3.6

[1]Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).
[2]For this report excludes categories relating to special conditions and examinations without sickness; complications of pregnancy, childbirth and the puerperium; congenital anomalies; certain causes of perinatal morbidity and mortality; accidents, poisonings, and violence; diagnosis "none" and "unknown."
[3]Face-to-face encounter between physician and patient.
[4]*Percents will not add to 100.0 because more than one disposition may have been possible.*

Table 22. Number of office visits for selected chronic diseases of the respiratory system and percent distribution of visits by physician specialty, according to diagnosis: United States, 1975-76

Diagnosis and ICDA code[1]	Number of visits in thousands	Physician specialty						
		Total	General and family practice	Internal medicine	Pediatrics	Otolaryngology	Allergy	All other specialties (residual)
		Percent distribution						
Chronic bronchitis 491	1,646	100.0	52.9	*25.8	*0.3	*1.2	*0.6	*19.2
Emphysema 492	5,223	100.0	52.4	30.3	*0.6	*0.0	*3.1	13.6
Asthma 493	10,951	100.0	29.5	10.6	21.9	*0.7	32.3	5.0
Chronic pharyngitis and nasopharyngitis 502	2,486	100.0	30.3	*4.2	*14.9	34.3	*11.9	4.4
Chronic sinusitis 503	8,284	100.0	60.5	10.2	*5.6	*13.5	*0.8	9.4
Hay fever 507	17,012	100.0	26.3	9.9	17.8	9.6	30.6	5.8

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

Table 23. Number of office visits to pediatricians for asthma and hay fever made by patients under 15 years of age and percent of visits by age of patient: United States, 1975-76

Patient age	Diagnosis and ICDA code[1]	
	Asthma (493)	Hay fever (507)
	Number in thousands	
All visits	2,399	3,034
	Percent[2]	
Under 3 years	*15.8	*9.0
3-15 years	24.0	18.4
6-10 years	31.5	32.9
11-14 years	*15.1	19.4

[1]Based on the *Eighth Revision International Classification of Diseases, Adapted for Use in the United States* (ICDA).
[2]Percents will not add to 100.0 because percents of age groups 15 years and over are not shown.

Table 24. Percent distribution of office visits for asthma and hay fever by patient age, problem status, and selected services ordered or provided, according to physician specialty: United States, 1975-76

Patient age, problem status, and selected services	Asthma				Hay fever			
	Physician specialty				Physician specialty			
	General and family practice	Internal medicine	Pediatrics	Allergy	General and family practice	Internal medicine	Pediatrics	Allergy
	Percent distribution							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Patient age								
Under 15 years	21.5	*4.9	86.3	17.8	21.7	*13.0	79.8	17.4
15-24 years	*10.3	*3.7	*5.8	17.1	17.0	*25.0	*8.8	19.6
25-44 years	18.7	*24.3	*4.6	24.6	35.5	*32.6	*7.7	36.2
45-64 years	39.4	*47.1	*2.7	29.1	19.8	*16.6	*2.7	21.5
65 years and over	*10.1	*20.0	*0.6	*11.5	*6.0	*12.8	*1.0	*5.3
Problem status								
New problem	*9.0	*10.6	*13.3	*6.1	26.3	*18.0	*11.3	*6.1
Continuing problem	91.0	89.4	86.7	93.9	73.7	82.0	88.7	93.9
Diagnostic or therapeutic services[1]								
Limited history and/or examination	64.2	60.3	44.7	45.5	39.2	36.5	25.6	42.2
General history and/or examination	*6.8	*13.8	*10.8	*10.9	*3.3	*9.8	*9.4	*7.3
Clinical laboratory test	*5.5	*11.9	*5.4	*4.1	*5.9	*11.8	*5.5	*2.2
X-ray	*4.6	*6.7	*4.3	*6.2	*1.8	*5.1	*0.9	*0.1
Blood pressure check	31.9	*46.4	*2.8	*9.8	16.5	*27.0	*0.9	*5.1
Drug prescribed[2]	62.4	55.0	41.2	39.8	37.4	26.5	26.5	21.6
Injection	42.9	*22.1	26.9	*12.7	37.4	*14.5	*14.5	16.2
Immunization	*14.0	*14.0	43.8	76.1	38.1	62.2	62.2	74.1
Medical counseling	*4.0	*24.2	*8.9	16.2	*8.4	*9.1	*9.1	12.4

[1]Percents will not add to 100.0 because more than one service may have been provided.
[2]Includes prescription and nonprescription drugs.

APPENDIXES

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APPENDIX I

TECHNICAL NOTES[i]

This report is based on data collected in the National Ambulatory Medical Care Survey (NAMCS). The NAMCS is an annual sample survey of office-based physicians conducted by the Division of Health Resources Utilization Statistics of the National Center for Health Statistics. The present report is based on information collected during 1975 and 1976.

Statistical Design

Scope of the survey.—The target population of NAMCS encompasses office visits within the conterminous 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, or radiology. Telephone contacts and nonoffice visits are excluded.

Sample design.—The NAMCS utilizes a multistage probability design that involves 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 NAMCS field and data processing operations and 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 files maintained by the American Medical Association (AMA) and American Osteopathic Association (AOA) who met the following criteria:

Office-based, as defined by 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.

Within each PSU, all eligible physicians were arranged by nine specialty groups; general and family medicine, internal medicine, pediatrics, other medical specialties, general surgery, obstetrics and gynecology, other surgical specialties, psychiatry, and all 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.

During 1975-76 the total NAMCS sample included 6,529 physicians. Sample physicians were screened at the time of the survey to assure that they met the aforementioned criteria; 925 physicians did not meet all of the criteria and were, therefore, ruled out of scope (ineligible)

[i]Prepared by Thomas McLemore, M.S.P.H., Division of Health Resources Utilization Statistics.

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 5,604 in-scope (eligible) physicians, 4,476 (79.9 percent) participated in the study. Of the participating physicians, 679 physicians saw no patients during their assigned reporting period because of vacations, illness, or other reasons for being temporarily not in practice. The physician sample size and response rates by physician specialty are shown in table I.

The final stage was the selection of patient visits within the annual practices of the 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 later in the Technical Notes and in the Induction Interview form displayed in appendix III. During 1975-76 information was collected on 113,921 patient visits by means of NAMCS.

Data Collection and Processing

Field procedures.—Both mail and telephone contacts were used to enlist sample physicians into NAMCS. Physicians received introductory letters from NCHS (see appendix III) and 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 from NORC telephoned the sample physician to explain the study briefly and to 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

Table I. Distribution of physicians in the 1975-76 National Ambulatory Medical Care Survey sample and response rates, by physician specialty

Physician's specialty	Gross total	Out of scope	Net total	Non-respondents	Respondents	Response rate
	Number of physicians					
All specialties	6,529	925	5,604	1,128	4,476	79.9
General practice	1,687	260	1,427	333	1,094	76.7
Medical specialties	1,765	245	1,520	337	1,183	77.8
Internal medicine	938	124	814	202	612	75.2
Pediatrics	435	74	361	53	308	85.3
Other	392	47	345	82	263	76.2
Surgical specialties	2,316	189	2,127	381	1,746	82.1
General surgery	679	54	625	113	512	81.9
Obstetrics and gynecology	558	48	510	94	416	81.6
Other	1,079	87	992	174	818	82.5
Other specialties	761	231	530	77	453	85.5
Psychiatry	468	79	389	45	344	88.4
Other	293	152	141	32	109	77.3

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 NORC 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 NAMCS. After the end of the survey year each sample physician was sent a thank-you letter from 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 visits for which data were to be recorded. A perforation between the patient names and patient visit characteristics permitted the physician to remove patient names thus protecting the confidentiality of the patient.

Based on the physician's estimate of the expected number of office visits and expected number of days in practice, 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; 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 NORC field staff, clerical edits were performed upon receipt of the data for central processing. These procedures proved quite efficient, reducing item nonresponse rates to a negligible amount—2 percent or less for each data item.

Information contained in items 5 and 9 of the Patient Record were coded in a separate medical coding operation. This coding was performed by the American Medical Records Association, under subcontract to NORC. The data in item 5, the patient's reason for visit, were coded according to a special classification system developed for that purpose.[9] The 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 entries was coded from each of these items. A two-way independent verification procedure with 100-percent verification was used to control the medical coding operation. Differences between coders were adjudicated at NCHS.

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.

NOTE: A list of references follows the text.

Estimation Procedures

Statistics produced from 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 in the material that follows.

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 within 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 NAMCS data were adjusted to account for sample physicians who refused to 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 that 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 NAMCS 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 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 which 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 error 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.[14,15]

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 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 following formula:

$$\text{RSE}\ (x) = \sqrt{0.0009113499 + \frac{54.14306}{x}} \cdot 100$$

where x is the aggregate of interest in thousands.

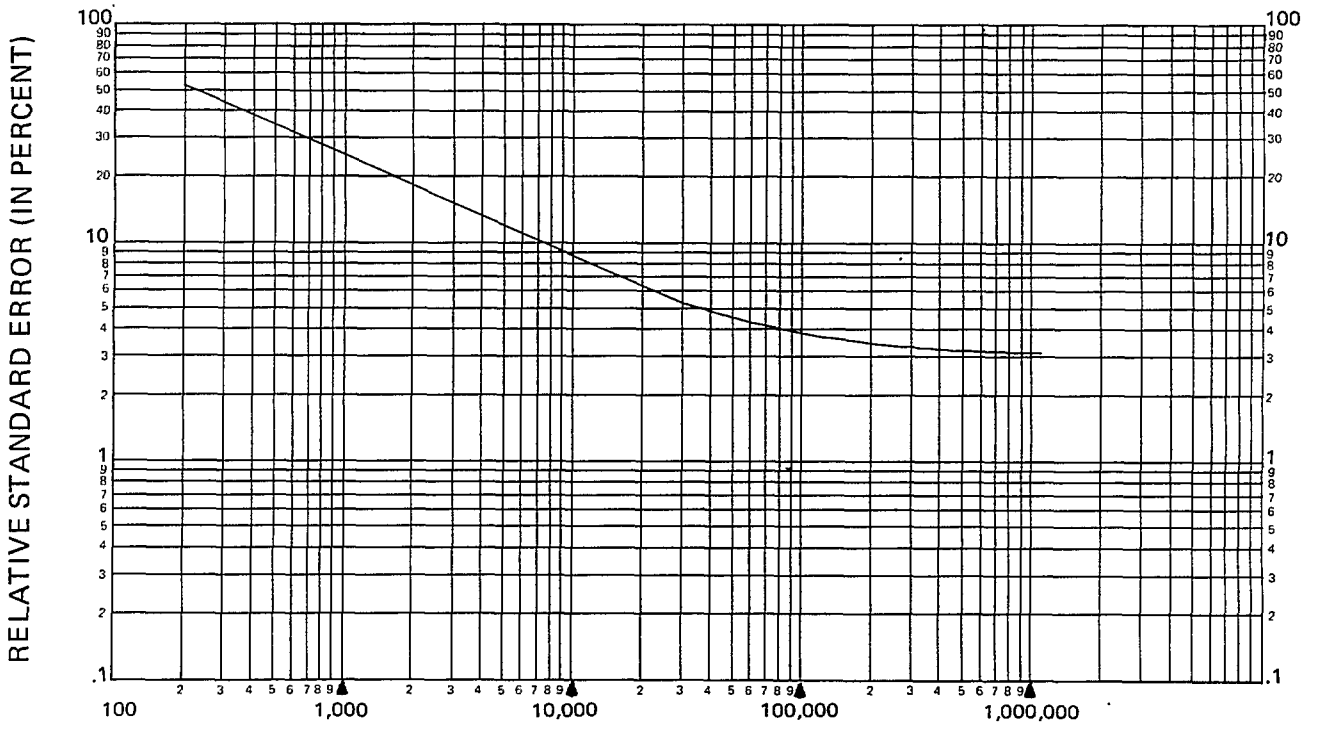
2. *Estimates of percentages:* Approximate relative standard errors (in percent) for estimates of this type can be calculated from the curve in figure I as follows. Obtain the relative standard error of the numerator and denominator. Square each of the relative standard errors, subtract the resulting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

$$\text{RSE}\ (p) = \sqrt{\frac{54.14306\ (1 - p)}{p \cdot x}} \cdot 100$$

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

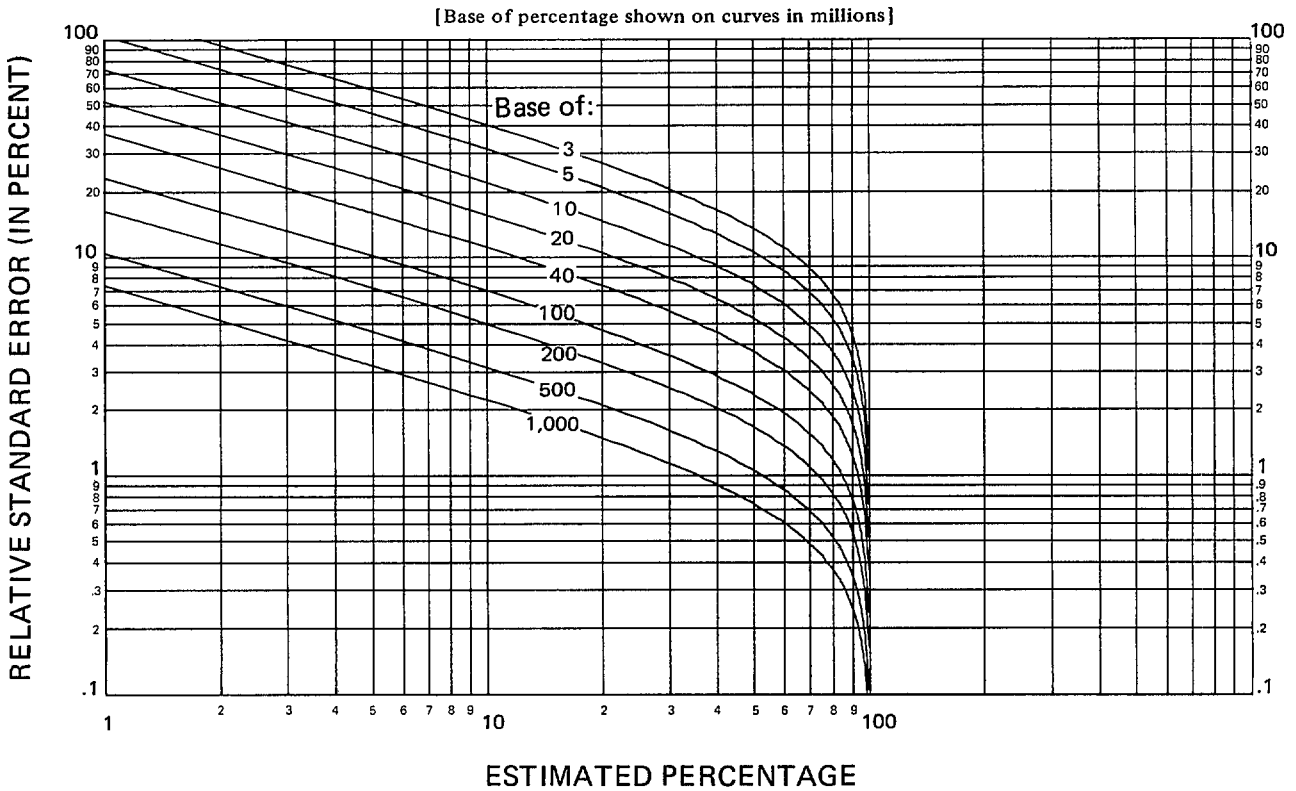
3. *Estimates of rates where the numerator is not a subclass of the denominator:* Approximate relative standard errors for rates where the denominator is the total U.S. population or one or more of the age-sex-race groups of the total population are equivalent to the relative standard error of the numerator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

Figure I. Approximate relative standard errors for estimated numbers of office visits, 1975-76 National Ambulatory Medical Survey



Example of use of this graph: An estimate of 10 million office visits (read from scale at bottom of graph) has a relative standard error of 8.0 percent (read from scale at left of graph) or a standard error of 800,000 office visits (8.0 percent of 10 million visits).

Figure II. Approximate relative standard errors for percentages of estimated numbers of office visits, 1975-76 National Ambulatory Medical Care Survey



Example of use of this graph: An estimate of 20 percent (read from scale at bottom of graph) based on an estimate of 10 million visits has a relative standard error of 14.7 percent (read from scale at left of graph) or a standard error of 2.9 percentage points (14.7 percent of 20 percent).

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.

The half-sample replication procedure was also used to calculate standard errors for the specific estimates of mean contact duration of visit presented in this report; these standard errors are presented in tables E and H along with the estimates.

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 and careful attention was given to phasing of the questions and the terms employed and their definitions in order to eliminate ambiguities and encourage uniformity. Steps taken to reduce nonresponse bias were 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 determination of statistical inference for single comparisons is based on the *t*-test with a critical value of 1.96 (0.05 level of significance). The Bonferroni technique is used for simultaneous testing of multiple comparisons. Terms relating to differences, such as "higher," "less," and so forth, indicate that the differences are statistically significant. Terms such as "similar," "no difference," and so forth, mean that the difference between the statistics being compared is not statistically significant. 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 and Rate Computation

The population figures used in computing average annual visit rates are presented in table II. These figures are based on an average of the July 1, 1975 and July 1, 1976, provisional estimates of the civilian noninstitutionalized population of the United States obtained from the U.S. Bureau of the Census. Because NAMCS includes data for only the conterminous 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

Table II. Estimated number of persons in the civilian noninstitutionalized population of the United States[1] used in computing average annual rates in this publication, by race and sex: United States, 1975-76

Race and sex	Age							
	All ages	Under 15 years	15-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65 years and over
	Number in thousands							
All races	208,610	52,723	38,729	30,369	22,353	23,349	19,608	21,479
Male	100,639	26,884	18,977	14,714	10,737	11,242	9,240	8,845
Female	107,971	25,839	19,752	15,655	11,616	12,107	10,368	12,634
White	181,285	43,988	33,147	26,567	19,571	20,790	17,727	19,496
Male	87,823	22,491	16,356	13,034	9,513	10,063	8,376	7,991
Female	93,462	21,497	16,791	13,533	10,058	10,727	9,352	11,505
All other races	27,324	8,736	5,582	3,803	2,782	2,558	1,881	1,983
Male	12,816	4,393	2,621	1,681	1,224	1,179	864	854
Female	14,509	4,343	2,961	2,122	1,558	1,379	1,016	1,129

[1] Excludes Alaska and Hawaii.

here solely for the purpose of providing denominators for rate computations.

Average annual visit rates in this report were calculated as follows. The numerator was obtained by dividing the estimated number of office visits for 1975-76 by 2, to obtain an average annual number of office visits. This number was then divided by the appropriate population figure to obtain an average annual visit rate. As previously discussed, reliability estimates for average annual visit rates can be calculated from figure I.

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. Some of those factors are:

1. The sampling frame for the 1975 and 1976 NAMCS included all nonfederally employed, "office-based, patient care" physicians on the AMA-AOA master files. There are certainly physicians not so classified who, at the time of the survey, would have met the criteria for that classification. Visits to these physicians are not represented in these data.
2. Physicians who participated in 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 bias into the data.

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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 (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 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 the physician's 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 or her 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 aftersurgery 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 that 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 under "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, and so forth. *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 that is limited to a specific body site or system, or that 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 to describe the physician's disposition of the case are provided 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

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National Medical Association
Alfred F. Fisher
Executive Director

American Academy of Dermatology
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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

1975-76

PATIENT RECORD AND PATIENT LOG

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 others for purposes or used for any other purpose

PATIENT LOG

As each patient arrives, record name and time of visit on the log below. For the patient entered on line #3, also complete the patient record to the right.

PATIENT'S NAME	TIME OF VISIT
1	a.m. / p.m.
2	a.m. / p.m.
3	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)*
- ☐ VERY SERIOUS
- ☐ SERIOUS
- 3 ☐ SLIGHTLY SERIOUS
- 4 ☐ NOT SERIOUS

7. HAVE YOU EVER SEEN THIS PATIENT BEFORE?

YES ☐ NO

If YES, for the problem indicated in ITEM 5a?

☐ YES ☐ 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
- ☐ IMMUNIZATION
- ☐ REFERRED BY OTHER PHYS/AGENCY
- ☐ 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
- 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-34-4
REV. 8-75

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

O.M.B. #68-S72106

INDUCTION INTERVIEW FORM

CONFIDENTIAL*
NORC-4233

Form Approved.
OMB No. 68R1498

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.	B. Total days in practice during week.						
	ENTER TOTAL FROM Q. 4-A. _____	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 BRIEF 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 (SPCIFY 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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DHEW Publication No. (PHS) 79-1793
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