Form Approved
OMB No. 0923-0051
Exp. Date 03/31/2018

Flint Medical Chart Abstraction Form

Reviewer Name: _____ Date of Review: ___ / ___ / ____ Data entered: ___ / ___ / ____
Facility: _____ ID: _____

Patient Name: _____ Patient Phone Number_____

Address: Street: _____ City: _____ State: _____ Zip: _____

Patient Demographics

DOB: ____ / ____ / _____ **Sex:** □ Male □ Female □ N/A **Occupation:** _____
MM DD YYYY
Ethnicity: □ Hispanic □ Not Hispanic

Insurance:
□ Private □ Medicare/Medicaid/Government program
□ None □ N/A □ Other: _____

Race: (check all that apply)
□ American Indian/ Alaskan Native □ Asian □ Black
□ Native Hawaiian/ Pacific Islander □ White

Visit Information

Date of Visit: ____ / ____ / _____ Time of arrival: ____:____ □ am □ pm
MM DD YYYY

Chief Complaint: _____
Initial Vital Signs: Height: _____ □ cm □ in Weight: _____ □ kg □ lb

Temp (°F): _____ Heart Rate: _____ Respiratory Rate: _____ BP (mmHg): _____ / _____

Current Signs and Symptoms (check all that apply)

	Location	Onset Date	End Date	Size(in)
□ Rash	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	_____
□ Hives	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	_____
□ Raised bumps	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	_____
□ Itchy Skin	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	_____
□ Painful Skin	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	_____
□ Eczema	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	_____
□ Psoriasis	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	_____
□ Erythema/Redness	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	_____
□ Numbness/Tingling	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	
□ Hair Loss/Alopecia	Description: _____ Location: _____	__/__/___	__/__/___	
	(*e.g. patchy, strands, etc*) (*e.g. right side, crown, hairline etc*)			
□ Tooth loss	Quantity: _____ Location: _____	__/__/___	__/__/___	
□ Fever		__/__/___	__/__/___	
□ Diarrhea		__/__/___	__/__/___	
□ Eye Irritation		__/__/___	__/__/___	

Notes/other symptoms: _____

Medical History (check all that apply)

□ Asthma
□ Shortness of Breath
□ Pregnant □ Breastfeeding
□ Wheezing
□ Diabetes
□ Allergies: _____
□ Hypertension
□ Congestive heart failure
□ COPD
□ Depression
□ Stress Screening: _____
□ Tobacco use: _____
□ Other: _____

Current Medications:
_____
_____

Medications Prescribed as a Result of Visit:
_____
_____

Skin History (check all that apply)

	Location	Onset Date	End Date	Size(in)
□ Rash	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	_____
□ Hives	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	_____
□ Raised bumps	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	_____
□ Itchy Skin	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	_____
□ Painful Skin	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	_____
□ Eczema	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	_____
□ Psoriasis	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	_____
□ Erythema/Redness	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	_____
□ Numbness/Tingling	□ Face □ Arms □ Legs □ Feet □ Neck □ Other_____	__/__/___	__/__/___	
□ Hair Loss/Alopecia	Quantity: _____ Location: _____	__/__/___	__/__/___	

Notes/other skin history: _____
_____

Diagnosis/Treatment/Recommendations

Diagnosis: _____

Treatment/Recommendations:
_____
_____
_____
_____