

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 American Indian/ Alaskan Native Asian Black
 None N/A Other: _____ Native Hawaiian/ Pacific Islander White

Race: (check all that apply)**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)
<input type="checkbox"/> Rash	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other _____	___/___/___	___/___/___	_____
<input type="checkbox"/> Hives	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other _____	___/___/___	___/___/___	_____
<input type="checkbox"/> Raised bumps	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other _____	___/___/___	___/___/___	_____
<input type="checkbox"/> Itchy Skin	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other _____	___/___/___	___/___/___	_____
<input type="checkbox"/> Painful Skin	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other _____	___/___/___	___/___/___	_____
<input type="checkbox"/> Eczema	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other _____	___/___/___	___/___/___	_____
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other _____	___/___/___	___/___/___	_____
<input type="checkbox"/> Erythema/Redness	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other _____	___/___/___	___/___/___	_____
<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other _____	___/___/___	___/___/___	_____
<input type="checkbox"/> Hair Loss/Alopecia	Description: _____ Location: _____ (e.g. patchy, strands, etc) (e.g. right side, crown, hairline etc)	___/___/___	___/___/___	_____
<input type="checkbox"/> Tooth loss	Quantity: _____ Location: _____	___/___/___	___/___/___	_____
<input type="checkbox"/> Fever		___/___/___	___/___/___	_____
<input type="checkbox"/> Diarrhea		___/___/___	___/___/___	_____
<input type="checkbox"/> Eye Irritation		___/___/___	___/___/___	_____

Notes/other symptoms: _____

Medical History (check all that apply)

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

Current Medications:**Medications Prescribed as a Result of Visit:**

Public reporting burden of this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS E-11 Atlanta, Georgia 30333. ATTN: PRA (0923-0051)

Skin History (check all that apply)

	Location	Onset Date	End Date	Size(in)
<input type="checkbox"/> Rash	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other_____	__/__/__	__/__/__	_____
<input type="checkbox"/> Hives	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other_____	__/__/__	__/__/__	_____
<input type="checkbox"/> Raised bumps	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other_____	__/__/__	__/__/__	_____
<input type="checkbox"/> Itchy Skin	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other_____	__/__/__	__/__/__	_____
<input type="checkbox"/> Painful Skin	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other_____	__/__/__	__/__/__	_____
<input type="checkbox"/> Eczema	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other_____	__/__/__	__/__/__	_____
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other_____	__/__/__	__/__/__	_____
<input type="checkbox"/> Erythema/Redness	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other_____	__/__/__	__/__/__	_____
<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Face <input type="checkbox"/> Arms <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Other_____	__/__/__	__/__/__	_____
<input type="checkbox"/> Hair Loss/Alopecia	Quantity: _____ Location: _____	__/__/__	__/__/__	_____

Notes/other skin history: _____

Diagnosis/Treatment/Recommendations

Diagnosis: _____

Treatment/Recommendations:

