### Attachment 17a.

**Agency for Toxic Substances and Disease Registry (ATSDR)**

Form Approved

OMB No. 0923-XXXX

Exp. Date xx/xx/201x xx/xx/20xxExDaxx/xx/20xx

Exp. Date xx/xx/20xx

Multi-Site Study

Medical Record Abstraction Form - Adult

Flesch-Kincaid Readability Score – 11.1

**Multi-Site Study**

ATSDR estimates the average public reporting burden for this collection of information as 20 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0923-xxxx).

**Medical Record Abstraction Form - Adult**

|  |  |  |  |
| --- | --- | --- | --- |
| **Study ID: [\_\_\_\_\_\_\_\_\_\_\_\_]** | **Participant Name: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]** | **Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_** | **SSN: xxx-xx-xxxx** |

The person named above, or his or her legal representative, has authorized you to release his or her medical records to [institution name] and ATSDR for research purposes. Please check If you have a record that a doctor or other health care provider diagnosed or is treating any of the following medical conditions.

Please fill out the table below. Circle appropriate response and specify requested details as directed. Thank you.

| Medical Condition | Record Located (Comments) | Year of Diagnosis or Treatment |
| --- | --- | --- |
| 1. High cholesterol? | Yes  No |  |
| 1. Other dyslipidemia? | Yes (Please specify diagnosis) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |  |
| 1. Heart disease? | Yes  No |  |
| 1. Hypertension? | Yes  No |  |
| 1. Pregnancy induced hypertension? | Yes  No |  |
| 1. Thyroid disease? | Yes (Please specify diagnosis) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |  |
| 1. Liver disease? | Yes (Please specify diagnosis) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |  |
| 1. Kidney disease? | Yes (Please specify diagnosis) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |  |
| 1. Diabetes? | Yes (Please specify diagnosis) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |  |
| j. Gestational diabetes? | Yes  No |  |
| 1. Osteoarthritis? | Yes (Please specify diagnosis) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |  |
| 1. Osteopenia or Osteoporosis? | Yes (Please specify diagnosis) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |  |
| 1. Ulcerative colitis? | Yes  No |  |
| 1. Rheumatoid arthritis? | Yes  No |  |
| 1. Autoimmune disease?   (i.e. Lupus, Multiple sclerosis, Emphysema, Fibromyalgia, Celiac Disease, Crohn’s Disease) | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |  |
| 1. Parkinson Disease | Yes  No |  |
| 1. Endometriosis? | Yes  No |  |
| 1. Asthma? | Yes  No |  |
| 1. Cancer? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |  |
| 1. Other cancer? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |  |
| 1. Atopic dermatitis/eczema? | Yes  No |  |
| 1. Allergies? | Yes  No |  |
| 1. Infertility? | Yes  No |  |
| 1. PPregnancy induced hypertension/preeclampsia? | Yes (Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No |  |
| 1. Gestational diabetes? | Yes  No |  |