Multi-Site Study
Medical Record Abstraction Form - Adult
Flesch-Kincaid Readability Score – 11.1

Attachment 17a.

Agency for Toxic Substances and Disease Registry (ATSDR)
Multi-Site Study

Form Approved
OMB No. 0923-XXXX
Exp. Date xx/xx/201x

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
a. High cholesterol?	Yes No	
b. Other dyslipidemia?	Yes (Please specify diagnosis) _____ No	
c. Heart disease?	Yes No	
d. Hypertension?	Yes No	
e. Pregnancy induced hypertension?	Yes No	
f. Thyroid disease?	Yes (Please specify diagnosis) _____ No	

Medical Condition	Record Located (Comments)	Year of Diagnosis or Treatment
g. Liver disease?	Yes (Please specify diagnosis) _____ No	
h. Kidney disease?	Yes (Please specify diagnosis) _____ No	
i. Diabetes?	Yes (Please specify diagnosis) _____ No	
j. Gestational diabetes?	Yes No	
j. Osteoarthritis?	Yes (Please specify diagnosis) _____ No	
k. Osteopenia or Osteoporosis?	Yes (Please specify diagnosis) _____ No	
l. Ulcerative colitis?	Yes No	
m. Rheumatoid arthritis?	Yes No	
n. Autoimmune disease? (i.e. Lupus, Multiple sclerosis, Emphysema, Fibromyalgia, Celiac Disease, Crohn's Disease)	Yes (Please specify) _____ No	
o. Parkinson Disease	Yes No	
p. Endometriosis?	Yes No	
q. Asthma?	Yes No	
r. Cancer?	Yes (Please specify) _____ No	
s. Other cancer?	Yes (Please specify) _____	

Medical Condition	Record Located (Comments)	Year of Diagnosis or Treatment
	No	
t. Atopic dermatitis/eczema?	Yes No	
u. Allergies?	Yes No	
v. Infertility?	Yes No	
w. PPregnancy induced hypertension/preeclampsia?	Yes (Please specify) _____ No	
x. Gestational diabetes?	Yes No	