

Attachment 17a.

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

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

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
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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	