Attachment 17b.

Multi-Site Study
Medical Record Abstraction Form - Child
Flesch-Kincaid Readability Score – 12.5

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

Agency for Toxic Substances and Disease Registry (ATSDR)
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 - Child

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. Allergies?	Yes (Please specify diagnosis)_______________________ No	
b. Atopic dermatitis/eczema?	Yes No	
c. Asthma?	Yes No	
d. Rhinitis?	Yes No	
e. High cholesterol?	Yes No	
f. Thyroid disease?	Yes (Please specify diagnosis)_______________________	

Medical Condition	Record Located (Comments)	Year of Diagnosis or Treatment
	No	
g. Delayed puberty?	Yes (Please specify diagnosis)________________________ No	
h. Obesity?	Yes No	
i. Lupus	Yes No	
j. Celiac disease	Yes No	
k. Diabetes type 1	Yes No	
l. Diabetes type 2	Yes No	
m. Attention deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD)?	Yes (Please specify diagnosis) _________________________ No	
n. Autism?	Yes No	
o. OOther learning or behavioral problems?	Yes (Please specify diagnosis) _________________________ No	
o. Cancer?	Yes (Please specify diagnosis) _________________________ No	
p. Other cancer?	Yes (Please specify diagnosis) _________________________ No	
q. Pregnancy induced	Yes (Please specify diagnosis) _________________________	

Medical Condition	Record Located (Comments)	Year of Diagnosis or Treatment
hypertension/preeclampsia?	No	
r. Gestational Diabetes?	Yes No	