

Cardiovascular Health Study

# NEUROLOGIC EVALUATION FOR STROKE/TIA

\*\*\* Attach Copies of Initial History and Physical \*\*\*  
 \*\*\* Attach Copies of All Neurologist's Notes \*\*\*  
 \*\*\* Attach Copies of Carotid Ultrasound or Duplex Reports \*\*\*  
 \*\*\* Attach Copies of Echocardiogram Reports \*\*\*  
 \*\*\* Attach Copies of MR Angiography Reports \*\*\*  
 \*\*\* Attach Copies of ECGs \*\*\*  
 \*\*\* Send Copies of CT/MRI Films to CC\*\*\*

## History, Hospital Record, Interview

1. Was the participant hospitalized as an immediate consequence of this event?  1 YES  0 NO  9 UNKNOWN
2. Did the stroke/TIA occur during hospitalization for a different reason?  1 YES  0 NO  9 UNKNOWN

3. Please answer the following for the first admission as an immediate consequence of this event:?

Date of admission:  /  /  Date of discharge or death:  /  /

4. Has the participant been diagnosed or treated for any of the following concurrent with this event?

1 0 9  
Yes No Unk

- ATRIAL FIBRILLATION/FLUTTER
- ANGINA PECTORIS, CORONARY INSUFFICIENCY OR OTHER CHRONIC ISCHEMIC HEART DISEASE
- CONGESTIVE FAILURE OR CONGESTIVE CARDIOMYOPATHY
- ECHOCARDIOGRAM OR CARDIAC CT SHOWING MURAL THROMBUS OR SOURCE OF EMBOLI

5. Evidence of valvular heart disease:

1 YES  0 NO  9 UNKNOWN

Specify valve(s):

6. Is there a past medical history of any of the following conditions/procedures/medications prior to this event?

1 0 9  
Yes No Unk

- A. CORONARY BYPASS SURGERY
- B. ANGIOGRAPHY
- C. CAROTID ENDARTERECTOMY

Public reporting burden for the collection of information is estimated to average 30-40 minutes, including the time for reviewing instructions, gathering needed information and completing and reviewing the questionnaire. If you have comments regarding this burden please send them to Reports Clearance Officer, PHS, 721 -H Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201, Attention:PRA, and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

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7. Did the participant develop the following complications?
- |                         | 1                     | 0                     | 9                     |
|-------------------------|-----------------------|-----------------------|-----------------------|
|                         | Yes                   | No                    | Unk                   |
| SEPSIS/SEPTIC SHOCK     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| PNEUMONIA/PNEUMONITIS   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| URINARY TRACT INFECTION | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| DEEP VEIN THROMBOSIS    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| PULMONARY EMBOLUS       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| GI BLEED                | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| DECUBITUS               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

8. Did the participant receive any of the following therapies or procedures?

	1	0	9
	Yes	No	UK
HEPARIN (EXCEPT TO KEEP I.V. LINE OPEN)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COUMADIN (WARFARIN)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
INTRAVENOUS PRESSORS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
INTUBATION AND MECHANICAL VENTILATION (BREATHING MACHINE)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. Did the participant receive TPA?

1 YES    0 NO    9 UNKNOWN

- a. If yes, reason for TPA:

1 STROKE    2 MI    8 OTHER, SPECIFY:

- b. Number of hours between onset of symptoms and TPA administration? \_\_\_\_\_ hours

**Onset**

10. At the time of onset, was there:
- |                              | 1                     | 0                     | 9                     |
|------------------------------|-----------------------|-----------------------|-----------------------|
|                              | Yes                   | No                    | Unk                   |
| SEVERE HEADACHE              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| VOMITING                     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| SEIZURES                     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| FOCAL DEFICIT                | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| DECREASED CONSCIOUSNESS/COMA | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

11. Steplike worsening?

1 YES    0 NO    9 UNKNOWN

12. Gradual worsening?

1 YES    0 NO    9 UNKNOWN

13. Improvement occurred even temporarily within the first 24 hours after onset?

1 YES    0 NO    9 UNKNOWN

14. Were anticoagulants (heparin, coumadin) being used at the time of the event?

1 YES    0 NO    9 UNKNOWN

15. Were antiplatelet drugs being used at the time of the event?

1 YES    0 NO    9 UNKNOWN

16. Characteristics of the event or events:

	1	0	9
	Yes	No	Unk
LASTED MORE THAN 24 HOURS OR UNTIL DEATH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LASTED MORE THAN 30 SECONDS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MAXIMAL DEFICIT WAS ATTAINED IN LESS THAN FIVE MINUTES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

17. During the attack, did the participant have visual loss?

	LEFT			RIGHT		
	1	0	9	1	0	9
	Yes	No	Unk	Yes	No	Unk
EYE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
VISUAL FIELD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. During the attack, did the participant have weakness, paralysis, or clumsiness?

	LEFT			RIGHT		
	1	0	9	1	0	9
	Yes	No	Unk	Yes	No	Unk
FACE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ARM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LEG	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19. During the attack, did the participant have loss of feeling, numbness or paresthesia?

	LEFT			RIGHT		
	1	0	9	1	0	9
	Yes	No	Unk	Yes	No	Unk
FACE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ARM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LEG	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

20. During the attack, did the participant have any of the following?

	1	0	9
	Yes	No	Unk
DYSARTHRIA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
APHASIA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LOSS OF BALANCE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
VERTIGO	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DIPLOPIA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DYSPHAGIA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

21.. Cervical bruit:

1 ABSENT     2 PRESENT     9 UNKNOWN

22. Cervical bruits-Check the appropriate codes. Check "8 - Not related" if an indicated abnormality is not related to present event.

Codes: 1-Absent                      2-Present  
          8-Not related                9-Unknown

	1	2	8	9
A. LEFT CAROTID	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. RIGHT CAROTID	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. LEFT SUBCLAVIAN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. RIGHT SUBCLAVIAN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## Examination

23. Was a neurologic examination done?

1 YES     0 NO     9 UNKNOWN

24. Degree of alertness

1 ALERT                                       5 COMA  
 2 LETHARGIC OR DROWSY                 8 UNTESTABLE  
 3 STUPOR                                       9 UNKNOWN

25. Verbal response (aphasics are untestable):

1 ORIENTED AND CONVERSES                 5 NONE  
 2 DISORIENTED                                 8 UNTESTABLE  
 3 INAPPROPRIATE WORDS                     9 UNKNOWN  
 4 INCOMPREHENSIBLE SOUNDS

26. Remainder of neurologic exam (including nuchal rigidity and cervical bruit):

1 NORMAL                                       3 ABNORMAL, MULTIFOCAL  
 2 ABNORMAL, FOCAL                         9 UNKNOWN

27. Are the above physical or nonfocal findings related to the present event?

1 YES     0 NO     9 UNKNOWN

28. Weakness:

1 NORMAL                                       4 QUADRIPARESIS  
 2 LEFT HEMIPARESIS                         9 UNKNOWN  
 3 RIGHT HEMIPARESIS

*If 1-Normal or 9-Unknown skip to Question 30.*

29. Complete the following, related to weakness.

Codes:

0--Normal                                      8--Not related  
1--Some weakness                            9--Unknown  
2--No movement

	LEFT				
	0	1	2	8	9
A. TONGUE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. FACE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. ARM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. LEG	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

  

	RIGHT				
	0	1	2	8	9
A. TONGUE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. FACE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. ARM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. LEG	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

30. Ataxia:

1 NORMAL     2 PRESENT     9 UNKNOWN

	LEFT			RIGHT		
	1	0	9	1	0	9
	Yes	No	Unk	Yes	No	Unk
ARM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
LEG	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
GAIT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

*If 1-Normal skip to Question 32.*

31. Related to present event?

1 YES     0 NO     9 UNKNOWN

32. Extraocular movements:

1 NORMAL                                       8 UNTESTED  
 2 ABNORMAL                                     9 UNKNOWN

33. Sensory deficits (pin test):

- 1 NORMAL     3 RIGHT     8 UNTESTED  
 2 ABNORMAL     4 BOTH     9 UNKNOWN  
 5 LEFT

If 1-Normal or 8-Untested or 9-Unknown skip to Question 35.

34. If sensory deficits scale above cannot be completed (i.e. answers are unknown) please complete the following:

- Codes: 1-Normal    8-Not related  
 2-Abnormal    9-Unknown

	LEFT					RIGHT			
	1	2	8	9		1	2	8	9
A. FACE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. ARM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. LEG	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

35. Visual Fields:

- 1 NORMAL     8 UNTESTED  
 2 ABNORMAL     9 UNKNOWN

If 1-Normal or 8-Untested or 9-Unknown skip to Question 37.

36. Visual fields--Check the appropriate codes. Check "8--Not Related" if an abnormality is not related to present event.

- Codes: 1-Absent    4-Both  
 2-Left    8-Not related  
 3-Right    9-Unknown

	A	L	R	B	NR	UK
	1	2	3	4	8	9
A. MONOCULAR	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. QUADRANTANOPIA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. HEMIANOPPIA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. HEMINEGLECT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

37. Language:

- 1 NORMAL     5 ANOMIC  
 2 BROCA     6 OTHER  
 3 WERNICKE     9 UNKNOWN  
 4 GLOBAL

If 1-Normal or 9-Unknown skip to Question 39.

38. Related to present event?

- 1 YES     0 NO     9 UNKNOWN

39. Dysarthria:

- 1 ABSENT     2 PRESENT     9 UNKNOWN

If 1-Absent or 9-Unknown skip to Question 41.

40. Related to present event?

- 1 YES     0 NO     9 UNKNOWN

41. Other hemispherical signs (apraxia, neglect):

- 1 NONE     8 UNTESTED  
 2 PRESENT     9 UNKNOWN

If 1-None or 8-Untested or 9-Unknown skip to Question 43.

Specify:

42. Related to present event?

- 1 YES     0 NO     9 UNKNOWN

**Diagnosis**

43. Primary diagnosis

- 1 NOT A STROKE OR TIA     5 EMBOLIC INFARCTION  
 2 SUBARACHNOID HEMORRHAGE     6 OTHER, UNKNOWN INFARCTION  
 3 INTRAPARENCHYMAL HEMORRHAGE     7 TIA  
 4 LACUNAR INFARCTION     9 UNKNOWN

If 1-Not a stroke or TIA skip to Question 46.

44. Cerebral site--record using 2-digit codes below:

A. Primary cerebral site:

B. Other cerebral sites:

C. Are more than five cerebral sites indicated?

- 1 Yes     0 No

Codes: Left		Right
01	Cerebral hemisphere (not further specified)	02
03	Frontal lobe	04
05	Parietal	06
07	Insular-operculum	08
09	Occipital lobe	10
11	Temporal lobe	12
13	Putamen	14
15	Thalamus	16
17	Internal capsule	18
19	Cerebellum	20
21	Fronto-parietal lobe	22
23	Parieto-occipital lobe	24
25	Temporo-parietal lobe	26
27	Temporo-occipital lobe	28
29	Fronto-temporo-parietal lobe	30
31	Basal ganglia and capsule	32
33	Midline (third ventricular callosum)	
34	Intracranial (not further specified)	
35	Brain stem	
36	Midbrain	
37	Pons	
38	Medulla	
39	Subarachnoid space	
40	Intraventricular space	
99	Unknown	

45. Vascular territory--record using 2-digit codes below:

A. Primary vascular territory:

B. Other Vascular territories:

C. Are more than five vascular territories: indicated?

1 Yes  0 No

Codes: Left		Right
01	Comon carotid	02
03	External carotid	04
05	Internal carotid	06
07	At bifucation	08
09	Distal extracranial	10
11	Intracranial	12
13	Junction of posterior communicating	14
15	Other	16
17	Anterior cerebral	18
19	Junction of anterior communicating	20
21	Other	22
23	Middle cerebral	24
25	Penetrating or lenticulostriate	26
27	Stem	28
29	Upper branch	30
31	Lower branch	32
33	Posterior communicating	34
35	Posterior cerebral	36
37	Penetrating	38
39	Stem	40
41	Calcarine branch	42
43	Superior cerebellar	44
45	Posterior inferior cerebellar	46
47	Vertebral	48
49	Subclavian	50
51	Anterior communicating	
52	Basilar	
53	Penetrating	
54	Full	
55	Upper branch	
56	Lower branch	
57	Innominate	
99	Unknown	

46. CT or MRI scan evidence of a lesion compatible with this event?

1 Yes  0 No  2 NOT DONE  9 UNKNOWN

*If 0-No, 2-Not done or 9-Unknown skip to Question 48.*

47. CT or MRI evidence of:

	1	0	9
	Yes	No	Unk
DEEP LACUNAR INFARCTION >2 CM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CORTICAL INFARCTION < 1/2 LOBE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
INFARCTION > 1/2 LOBE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MOTTLED HEMORRHAGIC INFARCTION	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SUBARACHNOIID HEMORRHAGE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
INTRAPARENCHYMAL HEMORRHAGE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
WATERSHED AREA INFARCTION	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MORE THAN 1 INFARCTION, OLD OR NEW	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OTHER SPECIFY	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

48. Noninvasive testing Shows evidence of severe stenosis (greater than 70%) or occlusion of relevant carotid?

1 Yes  0 No  2 NOT DONE  9 UNKNOWN

49. Angiographic (including DSA) evidence of a cause or source of event??

1 Yes  0 No  2 NOT DONE  9 UNKNOWN

*If 0-No, 2-Not done or 9-Unknown skip to Question 51.*

50. Angiographic evidence of:

	1	0	9
	Yes	No	Unk
AVM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ANEURYSM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MASS EFFECT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SOURCE FOR EMBOLUS (ULCERATED PLAQUE OR FREE CLOT)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
STENOSIS GREATER THAN OR EQUAL TO 70%. OR OCCLUSION OF:			
RELEVANT EXTRACRANIAL ARTERY	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RELEVANT MAJOR CEREBRAL STEM OR BASILAR	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RELEVANT BRANCH OCCLUSION	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ARTERITIS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DISSECTION OF THE ARTERIAL WALL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OTHER:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SPECIFY:

51. Did the participant die as an immediate consequence of this event?

1 YES    0 NO    9 UNKNOWN    2 DID NOT DIE

*If 2 - Did not die, skip to Question 54.*

52. If participant died, did death occur within 24 hours of event?

1 YES    0 NO    9 UNKNOWN

53. For deaths, autopsy evidence of stroke?

1 Yes    0 No    2 NOT DONE    9 UNKNOWN

54. Overall, is there evidence for:

	1	0	9
	Yes	No	Unk
HEMORRHAGIC STROKE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IF 1-YES TO HEMORRHAGIC STROKE:			
SUBARACHNOID HEMORRHAGE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
INTRAPARENCHYMAL HEMORRHAGE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ISCHEMIC STROKE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IF YES TO ISCHEMIC STROKE:			
LACUNAE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
EMBOLIC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ATHEROSCLEROTIC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
UNKNOWN TYPE STROKE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TIA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
NOT A STROKE OR TIA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OTHER:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SPECIFY:

## Administrative Information

Form Completed by:

Date:

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Month

Day

Year

7281394262



**Description of event:**

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