OMB #0925-0334 Exp.: xx/xxxx

PHYSICIAN QUESTIONNAIRE FOR STROKE/TIA

Please complete the following questionnaire to the best of your ability by completely filling in the appropriate circle or writing the answer neatly in the blank provided. We would appreciate copies of pertinent office notes, including reports of x-rays, echocardiograms, neurological examinations and/or carotid doppler testing.

Shade Circles Like This--> ●

Not Like This--> ⊗ ✓

PHYSICIAN: ______________________

1. Are you familiar with the participant's medical history?

   ○ 1 YES ○ 0 NO

   If NO, are you aware of another physician who could provide information regarding this patient?

   ○ 1 Yes ○ 0 No

   If YES, Please complete the question below:

   Name of Physician: ______________________

   Address: ______________________

   Thank you for your assistance. Please sign and date the form on the bottom of page 2.

2. When did you last see this patient?

   __ __ / __ __ / __ __ __ __
   Month / Day / Year

3. In your opinion, has the patient ever had a significant neurologic event such as a stroke, TIA or amorosus fugax? ○ 1 YES ○ 0 NO

4. If YES, when was the **first** event of this type?

   __ __ / __ __ / __ __ __ __
   Month / Day / Year

   A. This event was a

   ○ 1 Subarachnoid Hemorrhage
   ○ 2 Intercerebral Hemorrhage
   ○ 3 Ischemic Stroke
   ○ 4 TIA
   ○ 5 Amorosus Fugax
   ○ 6 Not a Stroke/TIA

   If not a Stroke or TIA, what was the diagnosis? ______________________

   B. The certainty of the diagnosis is:

   ○ 1 Definite ○ 3 Possible
   ○ 2 Probable ○ 4 Questionable

   C. Was the participant hospitalized? ○ 1 YES ○ 0 NO

   Name of hospital: ______________________

   City/State: ______________________

5. If YES, when was the **most recent** event of this type?

   __ __ / __ __ / __ __ __ __
   Month / Day / Year

   A. This event was a

   ○ 1 Subarachnoid Hemorrhage
   ○ 2 Intercerebral Hemorrhage
   ○ 3 Ischemic Stroke
   ○ 4 TIA
   ○ 5 Amorosus Fugax
   ○ 6 Not a Stroke/TIA

   If not a Stroke or TIA, what was the diagnosis? ______________________

   B. The certainty of the diagnosis is:

   ○ 1 Definite ○ 3 Possible
   ○ 2 Probable ○ 4 Questionable

   C. Was the participant hospitalized? ○ 1 YES ○ 0 NO

   Name of hospital: ______________________

   City/State: ______________________

Public reporting burden for the collection of information is estimated to average 5 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.

4121160241 __ __ __ __ __ __ __ __ __ __

6. Which (if any) of the following symptoms or physical findings were present in the most recent event?

	1 Yes	0 No	9 Unk
A. HEADACHE	○	○	○
B. DIMINISHED LEVEL OF CONSCIOUSNESS	○	○	○
C. LOSS OF CONSCIOUSNESS	○	○	○
D. LANGUAGE DEFICIT/APHASIA	○	○	○
E. DYSARTHRIA	○	○	○
F. VISUAL FIELD/DEFICIT/EXTINCTION	○	○	○
G. WEAKNESS OR DRIFT	○	○	○
H. HEMIPLEGIA	○	○	○
I. ATAXIA	○	○	○
J. SENSORY DEFICIT	○	○	○
K. ASYMMETRY OF REFLEXES	○	○	○
L. BABINSKI	○	○	○
M. ABNORMAL GAIT	○	○	○
N. ROMBERG	○	○	○
O. OTHER SPECIFY:	○	○	○

7. The symptoms were in the distribution of which vessel?

- ○ 1 RIGHT CAROTID
- ○ 2 LEFT CAROTID
- ○ 3 VERTEBRAL/BASILAR
- ○ 9 UNKNOWN

8. Did any neurological findings persist longer than 24 hours from onset?

○ 1 Yes ○ 0 No ○ 9 Unk

If you answered YES, please specify:

9. Which (if any) of the following diagnostic tests did the participant have? (Please send copy).

	1 Yes	0 No	9 Unk
A. CT OF THE HEAD	○	○	○
B. MRI OF THE BRAIN	○	○	○
C. CAROTID ULTRASOUND	○	○	○
D. ELECTROCARDIOGRAM	○	○	○
E. ECHOCARDIOGRAM	○	○	○
F. OTHER SPECIFY:	○	○	○

10. Which (if any) of the following medicines were prescribed as therapy?

	1 Yes	0 No	9 Unk
A. ASPIRIN	○	○	○
B. PERSANTINE	○	○	○
C. ANTI-COAGULANTS	○	○	○
D. TICLOPIDINE	○	○	○
E. OTHER SPECIFY:	○	○	○

Thank you very much for your contribution to the Cardiovascular Health Study. Please sign and date this questionnaire below and return it to us in the self-addressed, stamped envelope, with copies of pertinent office notes and procedures. If you do not have the envelope, the mailing address is:

Form completed by: ______ Month / Day / Year