O.M.B. 0925-0281
exp. 7-31-89

A-211

ARIC

ATHEROSCLEROSIS RISK IN COMMUNITIES STUDY

TIA / STROKE FORM

ID NUMBER: | | | | | | | | CONTACT YEAR: | 0 | 1 | FORM CODE: | T | I | A | VERSION: B 6/19/87

LAST NAME: | | | | | | | | | | | | | INITIALS: | | | DRAFT

INSTRUCTIONS:
This form should be completed during the interview portion of the participant's visit. ID Number and Name must be entered above. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes. If a number is entered incorrectly, mark through the incorrect entry with an "X". Code the correct entry clearly above the incorrect entry. For "multiple choice" and "yes/no" type questions, circle the letter corresponding to the most appropriate response. If a letter is circled incorrectly, mark through it with an "X" and circle the correct response.

TIA/STROKE FORM (TIAA screen 1 of 30)

A. MEDICAL HISTORY

1. Have you ever been told by a physician that you had a stroke, slight stroke, transient ischemic attack or TIA? ..... Yes Y
No N

Go to Item 3, Screen 1

2. When did the (first) stroke or TIA occur?

| | | Month | | | Year

B. SUDDEN LOSS OR CHANGE OF SPEECH

3. Have you ever had any sudden loss or changes in speech? ..... Yes Y
No N
Don't Know D

Go to Item 10, Screen 6

TIA/STROKE FORM (TIAA screen 2 of 30)

4. How many episodes of loss or changes in speech have you had? .....

1	A
2	B
3	C
4	D
5	E
6-20	F
More than 20, or frequent, intermittent events, too numerous to count.	G

5. When was the (most recent) episode? ...

In the past day	A
2-7 days ago	B
8-30 days ago	C
1-6 months ago	D
7-12 months ago	E
More than a year ago	F

TIA/STROKE FORM (TIAA screen 3 of 30)

6. How long did it (the longest episode) last? .....

Less than 30 seconds	A
At least 30 seconds, but less than 1 minute	B
At least 1 minute, but less than 3 minutes	C
At least 3 minutes, but less than 1 hour	D
At least 1 hour, but less than 6 hours	E
At least 6 hours, but less than 12 hours	F
At least 12 hours, but less than 24 hours	G
At least 24 hours	H

7. Did the (worst) episode come on suddenly? ..... Yes Y

No N

a. How long did it take for the symptoms to get as bad as they were going to get? .....

0-2 seconds (instantly)	A
At least 3 seconds, but less than 1 minute	B
At least 1 minute, but less than 1 hour	C
At least 1 hour, but less than 2 hours	D
At least 2 hours, but less than 24 hours	E
At least 24 hours	F

TIA/STROKE FORM (TIAA screen 4 of 30)

8. Do any of the following describe your change in speech? ..... {READ ALL CHOICES}

	Yes	No	Don't Know
a. Slurred speech like you were drunk	Y	N	D
b. Could talk but the wrong words came out	Y	N	D
c. Knew what you wanted to say, but the words would not come out	Y	N	D

9. While you were having your (worst) episode of change in speech, did any of the following occur? ..... {INCLUDE ALL THAT APPLY}

a. Numbness or tingling ..... Yes Y

No N

→ Go to Item 9.c Screen 5

b. Did you have difficulty on: ..... {READ ALL CHOICES}

The right side only R

The left side only L

Both sides B

TIA/STROKE FORM (TIAA screen 5 of 30)

c. Paralysis or weakness ..... Yes Y

No N

→ Go to Item 9.e Screen 5

d. Did you have difficulty on: ..... {READ ALL CHOICES}

The right side only R

The left side only L

Both sides B

e. Lightheadedness or dizzy spells ..... Yes Y

No N

f. Blackouts or fainting ..... Yes Y

No N

g. Seizures or convulsions ..... Yes Y

No N

h. Headache ..... Yes Y

No N

TIA/STROKE FORM (TIAA screen 6 of 30)

i. Visual Disturbances ..... Yes Y

No N

Go to Item 10, Screen 6

j. Did you have: .....
(READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN)

Double vision	A
Vision loss in right eye only	B
Vision loss in left eye only	C
Total loss of vision in both eyes	D
Trouble in both eyes seeing to the right	E
Trouble in both eyes seeing to the left	F
Other If "Other," specify ...	G

C. SUDDEN LOSS OF VISION

10. Have you ever had any sudden loss of vision, complete or partial?..... Yes Y

No N

Don't Know D

Go to Item 17, Screen 10

TIA/STROKE FORM (TIAA screen 7 of 30)

11. How many episodes of loss of vision have you had? .....

1	A
2	B
3	C
4	D
5	E
6-20	F
More than 20, or frequent, intermittent events, too numerous to count.	G

12. When was the (most recent) episode? ...

In the past day	A
2-7 days ago	B
8-30 days ago	C
1-6 months ago	D
7-12 months ago	E
More than a year ago	F

TIA/STROKE FORM (TIAA screen 8 of 30)

13. How long did it (the longest episode) last? ....

- Less than 30 seconds — A
- At least 30 seconds, but less than 1 minute — B
- At least 1 minute, but less than 3 minutes — C
- At least 3 minutes, but less than 1 hour — D
- At least 1 hour, but less than 6 hours — E
- At least 6 hours, but less than 12 hours — F
- At least 12 hours, but less than 24 hours — G
- At least 24 hours — H

14. Did the (worst) episode come on suddenly? ..... Yes — Y / No — N

a. How long did it take for the symptoms to get as bad as they were going to get? .....

- 0-2 seconds (instantly) — A
- At least 3 seconds, but less than 1 minute — B
- At least 1 minute, but less than 1 hour — C
- At least 1 hour, but less than 2 hours — D
- At least 2 hours, but less than 24 hours — E
- At least 24 hours — F

TIA/STROKE FORM (TIAA screen 9 of 30)

15. During the (worst) episode, which of the following parts of your vision were affected? ..... {READ ALL CHOICES}

- Only the right eye — R
- Only the left eye — L
- Both eyes — B

→ Go to Item 16, Screen 9

a. Did you have: ..... {READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN}

- Total loss of vision — B
- Trouble seeing to the right — R
- Trouble seeing to the left — L
- Other vision difficulties — O

16. While you were having your (worst episode of) loss of vision, did any of the following occur? {INCLUDE ALL THAT APPLY}

a. Speech disturbance ..... Yes — Y / No — N

b. Numbness or tingling ..... Yes — Y / No — N

→ Go to Item 16.d, Screen 10

c. Did you have difficulty on: ..... {READ ALL CHOICES}

- The right side only — R
- The left side only — L
- Both sides — B

TIA/STROKE FORM (TIAA screen 10 of 30)

d. Paralysis or weakness ..... Yes Y
No N

Go to Item 16.f, Screen 10

e. Did you have difficulty on: .....
{READ ALL CHOICES}

The right side only R
The left side only L
Both sides B

f. Lightheadedness or dizzy spells ..... Yes Y
No N

g. Blackouts or fainting ..... Yes Y
No N

h. Seizures or convulsions ..... Yes Y
No N

i. Headache ..... Yes Y
No N

D. DOUBLE VISION

17. Have you ever had a sudden spell of double vision? ..... Yes Y
No N
Don't Know D

Go to Item 23, Screen 15

a. If you closed one eye, did the double vision go away? ..... Yes Y
No N
Don't Know D

Go to Item 23, Screen 15

TIA/STROKE FORM (TIAA screen 11 of 30)

18. How many episodes of double vision have you had? .....

1 A
2 B
3 C
4 D
5 E
6-20 F
More than 20, or frequent, intermittent events, too numerous to count. G

19. When was the (most recent) episode? ...

In the past day A
2-7 days ago B
8-30 days ago C
1-6 months ago D
7-12 months ago E
More than a year ago F

TIA/STROKE FORM (TIAA screen 12 of 30)

20. How long did it (the longest episode) last? ....

Less than 30 seconds	A
At least 30 seconds, but less than 1 minute	B
At least 1 minute, but less than 3 minutes	C
At least 3 minutes, but less than 1 hour	D
At least 1 hour, but less than 6 hours	E
At least 6 hours, but less than 12 hours	F
At least 12 hours, but less than 24 hours	G
At least 24 hours	H

21. Did the (worst) episode come on suddenly? ..... Yes Y / No N

a. How long did it take for the symptoms to get as bad as they were going to get? .....

0-2 seconds (instantly)	A
At least 3 seconds, but less than 1 minute	B
At least 1 minute, but less than 1 hour	C
At least 1 hour, but less than 2 hours	D
At least 2 hours, but less than 24 hours	E
At least 24 hours	F

TIA/STROKE FORM (TIAA screen 13 of 30)

22. While you were having your (worst episode of) double vision, did any of the following occur? {INCLUDE ALL THAT APPLY}

a. Speech disturbances ..... Yes Y / No N

b. Numbness or tingling ..... Yes Y / No N

Go to Item 22.d, Screen 14

c. Did you have difficulty on: ..... {READ ALL CHOICES}

The right side only	R
The left side only	L
Both sides	B

TIA/STROKE FORM (TIAA screen 14 of 30)

d. Paralysis or weakness ..... Yes Y
No N

Go to Item 22.f, Screen 14

e. Did you have difficulty on: .....
(READ ALL CHOICES)

The right side only R
The left side only L
Both sides B

f. Lightheadedness or dizzy spells ..... Yes Y
No N

g. Blackouts or fainting ..... Yes Y
No N

h. Seizures or convulsions ..... Yes Y
No N

i. Headache ..... Yes Y
No N

TIA/STROKE FORM (TIAA screen 15 of 30)

E. SUDDEN NUMBNESS OR TINGLING

23. Have you ever had sudden numbness, tingling, or loss of feeling on one side of your body? ... Yes Y
No N
Don't Know D

Go to Item 32, Screen 20

24. Did the feeling of numbness or tingling occur only when you kept your arms or legs in a certain position? ..... Yes Y
No N
Don't Know D

Go to Item 32, Screen 20

25. How many episodes of numbness, tingling, or loss of sensation have you had?

1 A
2 B
3 C
4 D
5 E
6-20 F
More than 20, or frequent, intermittent events, too numerous to count. G

TIA/STROKE FORM (TIAA screen 16 of 30)

26. When was the (most recent) episode? ...

In the past day	A
2-7 days ago	B
8-30 days ago	C
1-6 months ago	D
7-12 months ago	E
More than a year ago	F

27. How long did it (the longest episode) last? ....

Less than 30 seconds	A
At least 30 seconds, but less than 1 minute	B
At least 1 minute, but less than 3 minutes	C
At least 3 minutes, but less than 1 hour	D
At least 1 hour, but less than 6 hours	E
At least 6 hours, but less than 12 hours	F
At least 12 hours, but less than 24 hours	G
At least 24 hours	H

TIA/STROKE FORM (TIAA screen 17 of 30)

28. Did the (worst) episode come on suddenly? ..... Yes Y

No N

a. How long did it take for the symptoms to get as bad as they were going to get? .....

0-2 seconds (instantly)	A
At least 3 seconds, but less than 1 minute	B
At least 1 minute, but less than 1 hour	C
At least 1 hour, but less than 2 hours	D
At least 2 hours, but less than 24 hours	E
At least 24 hours	F

29. During the (worst) episode, which part or parts of your body were affected? {READ ALL CHOICES}

	Yes	No	Don't Know
a. Left arm or hand	Y	N	D
b. Left leg or foot	Y	N	D
c. Left side of face	Y	N	D
d. Right arm or hand	Y	N	D
e. Right foot or leg	Y	N	D
f. Right side of face	Y	N	D
g. Other	Y	N	D

TIA/STROKE FORM (TIAA screen 18 of 30)

30. During this episode, did the abnormal sensation start in one part of your body and spread to another, or did it stay in the same place? .....

In one part and spread to another	S
Stayed in one part	O
Don't Know	D

31. While you were having your (worst) episode of numbness, tingling or loss of sensation, did any of the following occur? {INCLUDE ALL THAT APPLY}

a. Speech disturbance	Yes	Y
	No	N

TIA/STROKE FORM (TIAA screen 19 of 30)

b. Paralysis or weakness	Yes	Y
	No	N

→ Go to Item 31.d, Screen 19

c. Did you have difficulty on: ..... {READ ALL CHOICES}

The right side only	R
The left side only	L
Both sides	B

d. Lightheadedness or dizzy spells	Yes	Y
	No	N
e. Blackouts or fainting	Yes	Y
	No	N
f. Seizures or convulsions	Yes	Y
	No	N
g. Headache	Yes	Y
	No	N
h. Pain in the numb or tingling arm, leg or face	Yes	Y
	No	N

TIA/STROKE FORM (TIAA screen 20 of 30)

i. Visual disturbances ..... Yes Y

No N

Go to Item 32, Screen 20

j. Did you have: .....
{READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN

Double vision	A
Vision loss in right eye only	B
Vision loss in left eye only	C
Total loss of vision in both eyes	D
Trouble in both eyes seeing to the right	E
Trouble in both eyes seeing to the left	F
Other If "Other," specify ...	G

F. SUDDEN PARALYSIS OR WEAKNESS

32. Have you ever had any sudden episodes of paralysis or weakness on one side of your body? ..... Yes Y

No N

Don't Know D

Go to Item 40, Screen 25

TIA/STROKE FORM (TIAA screen 21 of 30)

33. How many episodes of paralysis or weakness have you had? .....

1	A
2	B
3	C
4	D
5	E
6-20	F
More than 20, or frequent, intermittent events, too numerous to count.	G

34. When was the (most recent) episode? ...

In the past day	A
2-7 days ago	B
8-30 days ago	C
1-6 months ago	D
7-12 months ago	E
More than a year ago	F

TIA/STROKE FORM (TIAA screen 22 of 30)

35. How long did it (the longest episode) last? ....

- Less than 30 seconds — A
- At least 30 seconds, but less than 1 minute — B
- At least 1 minute, but less than 3 minutes — C
- At least 3 minutes, but less than 1 hour — D
- At least 1 hour, but less than 6 hours — E
- At least 6 hours, but less than 12 hours — F
- At least 12 hours, but less than 24 hours — G
- At least 24 hours — H

36. Did the (worst) episode come on suddenly? ..... Yes — Y / No — N

a. How long did it take for the symptoms to get as bad as they were going to get? .....

- 0-2 seconds (instantly) — A
- At least 3 seconds, but less than 1 minute — B
- At least 1 minute, but less than 1 hour — C
- At least 1 hour, but less than 2 hours — D
- At least 2 hours, but less than 24 hours — E
- At least 24 hours — F

TIA/STROKE FORM (TIAA screen 23 of 30)

37. During this episode, what part or parts of your body were affected? {READ ALL CHOICES}

	Yes	No	Don't Know
a. Left arm or hand	Y	N	D
b. Left leg or foot	Y	N	D
c. Left side of face	Y	N	D
d. Right arm or hand	Y	N	D
e. Right foot or leg	Y	N	D
f. Right side of face	Y	N	D
g. Other	Y	N	D

38. During this episode, did the paralysis or weakness start in one part of your body and spread to another, or did it stay in the same place? .....

- Started in one part and spread to another — S
- Stayed in one part — O
- Don't know — D

39. While you were having your worst episode of paralysis or weakness did any of the following occur? {INCLUDE ALL THAT APPLY}

a. Speech disturbances ..... Yes — Y / No — N

TIA/STROKE FORM (TIAA screen 24 of 30)

b. Numbness or tingling ..... Yes Y
No N

Go to Item 39.d, Screen 24

c. Did you have difficulty on: .....
{READ ALL CHOICES}

The right side only R
The left side only L
Both sides B

d. Lightheadedness or dizzy spells ..... Yes Y
No N

e. Blackouts or fainting ..... Yes Y
No N

f. Seizures or convulsions ..... Yes Y
No N

g. Headache ..... Yes Y
No N

h. Pain in the weak arm, leg or face ..... Yes Y
No N

TIA/STROKE FORM (TIAA screen 25 of 30)

i. Visual Disturbances ..... Yes Y
No N

Go to Item 40, Screen 25

j. Did you have: .....
{READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN}

Double vision A
Vision loss in right eye only B
Vision loss in left eye only C
Total loss of vision in both eyes D
Trouble in both eyes seeing to the right E
Trouble in both eyes seeing to the left F
Other G
If "Other," specify ...

G. SUDDEN SPELLS OF DIZZINESS OR LOSS OF BALANCE

40. Have you ever had any sudden spells of dizziness, loss of balance, or sensation of spinning? ..... Yes Y
No N
Don't Know D

Go to Item 47, Screen 30

41. Did the dizziness, loss of balance or spinning sensation occur only when changing the position of your head or body? ..... Yes Y
No N
Don't Know D

Go to Item 47, Screen 30

TIA/STROKE FORM (TIAA screen 26 of 30)

42. While you were having your (worst) episode of dizziness, loss of balance or spinning sensation, did any of the following occur? {INCLUDE ALL THAT APPLY}

a. Speech disturbances ..... Yes Y
No N

b. Paralysis or weakness ..... Yes Y
No N

Go to Item 42.d, Screen 27

c. Did you have difficulty on: ..... {READ ALL CHOICES}

The right side only R
The left side only L
Both sides B

TIA/STROKE FORM (TIAA screen 27 of 30)

d. Numbness or tingling ..... Yes Y
No N

Go to Item 42.f, Screen 27

e. Did you have difficulty on: ..... {READ ALL CHOICES}

The right side only R
The left side only L
Both sides B

f. Blackouts or fainting ..... Yes Y
No N

g. Seizures or convulsions ..... Yes Y
No N

h. Headache ..... Yes Y
No N

TIA/STROKE FORM (TIAA screen 28 of 30)

i. Visual disturbances ..... Yes Y

No N

Go to Item 43, Screen 28

IF ALL OF ITEMS 42.a THROUGH 42.i ARE NO, GO TO ITEM 47 ON SCREEN 30

j. Did you have: .....
(READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN)

Double vision	A
Vision loss in right eye only	B
Vision loss in left eye only	C
Total loss of vision in both eyes	D
Trouble in both eyes seeing to the right	E
Trouble in both eyes seeing to the left	F
Other If "Other," specify ...	G

43. How many episodes of dizziness, loss of balance or spinning sensation have you had? .....

1	A
2	B
3	C
4	D
5	E
6-20	F
More than 20, or frequent, intermittent events, too numerous to count.	G

TIA/STROKE FORM (TIAA screen 29 of 30)

44. When was the (most recent) episode? ...

In the past day	A
2-7 days ago	B
8-30 days ago	C
1-6 months ago	D
7-12 months ago	E
More than a year ago	F

45. How long did it (the longest episode) last? ....

Less than 30 seconds	A
At least 30 seconds, but less than 1 minute	B
At least 1 minute, but less than 3 minutes	C
At least 3 minutes, but less than 1 hour	D
At least 1 hour, but less than 6 hours	E
At least 6 hours, but less than 12 hours	F
At least 12 hours, but less than 24 hours	G
At least 24 hours	H

TIA/STROKE FORM (TIAA screen 30 of 30)

46. Did the (worst) episode come on suddenly? ..... Yes Y

No N

a. How long did it take for the symptoms to get as bad as they were going to get? .....

0-2 seconds (instantly) A

At least 3 seconds, but less than 1 minute B

At least 1 minute, but less than 1 hour C

At least 1 hour, but less than 2 hours D

At least 2 hours, but less than 24 hours E

At least 24 hours F

H. ADMINISTRATIVE INFORMATION

47. Date of data collection: ... [ ][ ] - [ ][ ] - [ ][ ]
Month Day Year

48. Method of data collection: ..... Computer C

Paper form P

49. Code number of person completing this form: ... [ ][ ][ ]