

ID NUMBER: CONTACT YEAR: 1 0 FORM CODE: T I A VERSION: E 12/01/95

LAST NAME: INITIALS:

Public reporting burden for this collection of information is estimated to average 7-10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: PHS Reports Clearance Officer, Rm. 737-F, Humphrey Building, 200 Independence Ave., SW, Washington, D.C. 20201, ATTN: PRA (0925-0281). Do not return the completed form to this address.

INSTRUCTIONS: This form is completed during the interview portion of the participant's visit. ID Number, Contact Year, 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 on the paper form, 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 (TIAE screen 1 of 14)

A. MEDICAL HISTORY	B. SUDDEN LOSS OR CHANGE OF SPEECH
<p>1. Since the last ARIC visit, have you been told by a physician that you had a stroke, slight stroke, transient ischemic attack or TIA?</p> <p style="text-align: right;">Yes Y</p> <p style="text-align: right;">No N</p> <p style="text-align: center;">Go to Item 3.</p>	<p>3. Since the last ARIC visit, have you had any sudden loss or changes in speech? Yes Y</p> <p style="text-align: right;">No N</p> <p style="text-align: right;">Don't know D</p> <p style="text-align: center;">Go to Item 10, Screen 6</p>
<p>2. During this time, when did the (first) stroke or TIA occur?</p> <p>a. <input type="text"/> <input type="text"/> month, b. <input type="text"/> <input type="text"/> year</p>	

TIA/STROKE FORM (TIAE screen 2 of 14)

<p>4. During this time, how many episodes of loss or changes in speech have you had?</p> <p>1 A</p> <p>2 B</p> <p>3 C</p> <p>4 D</p> <p>5 E</p> <p>6-20 F</p> <p>More than 20, or frequent, intermittent events, too numerous to count G</p>	<p>5. During this same time period, when did the earliest occur?</p> <p>Within the last 6 months A</p> <p>Greater than 6 months, but less than 1 year ago B</p> <p>Greater than 1 year, but less than 2 years ago C</p> <p>Greater than 2 years, but less than 3 years ago D</p> <p>3 or more years ago E</p>
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TIA/STROKE FORM (TIAE screen 3 of 14)

<p>6. How long did it (the longest episode) last?</p> <p>Less than 30 seconds A</p> <p>At least 30 seconds, but less than 1 minute B</p> <p>At least 1 minute, but less than 3 minutes C</p> <p>At least 3 minutes, but less than 1 hour D</p> <p>At least 1 hour, but less than 6 hours E</p> <p>At least 6 hours, but less than 12 hours F</p> <p>At least 12 hours, but less than 24 hours G</p> <p>At least 24 hours H</p>	<p>7. Did the (worst) episode come on suddenly? Yes Y</p> <p>..... No N</p> <p>a. How long did it take for the symptoms to get as bad as they were going to get?</p> <p>0-2 seconds (instantly) A</p> <p>At least 3 seconds, but less than 1 minute B</p> <p>At least 1 minute, but less than 1 hour C</p> <p>At least 1 hour, but less than 2 hours D</p> <p>At least 2 hours, but less than 24 hours E</p> <p>At least 24 hours F</p>
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TIA/STROKE FORM (TIAE screen 4 of 14)

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 (TIAE screen 5 of 14)

9.c. Paralysis or weakness Yes Y

No N

Go to Item 9.e.

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

9.f. Blackouts or fainting Yes Y

No N

g. Seizures or convulsions Yes Y

No N

h. Headache Yes Y

No N

9.i. Visual Disturbances Yes Y

No N

Go to Item 10.

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:

C. SUDDEN LOSS OF VISION

10. Since the last ARIC visit, have you had any sudden loss of vision, complete or partial? Yes Y

No N

Don't Know D

Go to Item 17, Screen 10

11. During this time, 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. During this same time period, when did the earliest occur?

- Within the last 6 months A
- Greater than 6 months, but less than 1 year ago B
- Greater than 1 year, but less than 2 years ago C
- Greater than 2 years, but less than 3 years ago D
- 3 or more years ago E

TIA/STROKE FORM (TIAE screen 8 of 14)

<p>13. How long did it (the longest episode) last?</p> <p>Less than 30 seconds A</p> <p>At least 30 seconds, but less than 1 minute B</p> <p>At least 1 minute, but less than 3 minutes C</p> <p>At least 3 minutes, but less than 1 hour D</p> <p>At least 1 hour, but less than 6 hours E</p> <p>At least 6 hours, but less than 12 hours F</p> <p>At least 12 hours, but less than 24 hours G</p> <p>At least 24 hours H</p>	<p>14. Did the (worst) episode come on suddenly? Yes Y</p> <p>..... No N</p> <p>a. How long did it take for the symptoms to get as bad as they were going to get?</p> <p>0-2 seconds (instantly) A</p> <p>At least 3 seconds, but less than 1 minute B</p> <p>At least 1 minute, but less than 1 hour C</p> <p>At least 1 hour, but less than 2 hours D</p> <p>At least 2 hours, but less than 24 hours E</p> <p>At least 24 hours F</p>
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TIA/STROKE FORM (TIAE screen 9 of 14)

<p>15. During the (worst) episode, which of the following parts of your vision were affected?</p> <p>{READ ALL CHOICES}</p> <p>Go to Item 16. — Only the right eye R</p> <p>Only the left eye L</p> <p>Both eyes B</p> <p>a. Did you have:</p> <p>{READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN}</p> <p>Total loss of vision B</p> <p>Trouble seeing to the right R</p> <p>Trouble seeing to the left L</p> <p>Other vision difficulties O</p>	<p>16. While you were having your (worst episode of) loss of vision, did any of the following occur?</p> <p>{INCLUDE ALL THAT APPLY}</p> <p>a. Speech disturbance Yes Y</p> <p>..... No N</p> <p>b. Numbness or tingling Yes Y</p> <p>..... No N</p> <p>Go to Item 16.d, Screen 10</p> <p>c. Did you have difficulty on:</p> <p>{READ ALL CHOICES}</p> <p>The right side only R</p> <p>The left side only L</p> <p>Both sides B</p>
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TIA/STROKE FORM (TIAE screen 10 of 14)

16.d. Paralysis or weakness Yes	Y		
		Go to Item 16.f	No N
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
16.h. Seizures or convulsions Yes	Y		
			No N
i. Headache Yes	Y		
			No N
D. DOUBLE VISION			
17. Since the last ARIC visit, have you had a sudden spell of double vision?	Yes	Y	
			No N
			Don't Know D
		Go to Item 22j., Screen 14.	
a. If you closed one eye, did the double vision go away?	Yes	Y	
			No N
			Don't Know D
		Go to Item 22j., Screen 14.	

TIA/STROKE FORM (TIAE screen 11 of 14)

18. During this time, 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. During the same time period, when did the earliest occur?		
Within the last 6 months	A	
Greater than 6 months, but less than 1 year ago	B	
Greater than 1 year, but less than 2 years ago	C	
Greater than 2 years, but less than 3 years ago	D	
3 or more years ago	E	

TIA/STROKE FORM (TIAE screen 12 of 14)

<p>20. How long did it (the longest episode) last?</p> <p>Less than 30 seconds A</p> <p>At least 30 seconds, but but less than 1 minute B</p> <p>At least 1 minute, but less than 3 minutes C</p> <p>At least 3 minutes, but less than 1 hour D</p> <p>At least 1 hour, but less than 6 hours E</p> <p>At least 6 hours, but less than 12 hours F</p> <p>At least 12 hours, but less than 24 hours G</p> <p>At least 24 hours H</p>	<p>21. Did the (worst) episode come on suddenly? Yes Y</p> <p>..... No N</p> <p>a. How long did it take for the symptoms to get as bad as they were going to get?</p> <p>0-2 seconds (instantly) A</p> <p>At least 3 seconds, but less than 1 minute B</p> <p>At least 1 minute, but less than 1 hour C</p> <p>At least 1 hour, but less than 2 hours D</p> <p>At least 2 hours, but less than 24 hours E</p> <p>At least 24 hours F</p>
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TIA/STROKE FORM (TIAE screen 13 of 14)

<p>22. While you were having your (worst episode of) double vision, did any of the following occur?</p> <p>{INCLUDE ALL THAT APPLY}</p> <p>a. Speech disturbances Yes Y</p> <p>..... No N</p>	<p>22.b. Numbness or tingling Yes Y</p> <p>..... No N</p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;"> <p>Go to Item 22.d, Screen 14</p> </div> <p>22.c. Did you have difficulty on:</p> <p>{READ ALL CHOICES} The right side only R</p> <p>The left side only L</p> <p>Both sides B</p>
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22.d. Paralysis or weakness Yes Y
No N

Go to Item 22.f

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

22.h. Seizures or convulsions Yes Y
No N

i. Headache Yes Y
No N

E. ADMINISTRATIVE INFORMATION

j. Date of data collection:

		/			/		
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Month Day Year

k. Method of data collection Computer C
Paper form P

l. Code number of person completing this form:

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TIA/STROKE FORM (TIBE screen 1 of 16)

F. SUDDEN NUMBNESS OR TINGLING

23. Since the last ARIC visit, have you had any sudden numbness, tingling, or loss of feeling on one side of your body? Yes Y

Go to Item 32, Screen 6. — No N
 — Don't Know D

24. Did the feeling of numbness or tingling occur only when you kept your arms or legs in a certain position?

Go to Item 32, Screen 6. — Yes Y
 — No N
 — Don't Know D

25. During this time, 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 (TIBE screen 2 of 16)

26. During this same time period, when did the earliest occur?

Within the last 6 months A
 Greater than 6 months, but less than 1 year ago B
 Greater than 1 year, but less than 2 years ago C
 Greater than 2 years, but less than 3 years ago D
 3 or more years ago E

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 (TIBE screen 3 of 16)

<p>28. Did the (worst) episode come on suddenly? Yes Y</p> <p style="padding-left: 150px;">No N</p> <p>a. How long did it take for the symptoms to get as bad as they were going to get?</p> <p style="padding-left: 40px;">0-2 seconds (instantly) A</p> <p style="padding-left: 40px;">At least 3 seconds, but less than 1 minute B</p> <p style="padding-left: 40px;">At least 1 minute, but less than 1 hour C</p> <p style="padding-left: 40px;">At least 1 hour, but less than 2 hours D</p> <p style="padding-left: 40px;">At least 2 hours, but less than 24 hours E</p> <p style="padding-left: 40px;">At least 24 hours F</p>	<p>29. During the (worst) episode, which part or parts of your body were affected?</p> <p style="text-align: center;">(READ ALL CHOICES)</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> <th style="width: 20%; text-align: center;">Don't Know</th> </tr> </thead> <tbody> <tr> <td>a. Left arm or hand</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">D</td> </tr> <tr> <td>b. Left leg or foot</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">D</td> </tr> <tr> <td>c. Left side of face</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">D</td> </tr> <tr> <td>d. Right arm or hand</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">D</td> </tr> <tr> <td>e. Right foot or leg</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">D</td> </tr> <tr> <td>f. Right side of face</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">D</td> </tr> <tr> <td>g. Other</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">D</td> </tr> </tbody> </table>		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
	Yes	No	Don't Know																														
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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 (TIBE screen 4 of 16)

<p>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?</p> <p style="padding-left: 40px;">In one part and spread to another S</p> <p style="padding-left: 40px;">Stayed in one part O</p> <p style="padding-left: 40px;">Don't Know D</p>	<p>31. While you were having your (worst) episode of numbness, tingling or loss of sensation, did any of the following occur?</p> <p style="text-align: center;">(INCLUDE ALL THAT APPLY)</p> <p>a. Speech disturbance Yes Y</p> <p style="padding-left: 150px;">No N</p>
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TIA/STROKE FORM (TIBE screen 5 of 16)

31.b. Paralysis or weakness Yes Y
 No N

Go to Item 31.d.

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

31.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 (TIBE screen 6 of 16)

31.i. Visual Disturbances Yes Y
 No N

Go to Item 32.

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 PARALYSIS OR WEAKNESS

32. Since the last ARIC visit, have you had any sudden episodes of paralysis or weakness on one side of your body? Yes Y

Go to Item 40, Screen 11.

No N
 Don't Know D

TIA/STROKE FORM (TIBE screen 7 of 16)

<p>33. During this time, how many episodes of paralysis or weakness have you had?</p> <p>1 A</p> <p>2 B</p> <p>3 C</p> <p>4 D</p> <p>5 E</p> <p>6-20 F</p> <p>More than 20, or frequent, intermittent events, too numerous to count G</p>	<p>34. During this same time period, when did the earliest occur?</p> <p>Within the last 6 months A</p> <p>Greater than 6 months, but less than 1 year ago B</p> <p>Greater than 1 year, but less than 2 years ago C</p> <p>Greater than 2 years, but less than 3 years ago D</p> <p>3 or more years ago E</p>
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TIA/STROKE FORM (TIBE screen 8 of 16)

<p>35. How long did it (the longest episode) last?</p> <p>Less than 30 seconds A</p> <p>At least 30 seconds, but less than 1 minute B</p> <p>At least 1 minute, but less than 3 minutes C</p> <p>At least 3 minutes, but less than 1 hour D</p> <p>At least 1 hour, but less than 6 hours E</p> <p>At least 6 hours, but less than 12 hours F</p> <p>At least 12 hours, but less than 24 hours G</p> <p>At least 24 hours H</p>	<p>36. Did the (worst) episode come on suddenly? Yes Y</p> <p>..... No N</p> <p>a. How long did it take for the symptoms to get as bad as they were going to get?</p> <p>0-2 seconds (instantly) A</p> <p>At least 3 seconds, but less than 1 minute B</p> <p>At least 1 minute, but less than 1 hour C</p> <p>At least 1 hour, but less than 2 hours D</p> <p>At least 2 hours, but less than 24 hours E</p> <p>At least 24 hours F</p>
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TIA/STROKE FORM (TIBE screen 9 of 16)

<p>37. During this episode, which part or parts of your body were affected?</p> <p>(READ ALL CHOICES)</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> <th style="width: 20%; text-align: center;">Don't Know</th> </tr> </thead> <tbody> <tr> <td>a. Left arm or hand</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">D</td> </tr> <tr> <td>b. Left leg or foot</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">D</td> </tr> <tr> <td>c. Left side of face</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">D</td> </tr> <tr> <td>d. Right arm or hand</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">D</td> </tr> <tr> <td>e. Right foot or leg</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">D</td> </tr> <tr> <td>f. Right side of face</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">D</td> </tr> <tr> <td>g. Other</td> <td style="text-align: center;">Y</td> <td style="text-align: center;">N</td> <td style="text-align: center;">D</td> </tr> </tbody> </table>		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	<p>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?</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Started in one part and spread to another</td> <td style="width: 20%; text-align: right;">S</td> </tr> <tr> <td>Stayed in one part</td> <td style="text-align: right;">O</td> </tr> <tr> <td>Don't Know</td> <td style="text-align: right;">D</td> </tr> </table> <p>39. While you were having your worst episode of paralysis or weakness, did any of the following occur? (INCLUDE ALL THAT APPLY)</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">a. Speech disturbances</td> <td style="width: 10%; text-align: right;">Yes</td> <td style="width: 10%; text-align: right;">Y</td> </tr> <tr> <td></td> <td style="text-align: right;">No</td> <td style="text-align: right;">N</td> </tr> </table>	Started in one part and spread to another	S	Stayed in one part	O	Don't Know	D	a. Speech disturbances	Yes	Y		No	N
	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																																										
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a. Speech disturbances	Yes	Y																																											
	No	N																																											

TIA/STROKE FORM (TIBE screen 10 of 16)

<p>39.b. Numbness or tingling Yes Y</p> <p style="text-align: right;">No N</p> <div style="border: 1px solid black; display: inline-block; padding: 2px; margin-left: 20px;">Go to Item 39.d.</div> <p>c. Did you have difficulty on:</p> <p>(READ ALL CHOICES)</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">The right side only</td> <td style="width: 10%; text-align: right;">R</td> </tr> <tr> <td>The left side only</td> <td style="text-align: right;">L</td> </tr> <tr> <td>Both sides</td> <td style="text-align: right;">B</td> </tr> </table> <p>d. Lightheadedness or dizzy spells Yes Y</p> <p style="text-align: right;">No N</p>	The right side only	R	The left side only	L	Both sides	B	<p>39.e. Blackouts or fainting Yes Y</p> <p style="text-align: right;">No N</p> <p>f. Seizures or convulsions Yes Y</p> <p style="text-align: right;">No N</p> <p>g. Headache Yes Y</p> <p style="text-align: right;">No N</p> <p>h. Pain in the weak arm, leg or face Yes Y</p> <p style="text-align: right;">No N</p>
The right side only	R						
The left side only	L						
Both sides	B						

39.i. Visual Disturbances Yes Y
 No N

Go to Item 40.

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:

H. SUDDEN SPELLS OF DIZZINESS OR LOSS OF BALANCE

40. Since the last ARIC visit, have you had any sudden spells of dizziness, loss of balance, or sensation of spinning? Yes Y

Go to Item 47, Screen 16

- No N
- Don't Know D

41. Did the dizziness, loss of balance or spinning sensation occur only when changing the position of your head or body?

Go to Item 47, Screen 16

- Yes Y
- No N
- Don't Know D

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

42.b. Paralysis or weakness Yes Y

Go to Item 42.d, Screen 13

No N

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 (TIBE screen 13 of 16)

<p>42.d. Numbness or tingling Yes Y No N</p> <p style="text-align: center;">Go to Item 42.f. →</p> <p>e. Did you have difficulty on:</p> <p>(READ ALL CHOICES) The right side only R The left side only L Both sides B</p> <p>f. Blackouts or fainting Yes Y No N</p>	<p>42.g. Seizures or convulsions Yes Y No N</p> <p>h. Headache Yes Y No N</p>
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TIA/STROKE FORM (TIBE screen 14 of 16)

<p>42.i. Visual Disturbances Yes Y No N</p> <p style="text-align: center;">Go to Item 43. →</p> <p>j. Did you have:</p> <p>(READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN)</p> <p>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</p> <p>If "Other," specify: _____</p>	<p>43. During this time, how many episodes of dizziness, loss of balance or spinning sensation have you had?</p> <p>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</p>
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TIA/STROKE FORM (TIBE screen 15 of 16)

44. During this time period, when did the earliest occur?

- Within 6 months A
- Greater than 6 months, but less than 1 year ago B
- Greater than 1 year, but less than 2 years ago C
- Greater than 2 years, but less than 3 years ago D
- 3 or more years ago E

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

- Less than 30 seconds A
- At least 30 seconds, but 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 (TIBE screen 16 of 16)

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

I. 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: