Stroke Symptoms Form

FORM CODE: SSF
VERSION A 12/07/2000

ID NUMBER: | | | | | | | | CONTACT YEAR: 0 1

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

INSTRUCTIONS: This form should be completed during 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, 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.

A. STROKE HISTORY

1. Have you ever been told by a physician that you had a stroke? ..... Yes Y

   Go to Item 3 — No N

2. When did the first stroke occur? ..... | | | / | | | | | (m m / y y y y)

B. SUDDEN LOSS OR CHANGE OF SPEECH

3. Have you ever had any sudden loss or changes in speech lasting 24 hours or longer? ..... Yes Y

   Go to Item 7 — No N

   Don't know D

4. Did the episode come on suddenly? ..... Yes Y

   No N

5. Do any of the following describe your change in speech? [READ ALL CHOICES]

	Yes	No	Don't Know
5a. Slurred speech like you were drunk?	Y	N	D
5b. Could talk but the wrong words came out?	Y	N	D
5c. Knew what you wanted to say, but the words would not come out?	Y	N	D
5d. Could not think of the right words?	Y	N	D

5e. [IF MORE THAN ONE OF ITEMS A-D INDICATED, ASK "WHICH OF THESE MOST CLOSELY DESCRIBES THE PROBLEM?"] .....

Slurred speech	A
Wrong words came out	B
Words would not come out	C
Could not think of the right words	D

6. While you were having your episode of change in speech, did any of the following occur? [INCLUDE ALL THAT APPLY]

6a. Numbness or tingling?	Yes	Y
Go to Item 6c	No	N

6b. Did you have difficulty on: ..... The right side only R
[READ ALL CHOICES]

The left side only L

Both sides B

6c. Paralysis or weakness? ..... Yes Y

Go to Item 6e — No N

6d. Did you have difficulty on: ..... The right side only R
[READ ALL CHOICES]

The left side only L

Both sides B

6e. Lightheadedness, dizziness,
or loss of balance? ..... Yes Y

No N

6f. Blackouts or fainting? ..... Yes Y

No N

6g. Seizures or convulsions? ..... Yes Y

No N

6h. Headache? ..... Yes Y

No N

6i. Visual disturbances? ..... Yes Y

Go to Item 7 — No N

6j. Did you have: ..... Double vision A
[READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]

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

Trouble in both eyes seeing to both sides or straight ahead G

C. SUDDEN LOSS OF VISION

7. Have you ever had any sudden loss of vision, or blurring, lasting 24 hours or longer? ..... Yes Y

Go to Item 11a — No N

Don't know D

8. Did the episode come on suddenly?..... Yes Y

No N

9a. During the episode, which of the following parts of your vision were affected? ..... [READ ALL CHOICES]

- Only the right eye — R
- Only the left eye — L

→ Go to Item 10a

- Both eyes — B

9b. Did you have: ..... [READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]

- Trouble seeing to the right, but not to left — R
- Trouble seeing to the left, but not to right — L
- Trouble seeing both sides or straight ahead — B

10. While you were having your loss of vision, did any of the following occur? [INCLUDE ALL THAT APPLY]

10a. Speech disturbance? ..... Yes — Y

No — N

10b. Numbness or tingling? ..... Yes — Y

No — N

→ Go to Item 10d

10c. Did you have difficulty on: ..... [READ ALL CHOICES]

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

10d. Paralysis or weakness? ..... Yes Y

Go to Item 10f — No N

10e. Did you have difficulty on: ..... The right side only R
[READ ALL CHOICES]

The left side only L

Both sides B

10f. Lightheadedness, dizziness, or
loss of balance? ..... Yes Y

No N

10g. Blackouts or fainting? ..... Yes Y

No N

10h. Seizures or convulsions? ..... Yes Y

No N

10i. Headache? ..... Yes Y

No N

10j. Flashing lights? ..... Yes Y

No N

D. DOUBLE VISION

11a. Have you ever had a sudden spell of double vision, which lasted 24 hours or longer? ..... Yes Y

No N

Go to Item 14

Don't know D

11b. If you closed one eye, did the double vision go away? ..... Yes Y

Go to Item 14 — No N

Don't know D

12. Did the episode come on suddenly? ..... Yes Y

No N

13. While you were having your double vision did any of the following occur? [INCLUDE ALL THAT APPLY]

13a. Speech disturbance? ..... Yes Y

No N

13b. Numbness or tingling? ..... Yes Y

Go to Item 13d — No N

13c. Did you have difficulty on: ..... The right side only R
[READ ALL CHOICES]

The left side only L

Both sides B

13d. Paralysis or weakness? ..... Yes Y

Go to Item 13f — No N

13e. Did you have difficulty on:..... The right side only R
[READ ALL CHOICES]

The left side only L

Both sides B

13f. Lightheadedness, dizziness, or
loss of balance? ..... Yes Y

No N

13g. Blackouts or fainting? ..... Yes Y

No N

13h. Seizures or convulsions? ..... Yes Y

No N

13i. Headache? ..... Yes Y

No N

E. SUDDEN NUMBNESS OR TINGLING

14. Have you ever had sudden numbness, tingling, or loss of feeling on one side of your body, including your face, arm, or leg which lasted 24 hours or longer? ..... Yes Y

No N

Go to Item 20

Don't know D

15. Did the feeling of numbness or tingling occur only when you kept your arms or legs in a certain position? ..... Yes Y — Go to Item 20

No N

Don't know D

16. Did the episode come on suddenly? ..... Yes Y

No N

17. During the episode of sudden numbness or tingling, which part or parts of your body were affected? [READ ALL CHOICES]

	Yes	No	Don't Know
17a. Left arm or hand?	Y	N	D
17b. Left leg or foot?	Y	N	D
17c. Left side of face?	Y	N	D
17d. Right arm or hand?	Y	N	D

	Yes	No	Don't Know
17e. Right leg or foot?	Y	N	D
17f. Right side of face?	Y	N	D
17g. Other?	Y	N	D

18. 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? .....

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

19. While you were having your episode of numbness, tingling or loss of sensation, did any of the following occur? [INCLUDE ALL THAT APPLY]

19a. Speech disturbance?	Yes	Y
	No	N
19b. Paralysis or weakness?	Yes	Y
	Go to Item 19d — No	N

19c. Did you have difficulty on: ..... [READ ALL CHOICES]

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

19d. Lightheadedness, dizziness, or loss of balance? ..... Yes Y

No N

19e. Blackouts or fainting? ..... Yes Y

No N

19f. Seizures or convulsions? ..... Yes Y

No N

19g. Headache? ..... Yes Y

No N

19h. Pain in the numb or tingling arm, leg or face? ..... Yes Y

No N

19i. Visual disturbances? ..... Yes Y

Go to Item 20 — No N

19j. 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

Trouble in both eyes
seeing to both sides
or straight ahead G

F. SUDDEN PARALYSIS OR WEAKNESS

20. Have you ever had any sudden episode of paralysis or weakness on one side of your body, including your face, arm, or leg which lasted at least 24 hours? ..... Yes Y

No N

Go to Item 25

Don't know D

21. Did the episode come on suddenly? ..... Yes Y

No N

22. During this episode, which part or parts of your body were affected? [READ ALL CHOICES]

	Yes	No	Don't Know
22a. Left arm or hand?	Y	N	D
22b. Left leg or foot?	Y	N	D
22c. Left side of face?	Y	N	D
22d. Right arm or hand?	Y	N	D
22e. Right leg or foot?	Y	N	D
22f. Right side of face?	Y	N	D
22g. Other?	Y	N	D

23. 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

24. While you were having your episode of paralysis or weakness, did any of the following occur? [INCLUDE ALL THAT APPLY]

24a. Speech disturbances?	Yes	Y
	No	N

24b. Numbness or tingling? ..... Yes Y

Go to Item 24d — No N

24c. Did you have difficulty on: ..... The right side only R
[READ ALL CHOICES]

The left side only L

Both sides B

24d. Lightheadedness, dizziness, or loss of balance?..... Yes Y

No N

24e. Blackouts or fainting? ..... Yes Y

No N

24f. Seizures or convulsions? ..... Yes Y

No N

24g. Headache? ..... Yes Y

No N

24h. Pain in the weak arm, leg or face? ..... Yes Y

No N

24i. Visual disturbances? ..... Yes Y

Go to Item 25 — No N

24j. Did you have: ..... Double vision A

[READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]

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

Trouble in both eyes seeing to both sides or straight ahead G

G. SUDDEN SPELLS OF DIZZINESS OR LOSS OF BALANCE

25. Have you had any sudden spells of dizziness, loss of balance, or sensation of spinning which lasted 24 hours or longer? ..... Yes Y

Go to Item 29 — No N

Don't know D

26. Did the dizziness, loss of balance or spinning sensation occur only when changing the position of your head or body? ..... Yes Y — Go to Item 29

No N

Don't know D

27. While you were having your episode of dizziness, loss of balance or spinning sensation, did any of the following occur? [INCLUDE ALL THAT APPLY]

27a. Speech disturbances? ..... Yes Y

No N

27b. Paralysis or weakness? ..... Yes Y

Go to Item 27d — No N

27c. Did you have difficulty on: ..... The right side only R
[READ ALL CHOICES]

The left side only L

Both sides B

27d. Numbness or tingling? ..... Yes Y

Go to Item 27f — No N

27e. Did you have difficulty on: ..... The right side only R
[READ ALL CHOICES]

The left side only L

Both sides B

27f. Blackouts or fainting? ..... Yes Y

No N

27g. Seizures or convulsions? ..... Yes Y

No N

27h. Headache? ..... Yes Y

No N

27i. Visual disturbances? ..... Yes Y

Go to Item 28 — No N

27j. Did you have: ..... Double vision A
[READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]

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

Trouble in both eyes seeing to both sides or straight ahead G

28. Did the episode of dizziness, loss of balance, or spinning sensation come on suddenly? ..... Yes Y

No N

H. ADMINISTRATIVE INFORMATION

29. Date of data collection: ..... | | | / | | | / | | | | |
m m d d y y y y

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

Paper form P

31. Code number of person completing this interview: ..... | | | |