



# Stroke Symptoms Form

FORM CODE: SSF  
VERSION B 07/29/2005

ID NUMBER:

CONTACT YEAR:

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. Since your last Jackson Heart Study exam in (mm/dd /yyyy), have you been told by a physician that you had a stroke? .....Yes 1
- No 2  
 Don't know 7  
 Refused 8  
 Missing 9

2. When did this stroke occur? .....  /   
m m y y y y

## B. SUDDEN LOSS OR CHANGE OF SPEECH

3. In the past 5 years, since your last Jackson Heart Study exams, have you had any sudden loss or changes in speech lasting 24 hours or longer? .....Yes 1
- No 2  
 Don't know 7  
 Refused 8  
 Missing 9

4. Did the episode come on suddenly?.....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

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

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>	<u>Missing</u>
5a. Slurred speech like you were drunk? .....	1	2	7	8	9
5b. Could talk but the wrong words came out?.....	1	2	7	8	9
5c. Know what you wanted to say, but the words would not come out? .....	1	2	7	8	9
5d. Could not think of the right words? .....	1	2	7	8	9
5e. [IF MORE THAN ONE OF ITEMS A-D INDICATED, ASK "WHICH OF THESE MOST CLOSELY DESCRIBES THE PROBLEMS?"].....					
			Slurred speech		1
			Wrong words came out		2
			Words would not come out		3
			Could not think of the right		4

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	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 6c

6b. Did you have difficulty on:..... The right side only 1  
 [READ ALL CHOICES]  
 The left side only 2  
 Both sides 3  
 Don't know 7  
 Refused 8  
 Missing 9

6c. Paralysis or weakness? ..... Yes 1  
 No 2  
 Don't know 7  
 Refused 8  
 Missing 9

Go to Item 6e

6d. Did you have difficulty on:.....The right side only 1  
 [READ ALL CHOICES]  
 The left side only 2  
 Both sides 3  
 Don't know 7  
 Refused 8  
 Missing 9

6e. Lightheadedness, dizziness,  
 or loss of balance? ..... Yes 1  
 No 2  
 Don't know 7  
 Refused 8  
 Missing 9

6f. Blackouts or fainting? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
6g. Seizures or convulsions? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
6h. Headache? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
6i. Visual disturbances? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 7

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

Double vision	01
Vision loss in right eye only	02
Vision loss in left eye only	03
Total loss of vision in both eyes	04
Trouble in both eyes seeing to the right	05
Trouble in both eyes seeing to the left	06
Trouble in both eyes seeing to both sides or straight ahead	07
Don't know	77
Refused	88
Missing	99

**C. SUDDEN LOSS OF VISION**

7. In the past 5 years, since your last Jackson Heart Study exam, have you had any sudden loss of vision, or blurring, lasting 24 hours or longer? ..... Yes 1

Go to Item 11a	{	No	2
		Don't know	7
		Refused	8
		Missing	9

8. Did the episode come on suddenly?..... Yes 1

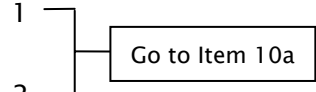
No 2

Don't know 7

Refused	8
Missing	9

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

Only the right eye	1
Only the left eye	2
Both eyes	3
Don't know	7
Refused	8
Missing	9



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

Trouble seeing to the right, but not the left	1
Trouble seeing to the left, but not the right	2
Trouble seeing both sides or straight ahead	3
Don't know	7
Refused	8
Missing	9

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
	Don't know	7
	Refused	8
	Missing	9

10b. Numbness or tingling? .....	Yes	1
	<input type="checkbox"/> No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 10d

10c. Did you have difficulty on:.....	The right side only	1
[READ ALL CHOICES]		
	The left side only	2
	Both sides	3
	Don't know	7
	Refused	8
	Missing	9

10d. Paralysis or weakness? .....	Yes	1
	<input type="checkbox"/> No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 10f

10e. Did you have difficulty on:.....	The right side only	1
[READ ALL CHOICES]		
	The left side only	2
	Both sides	3
	Don't know	7

	Refused	8
	Missing	9
10f. Lightheadedness, dizziness, or loss of balance? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
10g. Blackouts or fainting? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
10h. Seizures or convulsions? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
10i. Headache? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9



10j. Flashing lights? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

**D. DOUBLE VISION**

11a. In the past 5 years, since your last Jackson Heart Study visit, have you had a sudden spell of double vision, which lasted 24 hours or longer? ..... Yes 1

Go to Item 14	No	2
	Don't know	7
	Refused	8
	Missing	9

11b. If you closed one eye, did the double vision go away? ..... Yes 1

Go to Item 14	No	2
	Don't know	7
	Refused	8
	Missing	9

12. Did the episode come on suddenly? ..... Yes 1

	No	2
	Don't know	7
	Refused	8
	Missing	9

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

13a. Speech disturbance? ..... Yes 1  
No 2  
Don't know 7  
Refused 8  
Missing 9

13b. Numbness or tingling? ..... Yes 1  
No 2  
Don't know 7  
Refused 8  
Missing 9

Go to Item 13d

13c. Did you have difficulty on: ..... The right side only 1  
[READ ALL CHOICES] The left side only 2  
Both sides 3  
Don't know 7  
Refused 8  
Missing 9

13d. Paralysis or weakness? ..... Yes 1  
No 2  
Don't know 7  
Refused 8  
Missing 9

Go to Item

13e. Did you have difficulty on .....	The right side only	1
[READ ALL CHOICES]		
	The left side only	2
	Both sides	3
	Don't know	7
	Refused	8
	Missing	9

13f. Lightheadedness, dizziness, or loss of balance? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

13g. Blackouts or fainting? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

13h. Seizures or convulsions? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

13i. Headache? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

**E. SUDDEN NUMBNESS OR TINGLING**

14. In the past 5 years, since your last Jackson Heart Study exam, 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	1
No	2
Don't know	7
Refused	8
Missing	9

Go to Item 20

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

Yes	1	Go to Item 20
No	2	
Don't know	7	
Refused	8	
Missing	9	

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

Yes	1
No	2
Don't know	7
Refused	8
Missing	9

17. During the episode of sudden numbness or tingling, which part or parts of your body were affected?

[READ ALL CHOICES]

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>	<u>Missing</u>
17a. Left arm or hand?.....	1	2	7	8	9
17b. Left leg or foot? .....	1	2	7	8	9
17c. Left side of face? .....	1	2	7	8	9
17d. Right arm or hand? .....	1	2	7	8	9
17e. Right leg or foot? .....	1	2	7	8	9
17f. Right side of face?.....	1	2	7	8	9
17g. Other? .....	1	2	7	8	9

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	1
Stayed in one part	2
Don't know	7
Refused	8
Missing	9

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	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

19b. Paralysis or weakness? .....	Yes	1
	<input type="checkbox"/> No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 19d

19c. Did you have difficulty on: .....	The right side only	1
[READ ALL CHOICES]		
	The left side only	2
	Both sides	3
	Don't know	7
	Refused	8
	Missing	9

19d. Lightheadedness, dizziness, or loss of balance? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

19e. Blackouts or fainting? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

19f. Seizures or convulsions? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
19g. Headache? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
19h. Pain in the numb or tingling arm, leg or face? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
19i. Visual disturbances? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 20

— No	2
Don't know	7
Refused	8
Missing	9

19j. Did you have: [READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]

Double vision	01
Vision loss in right eye only	02
Vision loss in left eye only	03
Total loss of vision in both eyes	04
Trouble in both eyes seeing to the right	05
Trouble in both eyes seeing to the left	06
Trouble in both eyes seeing to both sides or straight ahead	07
Don't know	77
Refused	88
Missing	99

**F. SUDDEN PARALYSIS OR WEAKNESS**

20. In the past 5 years, since your last Jackson Heart Study exam, have you 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 1

Go to Item 25	No	2
	Don't know	7
	Refused	8
	Missing	9

21. Did the episode come on suddenly? ..... Yes 1  
No 2



Don't know	7
Refused	8
Missing	9

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

	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Refused</u>	<u>Missing</u>
22a. Left arm or hand? .....	1	2	7	8	9
22b. Left leg or foot? .....	1	2	7	8	9
22c. Left side of face? .....	1	2	7	8	9
22d. Right arm or hand? .....	1	2	7	8	9
22e. Right leg or foot? .....	1	2	7	8	9
22f. Right side of face? .....	1	2	7	8	9
22g. Other? .....	1	2	7	8	9

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	1
Stayed in one part	2
Don't know	7
Refused	8
Missing	9

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	1
	No	2

Don't know 7

Refused 8

Missing 9

24b. Numbness or tingling? ..... Yes 1

Go to Item 24d — No 2

Don't know 7

Refused 8

Missing 9

24c. Did you have difficulty on: ..... The right side only 1  
[READ ALL CHOICES]

The left side only 2

Both sides 3

Don't know 7

Refused 8

Missing 9

24d. Lightheadedness, dizziness, or loss of  
balance?..... Yes 1

No 2

Don't know 7

Refused 8

Missing 9

24e. Blackouts or fainting? ..... Yes 1

No 2

	Don't know	7
	Refused	8
	Missing	9
24f. Seizures or convulsions? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
24g. Headache? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
24h. Pain in the weak arm, leg or face? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9
24i. Visual disturbances? .....	Yes	1
	<input type="button" value="Go to Item 25"/> No	2
	Don't know	7
	Refused	8

	Missing	9
24j. Did you have: [READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]		
	Double vision	01
	Vision loss in right eye only	02
	Vision loss in left eye only	03
	Total loss of vision in both eyes	04
	Trouble in both eyes seeing to the right	05
	Trouble in both eyes seeing to the left	06
	Trouble in both eyes seeing to both sides or straight ahead	07
	Don't know	77
	Refused	88
	Missing	99

**G. SUDDEN SPELLS OF DIZZINESS OR LOSS OF BALANCE**

25. In the past 5 years, since your last Jackson Heart Study exam, have you had any sudden spells of dizziness, loss of balance, or sensation of spinning which lasted 24 hours or longer? ..... Yes		1
	No	2
	Don't know	7
	Refused	8
	Missing	9

Go to Item 29

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

Yes	1	<a href="#">Go to Item 29</a>
No	2	
Don't know	7	
Refused	8	
Missing	9	

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	1
No	2
Don't know	7
Refused	8
Missing	9

27b. Paralysis or weakness? .....

Yes	1
<a href="#">Go to Item 27d</a> No	2
Don't know	7
Refused	8
Missing	9

27c. Did you have difficulty on: ..... [READ ALL CHOICES]

The right side only	1
The left side only	2
Both sides	3
Don't know	7

Refused	8
Missing	9

27d. Numbness or tingling? ..... Yes 1

<div style="border: 1px solid black; display: inline-block; padding: 2px;">Go to Item 27f</div> — No	2
Don't know	7
Refused	8
Missing	9

27e. Did you have difficulty on: ..... The right side only 1  
 [READ ALL CHOICES]

The left side only	2
Both sides	3
Don't know	7
Refused	8
Missing	9

27f. Blackouts or fainting? ..... Yes 1

No	2
Don't know	7
Refused	8
Missing	9

27g. Seizures or convulsions? ..... Yes 1

No	2
Don't know	7
Refused	8

	Missing	9
27h. Headache? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

27i. Visual disturbances? .....	Yes	1
	<input type="checkbox"/> No	2
	Don't know	7
	Refused	8
	Missing	9

27j. Did you have:		
[READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]		
	Double vision	01
	Vision loss in right eye only	02
	Vision loss in left eye only	03
	Total loss of vision in both eyes	04
	Trouble in both eyes seeing to the right	05
	Trouble in both eyes seeing to the left	06
	Trouble in both eyes seeing to both sides or straight ahead	07
	Don't know	77

Go to Item 28

Refused 88

Missing 99

28. Did the episode of dizziness, loss of balance, or spinning sensation come on suddenly? .....	Yes	1
	No	2
	Don't know	7
	Refused	8
	Missing	9

**H. ADMINISTRATIVE INFORMATION**

29. Date of data collection: ..... 

		/			/				
m	m		d	d		y	y	y	y

30. Method of data collection: ..... Computer 1

Paper form 2

31. Data Collected: ..... In clinic 1

Off site 2

32. Code number of person completing this interview: ..... 

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