Stroke Symptoms Form

ID NUMBER: □□□□□□□□ □□□□□□□□ CONTACT YEAR: 06
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
   Go to Item 3 — No 2
   Don’t know 7
   Refused 8
   Missing 9

2. When did this stroke occur? .......... □□□□□□□□□ □□□□□□□□

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
   Go to Item 7 — 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]

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
<th>Refused</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>5a. Slurred speech</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>like you were drunk?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5b.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Could talk but the</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>wrong words came</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>out?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5c. Know what you</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>wanted to say, but</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the words would not</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>come out?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5d. Could not think</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>of the right words?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5e. [IF MORE THAN ONE OF ITEMS A–D INDICATED, ASK “WHICH OF THESE MOST CLOSELY DESCRIBES THE PROBLEMS?”] ......................................................

<table>
<thead>
<tr>
<th></th>
<th>Slurred speech</th>
<th>Wrong words came out</th>
<th>Words would not come out</th>
<th>Could not think of the right</th>
</tr>
</thead>
<tbody>
<tr>
<td>5e.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

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
                               Go to Item 6c No 2
                               Don’t know 7
                               Refused 8
                               Missing 9
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
      Go to Item 6e
            No 2
               Don’t know 7
                 Refused 8
                   Missing 9

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

Go to Item 7

No 2

Don’t know 7

Refused 8

Missing 9
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

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

Only the left eye
Both eyes
Don’t know
Refused
Missing

9b. Did you have: Trouble seeing to the right, but not the left
[READ ALL CHOICES UNTIL A POSITIVE RESPONSE IS GIVEN]

Trouble seeing to the left, but not the right
Trouble seeing both sides or straight ahead
Don’t know
Refused
Missing

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

10a. Speech disturbance? Yes

No
Don’t know
Refused
Missing
10b. Numbness or tingling? ......................................................... Yes 1
      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
      The left side only 2
      Both sides 3
      Don’t know 7
      Refused 8
      Missing 9

      [READ ALL CHOICES]

10d. Paralysis or weakness? .................................................... Yes 1
      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
      The left side only 2
      Both sides 3
      Don’t know 7

      [READ ALL CHOICES]
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

Go to Item 13d

No 2

Don’t know 7

Refused 8

Missing 9

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

Go to Item

No 2

Don’t know 7

Refused 8

Missing 9
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

15. Did the feeling of numbness or tingling occur only when you kept your arms or legs in a certain position? ................................................................. Yes 1

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]

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

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]

- Speech disturbance? | Yes 1
- No 2
- Don't know 7
- Refused 8
- Missing 9
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
<th>Refused</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td>19b. Paralysis or weakness?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Go to Item 19d</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19c. Did you have difficulty on:</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>[READ ALL CHOICES]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The right side only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The left side only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Both sides</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refused</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19d. Lightheadedness, dizziness, or loss of balance?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>19e. Blackouts or fainting?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
<td>Don’t know</td>
<td>Refused</td>
<td>Missing</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>------------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>19f. Seizures or convulsions?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>19g. Headache?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>19h. Pain in the numb or tingling arm, leg or face?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>19i. Visual disturbances?</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

Go to Item 20
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

   No 2

   Go to Item 25

   Don’t know 7

   Refused 8

   Missing 9

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

   No 2
22. During this episode, which part or parts of your body were affected? [READ ALL CHOICES]

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

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? 

<table>
<thead>
<tr>
<th></th>
<th>Started in one part and spread to another</th>
<th>Stayed in one part</th>
<th>Don't know</th>
<th>Refused</th>
<th>Missing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>24a. Speech disturbances?</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>24b. Numbness or tingling?</td>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Refused</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Missing</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>24c. Did you have difficulty on:</th>
<th>The right side only</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>[READ ALL CHOICES]</td>
<td>The left side only</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Both sides</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Refused</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Missing</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>24d. Lightheadedness, dizziness, or loss of balance?</th>
<th>Yes</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Don’t know</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Refused</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Missing</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>24e. Blackouts or fainting?</th>
<th>Yes</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>2</td>
</tr>
</tbody>
</table>
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
    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

Go to Item 29

- No 2
- Don't know 7
- Refused 8
- Missing 9
26. Did the dizziness, loss of balance or spinning sensation occur only when changing the position of your head or body? 

- Yes 1  — Go to Item 29
- 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  — Go to Item 27d
- No 2
- Don't know 7
- Refused 8
- Missing 9

27c. Did you have difficulty on: 

- The right side only 1
- The left side only 2
- Both sides 3
- Don't know 7
27d. Numbness or tingling? ......................................................... Yes 1
       No 2
       Don’t know 7
       Refused 8
       Missing 9

Go to Item 27f

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
    Go to Item 28
    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
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: .........................