

Multi-Ethnic Study of Atherosclerosis



Physician Questionnaire:
Stroke/TIA

Participant ID: 8000028 12

Sequence Num:

Two empty boxes for sequence number

(For MESA Field Center use only)

Public reporting burden for this collection of information is estimated to average 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. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD, 20892-7974, ATTN: PRA 0925-0493. Do not return the completed form to this address.

Participant Name: _____

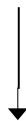
Date-of-Birth: ____/____/____

Please complete only this page if you are not familiar with this participant's medical history.

Please fill in the appropriate bubbles and write responses in the blanks provided.

1. Are you familiar with the participant's medical history?

Yes No →



Please continue to Question 2 on page 2

Are you aware of another physician who could provide information regarding this participant?

Yes No



Please sign and date the form at the bottom of page 3 and return form.

Please fill in the physician's name and address, sign and date the form at the bottom of page 3 and return form.

Three horizontal lines for writing the physician's name and address

2. When did you last see the patient?

		/			/				
Month			Day			Year			

3. In your opinion, has the patient ever had a cerebrovascular event such as a stroke, TIA or amaurosis fugax?

- Yes
 No
 Unsure

↓
If "No," skip to the end of the form, sign and date at the bottom of page 3 and return form..

4. When was the **most recent** event of this type?

		/			/				
Month			Day			Year			

4a. This most recent event was a(n):

- Subarachnoid hemorrhage
- Intraparenchymal hemorrhage
- Brain infarction
- TIA
- Stroke, uncertain type
- Not a stroke or TIA

If not a stroke or TIA, what was the diagnosis?

4b. The certainty of the diagnosis is:

- Definite
- Probable
- Possible

4c. Was the patient hospitalized?

- Yes
 No → *If "No," skip to Question 5.*

Name of Hospital: _____

City/State: _____

5. The symptoms were in the distribution of which vessel?

- Right carotid
- Left carotid
- Vertebral/Basilar
- Unknown

6. Which (if any) of the following diagnostic tests did the patient have?

	Yes	No	Unknown
CT of the head	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MRI of the brain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Carotid ultrasound	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Electrocardiogram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Echocardiogram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hypercoagulation work-up	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If other, Please specify:

7. Which (if any) of the following symptoms or physical findings were present in the most recent event?

	Yes	No	Unknown
Severe headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diminished level of consciousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Loss of consciousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Language deficit/aphasia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hemineglect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dysarthria	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Visual field deficit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Weakness or drift	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hemiplegia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ataxia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sensory deficit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asymmetry of reflexes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Babinski	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abnormal gait	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If other, please specify:

8. Did any neurological findings persist longer than 24 hours from onset?

- Yes No



Please specify:

9. Which (if any) of the following medications were prescribed as therapy?

	Yes	No	Unknown
Aspirin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dipyridamole	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anti-coagulants	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ticlopidine or Clopidogrel	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Extended Release Dipyridamole	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If other, please specify:

If there has been more than one event of this type, please continue to Question 10.

If not, please skip to the end of the form, sign and date, and return the form to the MESA clinic.

10. When was the **first** event of this type?

		/			/				
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Month Day Year

10a. This first event was a(n):

- Subarachnoid hemorrhage
- Intraparenchymal hemorrhage
- Brain infarction
- TIA
- Stroke, uncertain type
- Not a stroke or TIA

If not a stroke or TIA, what was the diagnosis?

10b. The certainty of the diagnosis

- Definite
- Probable
- Possible

10c. Was the patient hospitalized?

- Yes No

If "No," skip to Question 5.

Name of hospital: _____

City/State: _____

Thank you very much for your contribution to MESA. Please sign and date this questionnaire and return it to us in the self-addressed, stamped envelope. If you do not have the envelope, the address is:

Form completed by: _____ Date: _____

For MESA Field Center Use Only:

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Reviewer ID:

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Data Entry ID:

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