OMB #0925-0493 Exp: 10/31/07

Multi-Ethnic Study of Atherosclerosis

Physician Questionnaire:
Stroke/TIA

Participant ID: 8000028 12

Sequence Num: ☐☐ ***(For MESA Field Center use only)***

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****.*

_____

_____

_____

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	○	○	○
MRI of the brain	○	○	○
Carotid ultrasound	○	○	○
Electrocardiogram	○	○	○
Echocardiogram	○	○	○
Hypercoagulation work-up	○	○	○
Other	○	○	○

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	○	○	○
Diminished level of conciousness	○	○	○
Loss of conciousness	○	○	○
Language deficit/aphasia	○	○	○
Hemineglect	○	○	○
Dysarthria	○	○	○
Visual field deficit	○	○	○
Weakness or drift	○	○	○
Hemiplegia	○	○	○
Ataxia	○	○	○
Sensory deficit	○	○	○
Asymmetry of reflexes	○	○	○
Babinski	○	○	○
Abnormal gait	○	○	○
Other	○	○	○

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	○	○	○
Dipyridamole	○	○	○
Anti-coagulants	○	○	○
Ticlopidine or Clopidogrel	○	○	○
Extended Release Dipyridamole	○	○	○
Other	○	○	○

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?

□□ / □□ / □□□□

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:

□□ / □□ / □□□□ Reviewer ID: □□□ Data Entry ID: □□□