



Interview for Stroke/TIA
Symptoms

Introduction: You reported to us that you had either a stroke, a small stroke, or a transient ischemic attack, also called a TIA, on about [specify date]. We are interested in possible stroke or TIA symptoms you may have had related to that experience. You may have had one or more episodes during that experience, but I would like you to respond for the episode in which a doctor diagnosed a stroke or TIA, or otherwise the worst episode. [NOTE: If participant asks, "worst" can be defined in terms of severity, intensity, or association with other symptoms.]

Sudden Loss or Change of Speech

1. When you had your episode, did you have any sudden loss or changes in speech?

- Yes No

If "No," skip to question 12.

2. Did the change or loss last at least 24 hours?

- Yes No

3. Did the change or loss come on suddenly?

- Yes No

4. Do any of the following describe your change or loss in speech? (Read responses.)

	Yes	No
Slurred speech like you were drunk	<input type="radio"/>	<input type="radio"/>
Could talk but the wrong words came out	<input type="radio"/>	<input type="radio"/>
Knew what you wanted to say but the words would not come out	<input type="radio"/>	<input type="radio"/>
Could not think of the right words	<input type="radio"/>	<input type="radio"/>

Symptoms During Speech Disturbance

While you were experiencing this change in speech, did any of the following occur? (Mark "Yes" for each symptom that applies.)

5a. Numbness or tingling?

- Yes No

If "No," go to Question 6a.

b. Did you have this difficulty on: (Read responses.)

- The right side only
 The left side only
 Both sides

6a. Paralysis or weakness?

- Yes No

If "No," go to Question 7.

b. Did you have this difficulty on: (Read responses.)

- The right side only
 The left side only
 Both sides

7. Lightheadedness, dizziness, or loss of balance?

- Yes No

8. Blackouts or fainting?

- Yes No

9. Seizures or convulsions?

- Yes No

10. Headache?

- Yes No

11a. Vision loss or blurring of vision?

- Yes No

If "No," go to Question 12.

b. During this vision loss or blurring of vision, did you have: (Read responses until a positive response is given.)

- Double vision (If yes, probe to ensure that the participant saw two objects side by side or one on top of the other. If not, do not mark this bubble)
 Vision loss in right eye only
 Vision loss in left eye only
 Total loss of vision in both eyes
 Trouble in both eyes seeing to the right
 Trouble in both eyes seeing to the left
 Trouble in both eyes seeing to both sides or straight ahead
 None of the above

Sudden Loss of Vision

12. When you had your episode, did you have any sudden loss or blurring of vision, complete or partial?

- Yes
- No

If "No" skip to Question 24.

13. Did the visual symptoms last at least 24 hours?

- Yes
- No

14. Did the visual symptoms come on suddenly?

- Yes
- No

15a. During this episode, which of the following parts of your vision were affected? (Read responses.)

- Only the right eye
- Only the left eye
- Both eyes

If only right or left eye, go to Question 16.

b. Did you have: (Read choices until a positive response is given.)

- Trouble seeing to the right side but not the left
- Trouble seeing to the left side but not the right
- Trouble seeing to both sides or straight ahead

Other:

- None of the above

Symptoms During Sudden Vision Loss

While you were experiencing this loss of vision, did any of the following occur: (Mark "Yes" for each symptom that applies.)

16. Speech disturbance?

- Yes
- No

17a. Numbness or tingling?

- Yes
- No

If "No," go to Question 18a

b. Did you have this difficulty on: (Read responses.)

- The right side only
- The left side only
- Both sides

18a. Paralysis or weakness?

- Yes
- No

If "No," go to Question 19.

b. Did you have this difficulty on: (Read responses.)

- The right side only
- The left side only
- Both sides

19. Lightheadedness, dizziness, or loss of balance?

- Yes
- No

20. Blackouts or fainting?

- Yes
- No

21. Seizures or convulsions?

- Yes
- No

22. Headache?

- Yes
- No

23. Flashing lights?

- Yes
- No

Sudden Double Vision

24. When you had your episode, did you have a sudden spell of double vision; that is, did you see two objects side by side, or one on top of the other?

- Yes
- No

If "No," go to Question 35.

25. Did the double vision symptoms last at least 24 hours?

- Yes
- No

26. If you closed one eye, did the double vision go away?

- Yes
- No

If "No," go to Question 35.

27. Did the double vision come on suddenly?

- Yes
- No

Symptoms During Sudden Double Vision

While you were experiencing double vision, did any of the following occur? (Mark "Yes" for each symptom that applies.)

28. Speech disturbance?

- Yes
- No

29a. Numbness or tingling?

- Yes
- No

If "No," go to Question 30a.

b. Did you have this difficulty on: (Read responses.)

- The right side only
- The left side only
- Both sides

30a. Paralysis or weakness?

- Yes
- No

If "No," go to Question 31.

b. Did you have this difficulty on: (Read responses.)

- The right side only
- The left side only
- Both sides

31. Lightheadedness, dizziness, or loss of balance?

- Yes
- No

32. Blackouts or fainting?

- Yes
- No

33. Seizures or convulsions?

- Yes
- No

34. Headache?

- Yes
- No

Sudden Numbness or Tingling

35. When you had your episode, did you have sudden numbness, tingling, or loss of feeling in one side of your body, including your face, arm or leg?

- Yes
- No

If "No," go to Question 49.

36. Did the numbness or loss of feeling last at least 24 hours?

- Yes
- No

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

- Yes
- No

If "Yes," go to Question 49.

38. Did the feeling come on suddenly?

- Yes
- No

Symptoms During Sudden Numbness or Tingling

39. During the numbness or tingling, which part or parts of your body were affected? (Read responses.)

	Yes	No
Left arm or hand	<input type="radio"/>	<input type="radio"/>
Left leg or foot	<input type="radio"/>	<input type="radio"/>
Left side of face	<input type="radio"/>	<input type="radio"/>
Right arm or hand	<input type="radio"/>	<input type="radio"/>
Right leg or foot	<input type="radio"/>	<input type="radio"/>
Right side of face	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

40. When you experienced this numbness or tingling, did the abnormal sensation start in one part of your body and spread to another, or did it stay in the same place?

- In one part and spread to another
- Stayed in one part

While you were experiencing numbness, tingling, or loss of sensation, did any of the following occur?

41. Speech disturbance?

- Yes
- No

42a. Paralysis or weakness?

- Yes
- No

If "No," go to Question 43.

b. Did you have this difficulty on: (Read responses.)

- The right side only
- The left side only
- Both sides

43. Lightheadedness, dizziness, or loss of balance?

- Yes
- No

44. Blackouts or fainting?

- Yes
- No

45. Seizures or convulsions?

- Yes
- No

46. Headache?

- Yes
- No

47. Pain in the numb or tingling arm, leg or face?

- Yes
- No

48a. Vision loss or blurring of vision?

- Yes No

If "No," go to Question 49.

b. During this vision loss or blurring of vision, did you have: (Read responses until a positive response is given.)

- Double vision (If yes, probe to ensure that the participant saw two objects side by side or one on top of the other. If not, go on.)
- Vision loss in right eye only
- Vision loss in left eye only
- Total loss of vision in both eyes
- Trouble in both eyes seeing to the right
- Trouble in both eyes seeing to the left
- Trouble in both eyes seeing to both sides or straight ahead
- None of the above

Sudden Paralysis or Weakness

49. When you had your episode, did you have any sudden paralysis or weakness on one side of your body, including your face, arm or leg?

- Yes No

If "No," go to Question 62.

50. Did the paralysis or weakness last at least 24 hours?

- Yes No

51. Did the paralysis or weakness come on suddenly?

- Yes No

52. During the paralysis or weakness, which part or parts of your body were affected? (Read responses.)

	Yes	No
Left arm or hand	<input type="radio"/>	<input type="radio"/>
Left leg or foot	<input type="radio"/>	<input type="radio"/>
Left side of face	<input type="radio"/>	<input type="radio"/>
Right arm or hand	<input type="radio"/>	<input type="radio"/>
Right leg or foot	<input type="radio"/>	<input type="radio"/>
Right side of face	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>

53. During this experience of paralysis or weakness, did the paralysis or weakness start in one part of your body and spread to another, or did it stay in the same place?

- In one part and spread to another
- Stayed in one part

While you were experiencing this paralysis or weakness, did any of the following occur: (Mark "Yes" for each symptom that applies.)

54. Speech disturbance?

- Yes No

55a. Numbness or tingling?

- Yes No

If "No," go to Question 56.

b. Did you have this difficulty on: (Read responses.)

- The right side only
- The left side only
- Both sides

56. Lightheadedness, dizziness, or loss of balance?

- Yes No

57. Blackouts or fainting?

- Yes No

58. Seizures or convulsions?

- Yes No

59. Headache?

- Yes No

60. Pain in the weak arm, leg or face?

- Yes No

61a. Vision loss or blurring of vision?

- Yes No

If "No," go to Question 62.

b. During this vision loss or blurring of vision, did you have: (Read responses until a positive response is given.)

- Double vision (If yes, probe to ensure that the participant saw two objects side by side or one on top of the other. If not, do not mark this bubble.)
- Vision loss in right eye only
- Vision loss in left eye only
- Total loss of vision in both eyes
- Trouble in both eyes seeing to the right
- Trouble in both eyes seeing to the left
- Trouble in both eyes seeing to both sides or straight ahead
- None of the above

Dizziness or Loss of Balance

62. When you had your episode, did you have any sudden spells of dizziness, loss of balance or sensation of spinning?

- Yes No

If "No," go to End.

63. Did the dizziness or loss of balance last at least 24 hours?

- Yes No

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

- Yes No

If "Yes," go to End.

65. Did the dizziness, loss of balance, or spinning sensation come on suddenly?

- Yes No

Symptoms During Dizziness or Loss of Balance

While you were experiencing this dizziness, loss of balance, or spinning sensation, did any of the following occur: (Mark "Yes" for each symptom that applies.)

66. Speech disturbance?

- Yes No

67a. Paralysis or weakness?

- Yes No

If "No," go to Question 68a.

b. Did you have this difficulty on: (Read responses.)

- The right side only
 The left side only
 Both sides

68a. Numbness or tingling?

- Yes No

If "No," go to Question 69.

b. Did you have this difficulty on: (Read responses.)

- The right side only
 The left side only
 Both sides

69. Blackouts or fainting?

- Yes No

70. Seizures or convulsions?

- Yes No

71. Headache?

- Yes No

72a. Vision loss or blurring of vision?

- Yes No

If "No," go to End.

b. During this vision loss or blurring of vision, did you have: (Read responses until a positive response is given.)

- Double vision (If yes, probe to ensure that the participant saw two objects side by side or one on top of the other. If not, do not mark this bubble.)
 Vision loss in right eye only
 Vision loss in left eye only
 Total loss of vision in both eyes
 Trouble in both eyes seeing to the right
 Trouble in both eyes seeing to the left
 Trouble in both eyes seeing to both sides or straight ahead
 None of the above

End:

Thank you very much for taking the time to talk with us. Please remember to contact us should there be any change in your health in the future.

(Interviewer: continue to page 6 to complete reliability question, record any relevant notes, and insert date and ID.)

Reliability

73. What is your rating of the interview's reliability?

- Good
- Fair
- Poor

Notes

Notes in box are saved in MESA database. Notes on lines below are for Field Center paper copy use only.

For Administrative Use Only:

Interview Administered to:

- Participant
- Proxy (if participant is unable)

Interviewer ID:

--	--	--

Data Entry ID:

--	--	--

Date:

--	--

 /

--	--

 /

--	--	--	--

Month Day Year