Multi-Ethnic Study of Atherosclerosis

Participant ID: 8000028 12

Sequence Num: (For MESA Field Center use only)

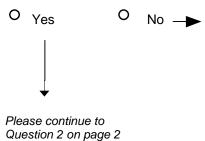
Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching axisting data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency 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?



	another physician who could provide rding this participant?					
O Yes	O 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.						
	J					

- When did you last see the patient? Day Month Year 3. In your opinion, has the patient ever had a cerebrovascular event such as a stroke, TIA or amaurosis fugax? O Yes O No O Unsure If "No," skip to the end of the form, sign and date at the bottom of page 3 and return form.. When was the **most recent** event of this type? Month Day Year This most recent event was a(n): 0 Subarachnoid hemorrhage 0 Intraparenchymal hemorrhage 0 Brain infarction 0 TIA Stroke, uncertain type 0 Not a stroke or TIA If not a stroke or TIA, what was the diagnosis? The certainty of the diagnosis is: 0 Definite 0 Probable 0 Possible 4c. Was the patient hospitalized? If "No," skip to O Yes O No → Question 5. Name of Hospital:
- 8000028 12 The symptoms were in the distribution of which vessel? 0 Right carotid 0 Left carotid 0 Vertebral/Basilar Unknown Which (if any) of the following diagnostic tests did the patient have? Yes No Unknown 0 0 0 CT of the head MRI of the brain 0 0 0 Carotid ultrasound 0 0 0 Electrocardiogram 0 0 0 Echocardiogram 0 0 0 Hypercoagulation work-up 0 0 0 Other 0 0 If other, Please specify: Which (if any) of the following symptoms or physical findings were present in the most recent event? Linknown

	Yes	No	Unknown
Severe headache	0	0	0
Diminished level of conciousness	0	0	0
Loss of conciousness	0	0	0
Language deficit/aphasia Hemineglect Dysarthria Visual field deficit	0 0 0	0 0 0	0 0 0
Weakness or drift Hemiplegia Ataxia Sensory deficit	0 0 0	0 0 0	0 0 0
Asymmetry of reflexes Babinski Abnormal gait Other	0 0 0	0 0 0	0 0 0
If other,	·	·	·

City/State: \_\_

3. Did any neurological findings persist longer than 24 hours from onset?				r than	10.	When was the <b>first</b> event of this type?		
	O Yes O	No			L	onth Day Year		
	Please specify:					23,		
	Flease specify.				10a.	This first event was a(n):		
					O Subarachnoid hemorrhage			
						Intraparenchymal hemorrhage		
_	Which (if any) of the following medications were prescribed as therapy?					O Brain infarction		
9.				were				
	Aspirin	0	0	Unknown O		Not a stroke or TIA		
				· ·				
	Dipyridamole	0	0	0		If not a stroke or TIA, what was the diagnosis?		
	Anti-coagulants	0	0	0				
	Ticlopidine or Clopidogrel	0	0	0	10b.	The certainty of the diagnosis		
	Extended Release Dipyridamole	0	0	0	0	Definite Probable		
	Other	0	0	0		Possible		
	If other, please				10c.	Was the patient hospitalized?		
	specify: L							
						100		
	If there has been more			of this type,		If "No," skip to Question 5.		
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.					Name	e of hospital:		
					City/	State:		
				,				
_								
	Thank you very n	nuch f	or you	r contributi	on to N	MESA. Please sign and date this		

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:	ı

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