



STROKE & TIA QUESTIONNAIRE

Client _____ Age/DOB _____

Check type of event:

- Stroke/CVA
- TIA
- Amaurosis Fugax

Date of event: _____

If more than one event, list dates here: _____

Check type of stroke, if known:

- Ischemic (blockage from a blood clot or atherosclerotic plaque)
- Hemorrhagic (bleeding from an aneurysm, AVM, subdural hematoma)
- Lacunar Infarct (incidental finding on imaging)

Check underlying cause, if known:

- Hypertension
- Atherosclerosis (CAD, carotid artery disease, peripheral vascular disease)
- Blood clot
- Aneurysm or AVM (Arteriovenous Malformation)
- PFO (Patent Foramen Ovale)...a congenital heart defect
- Valvular heart disease or mechanical heart valve
- Arrhythmia/Atrial Fibrillation
- Trauma/head injury
- Brain tumor
- Other

Are there any ongoing neurological residuals? YES NO

If yes, details: _____

Are you able to work a full-time job? YES NO

Did you have any surgery? YES NO

If yes, details: _____

Do you have any history of diabetes? YES NO

If yes, please complete diabetes questionnaire.

Do you currently use any type of nicotine/tobacco products? YES NO
If yes, type of tobacco used? Cigarettes Cigars Chew Pipe Patch/gum

Have you ever used nicotine/tobacco in the past? YES NO

Type used & date quit: _____

Any other health problems or impairments? _____

List medications & dosages: _____

*Please attach copies of test results (if possible) including brain imaging (CT scans/MRIs), carotid dopplers, echocardiograms, event monitors, etc.