

Stroke/TIA Database Information Form

PERSONAL INFORMATION

Name: _____

Date of birth: _____

Current Address: _____

Telephone number: _____

TIA

Have you experienced a TIA? Yes No

Have you experienced multiple TIAs? Yes No

Date (or approximate date) of first TIA: _____

Date (or approximate date) of most recent TIA: _____

STROKE

Have you experienced a stroke? Yes No

Have you experienced multiple strokes? Yes No

Date (or approximate date) of first stroke: _____

Date (or approximate date) of most recent stroke: _____

HOSPITAL (and city if outside of Kansas City metro area) where you received treatment for your TIA(s) or stroke(s):

HEALTH

What side of your body was affected?

Right Left Both None

HEALTH

Do you have any current problems or disabilities related to your stroke or TIA?
Please explain.
