



- ❖ Describe the event (stroke / TIA) in detail: _____

- ❖ When did your symptoms start? _____
- ❖ Which hospital you were evaluated at? _____
- ❖ Did you receive tPA (clot dissolving medication)? Yes / No _____
- ❖ What tests were done for the evaluation of your problem? _____

- ❖ Due to stroke what things you are not able to do, that you were able to do before? _____

- ❖ Were you taking aspirin / clopidogrel (Plavix) / Aggrenox before you had stroke / TIA? _____

- ❖ Do you have below mentioned stroke risk factors such as (circle “yes” or “no”, describe if necessary)
Previous history of stroke: Yes / No _____
Peripheral Arterial Disease / Coronary Artery Disease / Carotid Stenosis: _____
Hypertension (High blood pressure): Yes / No _____
Cigarette Smoking (or other nicotine use): Yes / No _____
Diabetes: Yes / No _____
Dyslipidemia (Increased Cholesterol): Yes / No _____
Obesity (over weight): Yes / No _____
Lack of physical activity: Yes / No _____
Snoring (obstructive sleep apnea) Yes / No _____
Atrial fibrillation (irregular rhythm of the heart): Yes / No _____
Sickle Cell Disease (or other blood disorders): Yes / No _____
Post-menopausal Hormone Replacement Therapy: Yes / No _____
Drug abuse (cocaine) Yes / No _____
- ❖ Potential risk factors (circle): oral contraceptive use, migraine with aura, periodontal disease, high CRP, elevated lipoprotein A, increased homocysteine level, family history of stroke, DVT, pulmonary embolism, coagulopathy, Cox II inhibitor use (e.g. Celebrex) : _____
- ❖ What rehab services you received since your stroke (Physical Therapy / Occupational Therapy / Speech Therapy) _____
- ❖ Do you need help with (circle): Depression, spasticity, home health or rehab

Stroke Resources:

www.stroke.org “mirror therapy for stroke” www.abledata.com “StrokeSmart Magazine – strokesmart.org”
“Recognizing Stroke” “call 911” “stroke support group at ARMC” www.apahasia.org “Lingraphica”
Apps – “Cozi, SmallTalk etc.” “Lend-A-Hand Arm Support” “WalkAid”