

**Cardiovascular/Cerebrovascular Events**

**Purpose:** To record new documented cardiovascular/cerebrovascular events known to occur during the course of the study.

**When:** At all clinic visits, baseline and followup, at which a new cardiovascular/cerebrovascular event is first identified/reported.

**By whom:** Study physician or clinic coordinator by interview with patient and/or review of medical records.

**A. Clinic, patient, and visit identification**

1. Clinic ID code: \_\_\_\_\_

2. Patient ID#: \_\_\_\_\_

3. Patient name code: \_\_\_\_\_

4. Date of visit:  
 \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 day mon year

5. Visit ID code: \_\_\_\_\_

6. Sequence number  
*First form completed on any one date is 01; if more forms are needed, number additional forms sequentially.*  
 \_\_\_\_\_

**B. Cardiovascular event**

7. Is this a new cardiovascular event:  
 ( Yes ) ( No )  
 ( 1 ) ( 2 )

a. Date of event:  
 \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 day mon year

b. What is the diagnosis:  
 Myocardial infarction (MI) ( 1 )  
 Stable angina ( 2 )  
 Unstable angina ( 3 )  
 Sudden cardiac death ( 4 )  
 Other (specify) ( 5 )

\_\_\_\_\_ specify

8. What was the 1st exam or test done to establish the diagnosis (*check only one*):

- Chest x-ray ( 1 )
- Electrocardiogram (ECG) ( 2 )
- Exercise ECG Stress Test ( 3 )
- Echocardiography Stress Test ( 4 )
- Echocardiogram ( 5 )
- Coronary angiogram/coronary arteriography (coronary catheterization) ( 6 )
- Nuclear imaging (*specify*) ( 7 )

\_\_\_\_\_ specify  
 Other (*specify*) ( 8 )

\_\_\_\_\_ specify

a. Date 1st exam/test done:  
 \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 day mon year

b. 1st diagnosis confirmed:  
 Yes ( 1 )  
 No ( 2 )  
 Indeterminate ( 3 )

9. What was the 2nd exam or test done to establish the diagnosis (*check only one*):

- None ( 1 )
- 11.**  Chest x-ray ( 2 )
- Electrocardiogram (ECG) ( 3 )
- Exercise ECG Stress Test ( 4 )
- Echocardiography Stress Test ( 5 )
- Echocardiogram ( 6 )
- Coronary angiogram/coronary arteriography (coronary catheterization) ( 7 )
- Nuclear imaging (*specify*) ( 8 )

\_\_\_\_\_ specify

Other (*specify*) ( 9 )

\_\_\_\_\_ specify

a. Date 2nd exam/test done:

\_\_\_\_ day \_\_\_\_ mon \_\_\_\_ year

b. 2nd diagnosis confirmed:

- Yes ( 1 )
- No ( 2 )
- Indeterminate ( 3 )

10. What was the 3rd exam or test done to establish the diagnosis (*check only one*):

- None ( 1 )
- 11.**  Chest x-ray ( 2 )
- Electrocardiogram (ECG) ( 3 )
- Exercise ECG Stress Test ( 4 )
- Echocardiography Stress Test ( 5 )
- Echocardiogram ( 6 )
- Coronary angiogram/coronary arteriography (coronary catheterization) ( 7 )
- Nuclear imaging (*specify*) ( 8 )

\_\_\_\_\_ specify

Other (*specify*) ( 9 )

\_\_\_\_\_ specify

a. Date 3rd exam/test done:

\_\_\_\_ day \_\_\_\_ mon \_\_\_\_ year

b. 3rd diagnosis confirmed:

- Yes ( 1 )
- No ( 2 )
- Indeterminate ( 3 )

**C. Cerebrovascular event**

11. Is this a new cerebrovascular event:

- Yes ( 1 )
- No ( 2 )

**15.**

a. Date of event:

\_\_\_\_ day \_\_\_\_ mon \_\_\_\_ year

b. What is the diagnosis:

- Transient ischemic attack (TIA) ( 1 )
- Hemorrhagic stroke ( 2 )
- Ischemic stroke ( 3 )
- Other (*specify*) ( 4 )

\_\_\_\_\_ specify

12. What was the 1st exam or test done to establish the diagnosis (*check only one*):

- History and physical examination ( 1 )
- Magnetic Resonance Imaging (MRI)/Nuclear Magnetic Resonance (NMR) Imaging ( 2 )
- Cardiac Computed Tomography (CT) ( 3 )
- Computerized Axial Tomographic scan (CAT scan) ( 4 )
- Cerebral angiogram/cerebral arteriogram ( 5 )
- Electrocardiogram (EKG) ( 6 )
- Electroencephalogram (EEG) ( 7 )
- Doppler Ultrasound ( 8 )
- Other (*specify*) ( 9 )

\_\_\_\_\_ specify

a. Date 1st exam/test done:

\_\_\_\_ day \_\_\_\_ mon \_\_\_\_ year

b. 1st diagnosis confirmed:

- Yes ( 1 )
- No ( 2 )
- Indeterminate ( 3 )

13. What was the 2nd exam or test done to establish the diagnosis (*check only one*):

- None ( 1 )
- 15. History and physical examination ( 2 )
- Magnetic Resonance Imaging (MRI)/Nuclear Magnetic Resonance (NMR) Imaging ( 3 )
- Cardiac Computed Tomography (CT) ( 4 )
- Computerized Axial Tomographic scan (CAT scan) ( 5 )
- Cerebral angiogram/cerebral arteriogram ( 6 )
- Electrocardiogram (EKG) ( 7 )
- Electroencephalogram (EEG) ( 8 )
- Doppler Ultrasound ( 9 )
- Other (*specify*) ( 10 )

\_\_\_\_\_ specify

a. Date 2nd exam/test done:

\_\_\_\_\_ day \_\_\_\_\_ mon \_\_\_\_\_ year

b. 2nd diagnosis confirmed:

- Yes ( 1 )
- No ( 2 )
- Indeterminate ( 3 )

14. What was the 3rd exam or test done to establish the diagnosis (*check only one*):

- None ( 1 )
- 15. History and physical examination ( 2 )
- Magnetic Resonance Imaging (MRI)/Nuclear Magnetic Resonance (NMR) Imaging ( 3 )
- Cardiac Computed Tomography (CT) ( 4 )
- Computerized Axial Tomographic scan (CAT scan) ( 5 )
- Cerebral angiogram/cerebral arteriogram ( 6 )
- Electrocardiogram (EKG) ( 7 )
- Electroencephalogram (EEG) ( 8 )
- Doppler Ultrasound ( 9 )
- Other (*specify*) ( 10 )

\_\_\_\_\_ specify

a. Date 3rd exam/test done:

\_\_\_\_\_ day \_\_\_\_\_ mon \_\_\_\_\_ year

b. 3rd diagnosis confirmed:

- Yes ( 1 )
- No ( 2 )
- Indeterminate ( 3 )

**D. Administrative information**

15. Date form reviewed:

\_\_\_\_\_ day \_\_\_\_\_ mon \_\_\_\_\_ year

16. Study physician ID: \_\_\_\_\_

17. Study physician signature: \_\_\_\_\_

18. Clinic coordinator ID: \_\_\_\_\_

19. Clinic coordinator signature: \_\_\_\_\_