### ACUTE STROKE DATA

| Date:                          | Stroke Onset Date:  |

**Source:**
- [ ] FMLH ED
- [ ] Outside ED
- [ ] Inpatient
- [ ] Other:

**Times (use 24-hour clock):**
- Onset
- EMS Called
- Patient @ ED
- F.A.S.T. Called
- F.A.S.T. @ Pt.
- CT Done

**Admission Data:**
- F.A.S.T. MD:
- ED MD:
- Admit MD:
- Admit Unit: [ ] NICU [ ] Neuro
- [ ] Other:

**Suspected Symptomatic Lesion:**
- [ ] Left
- [ ] Right
- [ ] ICA
- [ ] MCA
- [ ] ACA
- [ ] PCA
- [ ] Vertebral
- [ ] Basilar
- [ ] Lacunar
- [ ] Large Vessel
- [ ] Embolic

**IV tPA Exclusions:**
- [ ] Not Stroke
- [ ] Resolving
- [ ] Time (>3hours IV tPA)
- [ ] PMH
- [ ] BP
- [ ] Large Infarct (2/3 MCA Territory)
- [ ] Bleeding
- [ ] CT:
- [ ] Lab:
- [ ] Other:

**IA tPA Exclusions:**

**tPA Treatment Time:**

### NIH STROKE SCALE

1. **Level of Consciousness**
   - [ ] 0
   - [ ] 1
   - [ ] 2
   - [ ] 3

   0 = Alert; 1 = Arousable by minor stimulation; 2 = Obtunded, needs strong stimulation to attend; 3 = Unresponsive or reflex responses only.

2. **LOC Questions**
   - [ ] 0
   - [ ] 1
   - [ ] 2

   0 = Answers both; 1 = Answers one; 2 = Answers neither.

3. **LOC Commands**
   - [ ] 0
   - [ ] 1
   - [ ] 2

   0 = Performs both tasks; 1 = Performs one task; 2 = Performs neither task.

4. **Best Gaze**
   - [ ] 0
   - [ ] 1
   - [ ] 2
   - [ ] 3

   0 = Normal; 1 = Partial gaze palsy; 2 = Forced deviation or total gaze paresis.

5. **Visual**
   - [ ] 0
   - [ ] 1
   - [ ] 2
   - [ ] 3

   0 = Normal; 1 = Partial hemianopia; 2 = Complete hemianopia; 3 = Blind.

6. **Facial Palsy**
   - [ ] 0
   - [ ] 1
   - [ ] 2
   - [ ] 3

   0 = Normal; 1 = Minor paresis; 2 = Partial paralysis; 3 = Complete paralysis.

7. **Motor Arm - LEFT**
   - [ ] 0
   - [ ] 1
   - [ ] 2
   - [ ] 3
   - [ ] 4
   - [ ] N/A

8. **Motor Leg - LEFT**
   - [ ] 0
   - [ ] 1
   - [ ] 2
   - [ ] 3
   - [ ] 4
   - [ ] N/A

9. **Motor Arm - RIGHT**
   - [ ] 0
   - [ ] 1
   - [ ] 2
   - [ ] 3
   - [ ] 4
   - [ ] N/A

10. **Motor Leg - RIGHT**
    - [ ] 0
    - [ ] 1
    - [ ] 2
    - [ ] 3
    - [ ] 4
    - [ ] N/A

11. **Limb Ataxia**
    - [ ] 0
    - [ ] 1
    - [ ] 2
    - [ ] N/A

   0 = Absent; 1 = Unilateral; 2 = Bilateral; N/A = Unable to test.

12. **Sensory**
    - [ ] 0
    - [ ] 1
    - [ ] 2

    0 = Normal; 1 = Mild-moderate loss; 2 = Severe or total loss.

13. **Best Language**
    - [ ] 0
    - [ ] 1
    - [ ] 2
    - [ ] 3
    - [ ] 4
    - [ ] N/A

   0 = Normal; 1 = Mild-moderate aphasia, some deficits apparent but able to communicate; 2 = Severe aphasia, fragmentary expression only, unable to communicate well; 3 = Global aphasia, mute and no comprehension.

14. **Dysarthria**
    - [ ] 0
    - [ ] 1
    - [ ] 2
    - [ ] N/A

   0 = Normal; 1 = Mild-moderate, slurs some words; 2 = Severe, speech mostly unintelligible; N/A = Unable to test (e.g., intubation).

15. **Extinction/Inattention**
    - [ ] 0
    - [ ] 1
    - [ ] 2

   0 = Normal; 1 = Visual, tactile, auditory or other extinction to bilateral simultaneous stimulation, but no severe neglect; 2 = Answers neither.

**NIH Score:** Complete ______

**Blood Pressure @ Infusion:**
- [ ] SBP/DBP
- [ ] MAP

**Did pt receive BP treatment acutely prior to tPA?**
- [ ] Yes
- [ ] No
PMD: ___________________________  Handedness: [ ] Right  [ ] Left  [ ] Amb

First Language: ___________________________  Race: [ ] African-American  [ ] Hispanic/Latino
[ ] White  [ ] Hawaiian/Pacific-Islander
[ ] Asian  [ ] Native-American/Alaskan  [ ] Other/Unknown

CC: ___________________________

HPI: TIA / Stroke Onset Date: __________  Time: __________

Activity at Onset:  Tempo at Onset:
[ ] Sleeping  [ ] Abrupt
[ ] Resting  [ ] Gradual over minutes
[ ] Light Activity  [ ] Gradual over hours
[ ] Moderate Activity  [ ] Stuttering
[ ] Strenuous Activity  [ ] Unknown

Duration:
[ ] Persistent deficit  [ ] Resolved after _____ minutes

Person Initiating Medical Contact:
[ ] Patient  [ ] Person present at onset
[ ] Unknown  [ ] Person NOT present at onset

SYMPTOMS:

Motor: [ ] Right  [ ] Left  [ ] Weakness
[ ] Clumsiness
[ ] Face/Mouth/Tongue
[ ] Hand  [ ] Arm
[ ] Leg  [ ] Foot
[ ] Gait Impaired
[ ] Speech Slurred
[ ] Other Weakness:

Sensory: [ ] Right  [ ] Left  [ ] Paresthesia
[ ] Hypesthesia
[ ] Face/Mouth/Tongue
[ ] Hand  [ ] Arm
[ ] Leg  [ ] Foot
[ ] Right Visual Field Loss
[ ] Left Visual Field Loss
[ ] Other Sensory Loss:

Behavioral:
[ ] Lethargic/Obtunded
[ ] Mute
[ ] Speech Anomic
[ ] Speech Unintelligible
[ ] Comprehension Impaired
[ ] Unable to Read
[ ] Other Behavioral:

[ ] Unable to Write
[ ] Unable to Calculate
[ ] Unable to Dress
[ ] Unable to Follow a Route
[ ] Repeats Questions/Statements
[ ] Delirious/Agitated

Other:
[ ] Headache: [ ] Right  [ ] Left
[ ] Horizontal Diplopia
[ ] Vertical Diplopia
[ ] Vertigo
[ ] Light-headedness
[ ] Nausea
[ ] Swallowing Difficulty
[ ] Hiccups
[ ] Loss of Taste or Smell
[ ] Loss of Coordination
[ ] Other: ___________________________

ADVANCE DIRECTIVES? [ ] N  [ ] Y

Date: ___________________________

Copy in chart? [ ] N  [ ] Y

NARRATIVE: ___________________________

Resident Signature: ___________________________

Staff Physician Signature: ___________________________  ID No: ________

Date: ___________________________  Time: ___________________________

Race: [ ] African-American  [ ] Hispanic/Latino
[ ] White  [ ] Hawaiian/Pacific-Islander
[ ] Asian  [ ] Native-American/Alaskan  [ ] Other/Unknown

Original - Medical Records
Canary - Neurology Department

Froedtert Hospital
9200 West Wisconsin Avenue
P.O. Box 26099
Milwaukee, WI  53226-3596

40632  5/04

Primary Affiliate of the Medical College of Wisconsin
**PAST MEDICAL HISTORY:**

### Prior Strokes:
- # of Prior Strokes __________
- Year of Stroke 1 __________
- Year of Stroke 2 __________
- Others __________

### Residual Symptoms:
- ☐ Weakness ☐ Right ☐ Left ☐ Aphasia ☐ Memory Loss
- ☐ Visual loss ☐ Right ☐ Left ☐ Ataxia ☐ Diplopia
- ☐ Numbness ☐ Right ☐ Left ☐ Dysarthria ☐ Confusion
- ☐ Other: __________

### Other Neurologic:
- ☐ TIA __________
- Date of Last TIA __________
- ☐ Migraine ☐ Dementia ☐ Other: __________

### Cardiac:
- ☐ Hypertension __________ (Duration yrs)
- ☐ MI __________ (years)
- ☐ Angina __________
- ☐ CABG __________ (years)
- ☐ Cor Stent/Angioplasty __________ (years)
- ☐ CHF __________ (yr of onset)
- ☐ Atrial Fib / Flutter __________ (yr of onset)
- ☐ Pacemaker __________ (year)
- ☐ PFO/Atrial Septal Aneurysm __________

### Vascular Risks:
- ☐ DM __________ (Duration yrs)
- ☐ Hypercoagulable State __________ (Type)
- ☐ Spont. Abortion __________ # episodes
- ☐ DVT __________ (# Episodes)
- ☐ Hyperlipidemia: Total _____ LDL _____ HDL _____ TG _____
- ☐ Obesity __________
- ☐ Hyperhomocysteinemia __________
- ☐ Endarterectomy: ☐ Right ☐ Left ☐ ICA Stenosis: ☐ Right _____ % ☐ Left _____ %

### Other past history:

### Allergies:

### Medications:

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<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Doses/Day</th>
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### FAM HX:
- ☐ No Familial Diseases

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<tr>
<th></th>
<th>Mom</th>
<th>Dad</th>
<th>Sibs</th>
<th>GP</th>
<th>Other</th>
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<tr>
<td>Stroke</td>
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<td>Psychiatric Disease</td>
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<td>Coronary Artery Disease</td>
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<tr>
<td>Periph Vascular Disease</td>
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<tr>
<td>Cancer</td>
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<td>Other:</td>
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### Prior Stroke Medications:

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<th>Name</th>
<th>Date Stopped</th>
<th>Reason</th>
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</table>

### Resident Signature: ____________________________

### Staff Physician Signature: ____________________________  ID No: __________

Date: __________  Time: __________
SOCIAL HISTORY (SH):

Marital Status:
- [ ] Married
- [ ] Single
- [ ] Divorced
- [ ] Widowed

Living Arrangement:
- [ ] Home Alone
- [ ] Home, Cohabiting
- [ ] Nursing Home
- [ ] Other: __________

Work Status:
- [ ] Full-time
- [ ] Part-time
- [ ] Homemaker
- [ ] Student
- [ ] Unemployed
- [ ] Retired
- [ ] Disabled

# Children: __________

Education Level:
- [ ] < 10 years
- [ ] 10-11 years

Drug exposure:
- [ ] Tobacco: year quit __________ # packs - year __________
- [ ] Alcohol: year quit __________ # drinks - week __________
- [ ] Cocaine: year quit __________ # uses - week __________

Other drugs used:

Functional Status Prior to Current Stroke / Rankin Score:
- [ ] No symptoms at all.
- [ ] No significant disability despite symptoms: able to carry out all usual duties and activities.
- [ ] Slight disability: unable to carry out all previous activities, but able to look after own affairs without assistance.
- [ ] Moderate disability: requiring some help, but able to walk without assistance.
- [ ] Moderately severe disability: unable to walk or attend to own bodily needs without assistance.
- [ ] Severe disability: bedridden, incontinent and requiring constant nursing care and attention.

Other SH:

ROS:
- [ ] fevers
- [ ] chills
- [ ] wt loss
- [ ] wt gain
- [ ] night sweats
- [ ] fatigue
- [ ] cold intolerance
- [ ] heat intolerance
- [ ] polyuria
- [ ] polydipsia
- [ ] Other: __________

NEUROLOGIC:
- [ ] headache
- [ ] dizziness
- [ ] numbness
- [ ] pain
- [ ] weakness
- [ ] gait change
- [ ] memory loss
- [ ] speech problem
- [ ] seizure
- [ ] tremor
- [ ] Other: __________

PSYCHIATRIC:
- [ ] anxiety
- [ ] depression
- [ ] suicidal
- [ ] hallucinations
- [ ] psychosis
- [ ] paranoia
- [ ] insomnia
- [ ] malaise
- [ ] mania
- [ ] Other: __________

OPHTHO/ENT:
- [ ] visual changes
- [ ] eye pain
- [ ] discharge
- [ ] tinnitus
- [ ] hearing loss
- [ ] ear pain
- [ ] vertigo
- [ ] epistaxis
- [ ] rhinorrhea
- [ ] oral lesions
- [ ] Other: __________

CARDIO/PULMONARY:
- [ ] angina
- [ ] palpitations
- [ ] syncope
- [ ] orthopnea
- [ ] edema
- [ ] cough
- [ ] dyspnea
- [ ] hemoptysis
- [ ] sputum
- [ ] pleurisy
- [ ] Other: __________

GI/GU:
- [ ] nausea
- [ ] abd pain
- [ ] constipation
- [ ] diarrhea
- [ ] hematochezia
- [ ] melena
- [ ] dysuria
- [ ] discharge
- [ ] frequency
- [ ] hematuria
- [ ] nocturia
- [ ] Other: __________

DERM/HEM/RHEUM:
- [ ] nevi
- [ ] pruritis
- [ ] rash
- [ ] anemia
- [ ] bleeding
- [ ] bruising
- [ ] lymphadenopathy
- [ ] arthralgia
- [ ] gout
- [ ] myalgia
- [ ] back pain
- [ ] Other: __________

OTHER: __________

Resident Signature: __________

Staff Physician Signature: __________

ID No: ______

Date: __________

Time: __________
### Neurological Exam:
#### Mental Status:

**Orientation**
- Correct: [ ]
- Error: [ ]
- Correct: [ ]
- Error: [ ]
- Month: [ ]
- Year: [ ]
- Weekday: [ ]
- Age: [ ]
- President: [ ]
- City: [ ]

**Memory & Attention**
- Immediate Recall: [ ] / 6
- Count Forward (1-34): [ ]
- Count Bkwd (50-19): [ ]
- Delayed Recall: [ ] / 6

**Scene Description**
- Neglect: [ ]
- Right: [ ]
- Left: [ ]
- Line Bisection: [ ] % deviation from center: R [ ] L [ ]

**Attention**
- Normal: [ ]
- Abnormal: [ ]

**Other Neglect:**

**Language**
- Naming: [ ]
- Repetition: [ ]
- Reading: [ ]
- Spont Speech: [ ]
- Writing: [ ]
- Comprehension: [ ]

**Other Language:**

**Fund of Knowledge:**
- Normal: [ ]
- Abnormal: [ ]

---

**Cranial Nerves**

<table>
<thead>
<tr>
<th>Number</th>
<th>Item</th>
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<tbody>
<tr>
<td>2</td>
<td>Visual Acuity</td>
</tr>
<tr>
<td>3</td>
<td>Pupils</td>
</tr>
<tr>
<td>4</td>
<td>EOMS</td>
</tr>
<tr>
<td>5</td>
<td>Face Sensory</td>
</tr>
<tr>
<td>6</td>
<td>Facial Nerve</td>
</tr>
<tr>
<td>7</td>
<td>Hearing/Nystagmus</td>
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<tr>
<td>8</td>
<td>Articulation</td>
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<td>9</td>
<td>Palate</td>
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<tr>
<td>10</td>
<td>SCMS/Trapezius</td>
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<tr>
<td>11</td>
<td>Tongue</td>
</tr>
<tr>
<td>12</td>
<td>Others</td>
</tr>
</tbody>
</table>

**Sensation**
- Intact: [ ]
- Deficit: [ ]

- Pin/Temp: [ ]
- Vibration: [ ]
- DSS to LT: [ ]
- Localization: [ ]
- Other Sensory: [ ]

---

Resident Signature: ____________________________

Staff Physician Signature: ____________________  ID No: ______

Date: ___________  Time: ___________
### Motor

<table>
<thead>
<tr>
<th>Muscle Group</th>
<th>Strength Right</th>
<th>Strength Left</th>
<th>Tendon Reflexes &amp; Toe Signs</th>
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<tbody>
<tr>
<td>Face</td>
<td>___</td>
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<tr>
<td>Shoulder / Elbow</td>
<td>___</td>
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<tr>
<td>Wrist / Hand</td>
<td>___</td>
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<tr>
<td>Hip / Knee</td>
<td>___</td>
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<tr>
<td>Ankle / Foot</td>
<td>___</td>
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</tbody>
</table>

**Muscle Tone**: □ Abnormality:

**Other Motor**: ____________________

### Coordination, Gait & Other

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<thead>
<tr>
<th>Test</th>
<th>Normal</th>
<th>Abnormality</th>
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<tbody>
<tr>
<td>Finger-to-Nose</td>
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<td>Heel-Knee-Shin</td>
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<tr>
<td>Gait</td>
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<tr>
<td>Romberg Test</td>
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<tr>
<td>Other Neurologic</td>
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### Labs

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<th>Abnormality</th>
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<td>ESR</td>
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</table>

**Others**: ____________________

### Resident Assessment and Plan

- ____________________
- ____________________
- ____________________
- ____________________
- ____________________
- ____________________
- ____________________
- ____________________
- ____________________
- ____________________
- ____________________
- ____________________

**Resident Signature**: ____________________  **Staff Physician Signature**: ____________________  **ID No**: ______

**Date**: __________  **Time**: __________

---

**History & Physical**

---

**Froedtert Hospital**

---
ATTENDING PHYSICIAN: I have reviewed the history of Dr. ____________________________ as recorded above. I have examined the patient and reviewed the findings as documented by the resident. I have reviewed the resident's assessment and plan of care. My key findings are as follows:

PHYSICIAN DOCUMENTATION & FINDINGS: ____________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

EXAM SUMMARY: ________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

MEDICAL DECISION MAKING: ______________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

May also want to use for consult. If yes use: □ Service done in consultation requested by: ____________________________

Resident Signature: ____________________________
Staff Physician Signature: ____________________________    ID No: ______

Date: __________    Time: ______