

Cerebrovascular Disease Elements

Principal Investigator Responsible for Accuracy of Data (Name): _____ **Subject ID Number:** _____

Is this data Longitudinal (Follow-Up) Data? Yes No

Subject Zip Code (1st 3 digits): _____ **Country of Residence** _____

Family Member Samples in Repository? Yes No Unknown (subject adopted) If Yes, list subject ID/s: _____

Year of birth: _____ **Gender:** Male Female

Ethnic Category (as reported by subject)-Check one: Hispanic or Latino Not Hispanic or Latino

Racial Categories (as reported by subject) Check One:

American Indian/Alaska Native Asian Native Hawaiian/ Other Pacific Islander

Black/African American White/Caucasian More than One Race Other Unknown

Additional Racial and Ethnicity Information: Other: _____

Diagnosed By: Neurosurgeon Neurologist Pediatric Neurologist Pediatrician Other
 Primary Care Physician Psychiatrist Psychologist Does Not Apply (Population or Family-Based Control)

Data Collected By: Neurosurgeon Neurologist Pediatric Neurologist Primary Care Physician Pediatrician
 Psychiatrist Psychologist Research Coordinator Registered Nurse Research Coordinator/ RN

Smoking History Never Previous Current Years Smoking, if Applicable _____

Family History of Cerebrovascular Disease: Present Absent Unknown (Subject is adopted)

If Present, List Affected Family Members and Indicate Specific Disease for each: _____

Family History of Aneurysm: Present Absent Unknown (Subject is adopted)

If Present, List Affected Family Members: _____

Specific Diagnosis	Present	Absent		Present	Absent
Silent cerebral infarction	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysmal subarachnoid hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>
Transient ischemic attack	<input type="checkbox"/>	<input type="checkbox"/>	Vascular cognitive impairment	<input type="checkbox"/>	<input type="checkbox"/>
Unruptured intracranial aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Arteriovenous malformations (AVM)	<input type="checkbox"/>	<input type="checkbox"/>
Symptomatic Ischemic stroke	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Cavernous Malformation (CCM)	<input type="checkbox"/>	<input type="checkbox"/>
Intracerebral hemorrhage	<input type="checkbox"/>	<input type="checkbox"/>	Hereditary Hemorrhagic Telangiectasia (HHT)	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify): _____					

Age at symptom onset _____ **Age of Diagnosis** _____ **Did a neurologist confirm the diagnosis?** Yes No

Prior Medical History Present Absent Present Absent Not Applicable

Pre-existing history of dementia **Pre-hemorrhage history of ischemic stroke**

Ischemic Stroke Sybtype Based on TOAST Criteria (select one):

Large-vessel Other
 Small-vessel unknown
 Cardioembolic not applicable

AVM Subtype Criteria:

AVM type: ruptured unruptured not applicable Spetzler-Martin score: _____
 Size: <30 mm 30 – 60 mm >60 mm AVM Location: Eloquent Non-eloquent
 Venous drainage: superficial deep both Drainage Location: Cortical subcortical/deep posterior fossa

Medical History Present Absent

Hypertension **Known mutation/s in subject's DNA:** Present Absent Unknown
 Diabetes mellitus **If known mutation/s present or absent, describe:** _____
 Atrial fibrillation
 Myocardial infarction **Hypertension treated with medication** Yes No

Other Risk Factors: _____ **Blood pressure (at time of blood draw)** ____/____

Other Diagnoses: Present Absent Present Absent

Parkinson's disease Epilepsy
 Alzheimer's Disease ALS
 Dementia

Optional Data:

Mini-Mental status score _____ Neurological exam completed Yes No
 Handedness Left Right Ambidextrous