conformal THE SHAPE OF STROKE PREVENTION	**CONFORM QVSFS** ☐ Source ☐ Data Transfer Tool
	Site Number: _____ Subject ID: _____

Was the QVSFS assessment completed?	☐ Yes ☐ No *(Complete protocol deviation form)*
Is this assessment performed because of a neurological event?	☐ Yes *If yes, assess for an adverse event* ☐ No
Date of QVSFS assessment	__ __ / __ __ __ / __ __ __ __ (DD/MMM/YYYY)

Since the last study contact (by phone or clinic)	**Yes**	**No**	**Unknown**
1. Were you told by a physician that you had a stroke?	☐	☐	☐
2. Were you ever told by a physician that you had a TIA, ministroke, or a transient ischemic attack?	☐	☐	☐
3. Have you ever had a sudden weakness on one side of your body?	☐	☐	☐
4. Have you ever had a sudden numbness or dead feeling on one side of your body?	☐	☐	☐
5. Have you ever had a sudden painless loss of vision in one or both eyes?	☐	☐	☐
6. Have you ever suddenly lost one half of your vision?	☐	☐	☐
7. Have you ever suddenly lost the ability to understand what people are saying?	☐	☐	☐
8. Have you ever suddenly lost the ability to express yourself verbally or in writing?	☐	☐	☐

_____ **Site Personnel Signature**

__ __ / __ __ __ / __ __ __ __ **Date (DD/MMM/YYYY)**