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## Follow-up Screening: ATE

<b>ATE Screening</b>													
<b>1. Follow-Up Visit / Phone or Video Call:</b> <input type="checkbox"/> 6 weeks (Visit/Call) <input type="checkbox"/> 90 days (Call) <input type="checkbox"/> Unscheduled (Visit/Call)													
<b>2. Follow-Up Date:</b> <table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr> <td style="width: 20px; height: 20px;">D</td> <td style="width: 20px; height: 20px;">D</td> <td style="width: 20px; height: 20px;">M</td> <td style="width: 20px; height: 20px;">M</td> <td style="width: 20px; height: 20px;">M</td> <td style="width: 20px; height: 20px;">Y</td> <td style="width: 20px; height: 20px;">Y</td> <td style="width: 20px; height: 20px;">Y</td> <td style="width: 20px; height: 20px;">Y</td> </tr> </table>					D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y					
<b>Instructions:</b> Use the following categories to rate each symptom. Choose the one best answer. <b>None:</b> Patient is not experiencing this symptom today. <b>New:</b> Patient has this symptom today, but did not have it at her last study visit. <b>Worse:</b> Patient had this symptom at her last study visit and it has gotten worse. <b>Same:</b> Patient had this symptom at her last study visit and it has not changed.													
<b>3. Myocardial Infarction Symptoms:</b>	None	New	Worse	Same									
Pressure, tightness or pain in chest • Arm or jaw radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Cold sweat (Diaphoresis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Fainting or near fainting episodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
<b>4. Stroke / TIA Symptoms:</b>	None	New	Worse	Same									
Weakness of the face, arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Numbness or tingling to the face, arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Slurred speech, trouble speaking or understanding speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Sudden vision loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Sudden loss of balance or coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									

**Important:** Any NEW or WORSE chest symptoms or neurological symptoms will prompt response of study personnel to collect all pertinent source documents to diagnose or exclude ATE as indicated in the Protocol, including arranging for patient assessment if required.