

Stroke Risk Awareness

To reduce your stroke risk:

1. Know your blood pressure. If high, work with your physician to lower it.
2. Find out from your physician if you have atrial fibrillation.
3. If you smoke, stop.
4. If you drink alcohol, do so in moderation.
5. Find out if you have high cholesterol. If so, work with your physician to control it.
6. If you are diabetic, follow your physician's recommendations carefully to control your diabetes.
7. Include exercise in your daily routine.
8. Adopt a lower sodium (salt) and lower fat diet.
9. Ask your physician how you can lower your risk of stroke.
10. **KNOW THE SYMPTOMS OF STROKE**

If you have any stroke symptoms, seek immediate medical attention.

Symptoms include:

- › Sudden numbness or weakness of face, arm or leg - especially on one side of the body
- › Sudden confusion, trouble speaking or understanding
- › Sudden trouble seeing out of one or both eyes
- › Sudden trouble walking, dizziness, loss of balance or coordination
- › Sudden severe headache with no known cause

**If you have experienced any of these symptoms,
Time is Brain — call 911 immediately.**



HALIFAX HEALTH
COMPREHENSIVE STROKE CENTER

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Stroke Risk Scorecard

Check each box that applies to you. Total the number of boxes checked at the bottom of each column.

Risk Factor	High Risk	Caution	Low Risk
Blood Pressure	<input type="checkbox"/> Greater than 140/90 or I do not know	<input type="checkbox"/> 139/80 to 120/89	<input type="checkbox"/> Less than 120/80
Cholesterol	<input type="checkbox"/> Greater than 240 or I do not know	<input type="checkbox"/> 200 to 239	<input type="checkbox"/> Less than 200
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> Borderline	<input type="checkbox"/> No
Smoking	<input type="checkbox"/> I am a smoker	<input type="checkbox"/> I am trying to quit	<input type="checkbox"/> I am a non-smoker
Atrial Fibrillation	<input type="checkbox"/> I have an irregular heartbeat	<input type="checkbox"/> I don't know	<input type="checkbox"/> My heartbeat is not irregular
Diet	<input type="checkbox"/> I am overweight	<input type="checkbox"/> I am slightly overweight	<input type="checkbox"/> My weight is healthy
Exercise	<input type="checkbox"/> I am inactive	<input type="checkbox"/> I exercise occasionally	<input type="checkbox"/> I exercise regularly
Family History of Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> Not sure	<input type="checkbox"/> No
Stroke Risk Score <i>(Total number of boxes checked in each column)</i>	Total <input type="text"/>	Total <input type="text"/>	Total <input type="text"/>
Stroke Risk Levels	If you checked 3 or more boxes in this column, please ask your physician about stroke prevention right away.	If you checked 4 to 6 boxes in this column, you are off to a good start. Keep working on it.	If you checked 6 to 8 boxes in this column, great job. You are doing very well at controlling your risk for stroke.