American Stroke Association.
A division of the American Heart Association.

GETTING TO THE
HEART OF STROKE™

Secondary Stroke Prevention Checklist

Taking Steps to Prevent Another Stroke

QUESTIONS	YES	RISK / RECOMMENDATION
1. Has the patient had a **stroke** or **TIA**?	☐	Approximately 23% of strokes each year are recurrent. Risk of recurrent stroke or TIA is high (5% at 1 year) but can be mitigated with appropriate prevention strategies.
2. Does the patient need to undergo **diagnostic evaluation** to determine the etiology of the stroke?	☐	Given the relatively high risk of recurrent stroke, a diagnostic evaluation is recommended for gaining insights into the etiology and planning optimal prevention strategies, with testing completed or underway within 48 hours of stroke symptom onset.
3. Does the patient have **blood pressure** greater than 130/80 mm Hg?	☐	Treatment of hypertension is possibly the most important intervention for secondary prevention of ischemic stroke. An office blood pressure goal of <130/80 mm Hg is recommended for most patients. Antihypertensive medication is useful.
4. Has the patient been screened for **diabetes mellitus** (DM)?	☐	DM is an independent risk factor for stroke recurrence. After a TIA or ischemic stroke, screening for DM is recommended as part of the basic laboratory evaluation. New cases of Type 2 DM have been detected in about 11.5% of patients presenting with acute ischemic stroke and prediabetes in 36.2%. For most patients, achieving a goal of hemoglobin A1c ≤7% is recommended.
5. Does the patient's **cholesterol level** need to be lowered?	☐	Patients with ischemic stroke and no known coronary heart disease, no major cardiac sources of embolism, and LDL-C >100 mg/dL, should be treated with atorvastatin 80 mg daily to reduce risk of stroke recurrence. Patients with ischemic stroke or TIA and atherosclerotic disease should be treated with a statin and also ezetimibe, if needed, to a goal LDL-C of <70 mg/dL.
6. Is the patient **physically inactive**?	☐	Regular physical activity reduces stroke risk, positively impacts stroke risk factors and aids in recovery. Patients who are able should engage in at least moderate-intensity aerobic activity for a minimum of 10 minutes 4 times a week or vigorous-intensity aerobic activity for a minimum of 20 minutes twice a week. For patients with deficits that impair their ability to exercise, a supervised exercise program can be beneficial.
7. Does the patient **smoke**?	☐	Smoking approximately doubles the risk of stroke. Counseling with or without drug therapy should be recommended to help patients quit smoking.
8. Does the patient need to make **dietary changes**?	☐	It is reasonable to recommend that patients follow a diet emphasizing vegetables, fruits, whole grains, low-fat dairy products, fish, legumes and nuts, and limits sodium, sweets and red meats.
9. Does the patient drink large amounts of **alcohol**?	☐	Patients who are heavy drinkers should be counseled to eliminate or reduce their consumption of alcohol. Light to moderate amounts of alcohol consumption (up to 2 drinks per day for men and up to 1 drink per day for nonpregnant women) may be reasonable.
10. Has the patient been screened for or diagnosed with **atrial fibrillation** (AF)?	☐	AF is a powerful risk factor for ischemic stroke, increasing the risk 4- to 5-fold. In patients with non-valvular AF or atrial flutter and stroke or TIA, oral anticoagulation is recommended.
11. Is this an **ischemic stroke** or **TIA** patient who should be on aspirin or other antiplatelet therapy?	☐	In patients with noncardioembolic ischemic stroke or TIA, antiplatelet therapy is indicated in preference to oral anticoagulation. More specifically, Guidelines recommend aspirin 50-325mg daily, or clopidogrel 75mg, or the combination of aspirin 25mg and extended release dipyridamole 200mg twice daily. Dual antiplatelet therapy is only recommended short-term and in very specific patients.
12. Does the patient have **sleep apnea**?	☐	Sleep apnea affects about 38%-40% of patients with stroke. Treatment with positive airway pressure can be beneficial.

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