TMS Safety Screening

Patient name:________________________________ Date of birth:___________________

Today's date:________________________

		Yes	No	Other
1	Have you undergone TMS in the past? *If yes, were there any adverse reactions?*			
2	Do you have epilepsy?			
3	Have you ever had a convulsion or a seizure? *If yes, please describe:*			
4	Does anyone in your family have epilepsy?			
5	Have you ever had a fainting spell or syncope? *If yes, please describe the occasion(s)?*			
6	Have you ever had a stroke?			
7	Have you ever had a head injury or neurosurgery? *If yes, was this associated with a concussion or loss of consciousness?*			
8	Have you had any illness that caused brain injury?			
9	Do you have metal in the brain, skull or elsewhere in your body such as shrapnel, surgical clips, splinters or fragments from welding or metal work? *If so, please specify position and type of metal:*			
10	Do you have a cardiac peacemaker or intracardiac lines?			
11	Do you have a medication infusion device?			
12	Do you have an implanted neurostimulator? (e.g. DBS, epidural/subdural, VNS)			
13	Do you have any hearing problems or ringing in your ears?			
14	Do you have cochlear implants?			
15	Do you suffer from frequent or severe headaches?			
16	Have you had retinal detachment?			
17	Have you ever had any other brain-related condition?			
18	Are you pregnant or is there a chance that you might be?			

19	Are you taking any prescribed medication? *If so, please list:*			
20	Have you had any alcoholic drinks over the last 12 months? *If so, please count the number of standard alcoholic drinks you would have in an average week:* *1 standard drink ≈ 100mls of wine, 30mls of spirit, 1 mid strength beer*			
21	Do you use recreational drugs? *If so, please specify the type/s, amount and frequency:*			
22	Have you ever had an electroencephalogram (EEG)? *If so, what was the reason?*			
23	Have you ever undergone an MRI in the past? *If so, were there any issues?*			

Thank you for your assistance. Please sign below:
I ____(please print name) acknowledge that to the best of my knowledge the above answers relating to the safety of TMS treatment are accurate. Signature:____ Date:_________________________
TMS Staff only:
Checked by: ____ Date:_________________________