rTMS Safety Screening

Patient name:_____ Date of birth:_____

Today's date:_____

Past history:

			Details (if yes)
Cochlear implant	**No**	**Yes**	
Epilepsy or Past seizures	**No**	**Yes**	
Family history of seizures	**No**	**Yes**	
Fainting/Syncopal episodes	**No**	**Yes**	
Eye injuries	**No**	**Yes**	
Retinal detachment	**No**	**Yes**	
Head injuries or past neurosurgery	**No**	**Yes**	
Chronic severe headaches	**No**	**Yes**	
Stroke	**No**	**Yes**	
Implanted electrodes or neurostimulators eg. Deep brain stimulator, Vagus Nerve Stimulator	**No**	**Yes**	
Pacemaker or Intra-cardiac lines	**No**	**Yes**	
Implanted Cardioverter Defibrillator (ICD) or Wearable Cardioverter Defibrillator	**No**	**Yes**	
Aneurysm clips/coils	**No**	**Yes**	
Stents	**No**	**Yes**	
Cerebral Spinal Fluid Shunt	**No**	**Yes**	
Metallic devices or foreign bodies in the head or neck region (eg. Shrapnel or fragments from metal work/welding)	**No**	**Yes**	
Facial tattoos w/metallic ink	**No**	**Yes**	
Metallic devices implanted in head	**No**	**Yes**	
Medication infusion device	**No**	**Yes**	
Current pregnancy	**No**	**Yes**	

Past treatments:

Previous TMS:	**No**	**Yes**	Any complications?
Previous ECT:	**No**	**Yes**	Number of treatment sessions, effectiveness, and adverse effects.

Past investigations:

Past EEGs:	**No**	**Yes**	Findings?
Past MRIs:	**No**	**Yes**	Any complications?

Medication:

Do you take any prescribed medication?	**No**	**Yes**	Please list:
Have you had any recent changes to your medication?	**No**	**Yes**	

Drug and Alcohol use:

Alcohol	No	Yes	Type of alcohol: Standard drinks per week:
Recreational drugs	**No**	**Yes**	Type of recreational drug: Amount used per week:

I _____ acknowledge that the above information regarding my medical history in relation to the safety of TMS treatment is complete and accurate.

_____

Patient name

_____

Patient signature

_____

Date

_____

TMS operator or TMS Psychiatrist name

_____

TMS operator signature

_____

Date