TANNER CLINIC

Transcranial Magnetic Stimulation (TMS) Screening Form

Given the nature of this procedure, it is imperative that the questions below are answered accurately to help ensure the safety of the patient. Please answer accordingly.

This section is to be filled out by the PATIENT/patient representative.

Please indicate if you have any of the following:

Aneurysm clips or coils	☐ YES ☐ NO	Wearable cardioverter defibrillator	☐ YES ☐ NO
Cardiac pacemaker or wires	☐ YES ☐ NO	Implanted insulin pump	☐ YES ☐ NO
Internal Cardioverter defibrillator (ICD)	☐ YES ☐ NO	Programmable shunt or valve	☐ YES ☐ NO
Carotid or cerebral stents	☐ YES ☐ NO	Hearing Aid	☐ YES ☐ NO
Deep brain stimulator	☐ YES ☐ NO	Cervical fixation devices	☐ YES ☐ NO
Metallic devices implanted in your head	☐ YES ☐ NO	Surgical clips, staples, or sutures	☐ YES ☐ NO
Dental implants	☐ YES ☐ NO	VeriChip micro transponder	☐ YES ☐ NO
Cochlear implant/ear implant	☐ YES ☐ NO	Wearable monitor (e.g., heart monitor)	☐ YES ☐ NO
CSF (cerebrospinal fluid) stint	☐ YES ☐ NO	Bone growth stimulator	☐ YES ☐ NO
Eye implants	☐ YES ☐ NO	Wearable infusion pump	☐ YES ☐ NO
Cardiac stents, filters, or metallic valves	☐ YES ☐ NO	Radioactive seeds	☐ YES ☐ NO
Tattoo	☐ YES ☐ NO	Portable glucose monitor	☐ YES ☐ NO
Vagus nerve stimulator (VNS)	☐ YES ☐ NO	Tracheostomy	☐ YES ☐ NO
Blood vessel coil	☐ YES ☐ NO	Medication patch/nicotine patch	☐ YES ☐ NO
Shrapnel, bullets, pellets, BBs, or other metal fragments	☐ YES ☐ NO	Other implanted metal or device IF yes, please specify: _____	☐ YES ☐ NO

DOB: _____ Weight (lbs): _____ Height (ft', in"): _____ Last Menstrual Period: _____

Have you ever been a machinist, welder, or metal worker? ☐ YES ☐ NO
Have you ever had a facial injury from metal and/or metal removed from your eyes? ☐ YES ☐ NO
Are you pregnant? ☐ YES ☐ NO
Have you ever had complications from an MRI? ☐ YES ☐ NO

Signature of patient completing this form: _____ Date: _____

Printed name of patient completing this form: _____ Date: _____

Signature of patient representative completing this form: _____ Date: _____
(If patient is a minor or not able to complete this form)

Signature of physician or healthcare provider: _____ Date: _____