



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

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: _____
(If patient is a minor or not able to complete this form)

Date: _____

Signature of physician or healthcare provider: _____

Date: _____