



**TRANSMAGNETIC MAGNETIC STIMULATION (TMS)
ADULT SAFETY SCREEN**

FM473

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth:

Sex: M F

Please answer the following:

1. Have you undergone TMS in the past? Yes No
If yes, were there any adverse reactions? _____

2. Do you have epilepsy? Yes No

3. Have you ever had a convulsion or a seizure? Yes No
If yes, please describe: _____

4. Does anyone in your family have epilepsy? Yes No

5. Have you ever had a fainting spell or syncope? Yes No
If yes, please describe the occasion(s)? _____

6. Have you ever had a stroke? Yes No

7. Have you ever had a head injury or neurosurgery? Yes No
If yes, was this associated with a concussion or loss of consciousness? _____

8. Have you had any illness that caused brain injury? Yes No

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? Yes No
If so, please specify position and type of metal: _____

10. Do you have a cardiac pacemaker or intracardiac lines? Yes No

11. Do you have a medication infusion device? Yes No

12. Do you have an implanted neurostimulator? Yes No
(e.g., DBS, epidural/subdural, VNS)

13. Do you have any hearing problems or ringing in your ears? Yes No

14. Do you have cochlear implants? Yes No

15. Do you suffer from frequent or severe headaches? Yes No

16. Have you ever had any other brain-related condition? Yes No

17. Are you pregnant or is there any chance that you might be? Yes No

.....Please turn over **P.1**

18. Are you taking any prescribed medication?

Yes No

If so, please list:

19. Over the last 12 months, how many standard alcoholic drinks would you drink in an average week?

_____ standard drinks (eg 100mls of wine, 30mls spirits, 1 mid strength beer)

20. Do you use any recreational drugs?

Yes No

Type/s _____ Amount _____

Frequency _____

21. Have you ever had an electroencephalogram (EEG)?

Yes No

If so, what was the reason?

22. Have you ever undergone MRI in the past?

Yes No

If so, were there any issues?

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: _____

Thank you for your assistance

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TMS staff only: Checked by: _____ Date: _____

TMS ADULT SAFETY SCREEN