Martha St. John, MD & Associates

TMS ADULT SAFETY SCREENING QUESTIONNAIRE

1. Have you ever had an adverse reaction to TMS? ☐ NO ☐ YES
2. Have you ever had a seizure? ☐ NO ☐ YES
3. Have you ever had an EEG (electroencephalogram)? ☐ NO ☐ YES
4. Have you ever had a stroke? ☐ NO ☐ YES
5. Have you ever had a head injury (include neurosurgery)? ☐ NO ☐ YES
6. Do you have any metal in your head (outside of the mouth) such as shrapnel, surgical clips, or fragments from welding or metalwork? ☐ NO ☐ YES
7. Do you have any implanted devices such as cardiac pacemakers, medical pumps, or intracardiac lines? ☐ NO ☐ YES
8. Do you suffer from frequent or severe headaches? ☐ NO ☐ YES
9. Have you ever had any other brain-related condition? ☐ NO ☐ YES
10. Have you every had any illness that caused brain injury? ☐ NO ☐ YES
11. Are you taking any medications? ☐ NO ☐ YES
12. If you are a woman of childbearing age, are you sexually active, and if so, are you using a reliable method of birth control? ☐ NO ☐ YES
13. Does anyone in your family have epilepsy? ☐ NO ☐ YES
14. Do you need further explanation of TMS and its associated risks? ☐ NO ☐ YES

NOTE: Any "YES" answer is considered a positive screen and indicates further investigation by the clinician (but does not necessary indication an exclusion from obtaining TMS).

Patient Name: _____ Date: _____

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