Safety Screening Questionnaire for rTMS Candidates (circle yes or no)

Y N 1. Do you have epilepsy or have you ever had a convulsion or a seizure?
Y N 2. Have you ever had a fainting spell or syncope? If yes, please describe below.
Y N 3. Have you ever had severe head trauma (i.e., followed by loss of consciousness)
Y N 4. Do you have any hearing problems or ringing in your ears?
Y N 5. Are you pregnant or is there any chance that you might be?
Y N 6. Do you have metal in the brain/skull/eyes (except titanium)? (e.g., splinters, fragments, clips, etc.)
Y N 7. Do you have cochlear implants?
Y N 8. Do you have an implanted neuro-stimulator? (e.g., DBS, epidural/subdural, VNS)
Y N 9. Do you have a cardiac pacemaker or intra-cardiac lines or metal in your body?
Y N 10. Do you have a medication infusion device?
Y N 11. Are you taking any medications? (Please list on page of this form)
Y N 12. Did you ever have a surgical procedure to your spinal cord?
Y N 13. Have you ever had a retinal detachment or serious eye problem?
Y N 14. Did you ever undergo TMS in the past?
Y N 15. Did you ever undergo MRI in the past?

Notes:

____________________	__________	____________________
Patient Name	Date	cosigned by TMS prescriber

Affirmative answers to one or more of questions 1–13 do not represent absolute contraindications to TMS, but the risk/benefit ratio should be carefully balanced by the by the responsible (treating) physician.