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PATIENT SAFETY SCREENING

PATIENTS NAME:

DOB:

Check One	Yes	No
Do you have epilepsy or have you ever had a convulsion or a seizure?		
Does anyone in your family have epilepsy?		
Have you had an EEG?		
Have you had a stroke?		
Do you have any implanted devices such as cardiac pacemakers, medical pumps, or intracardiac lines?		
Do you have a medication infusion device?		
Do you have any hearing problems or ringing in your ears?		
Do you have cochlear implants?		
Do you have any metal in your head (outside of the mouth) such as shrapnel, surgical clips, or fragments from welding or metalwork?		
Have you had a head injury (including neurosurgery)?		
Do you suffer from frequent or severe headaches?		
Have you ever had any other brain-related condition, fainting spell or syncope?		
Have you ever had any illness that caused brain injury?		
Are you pregnant or is there a chance you might be?		
Do you have an implanted neurotransmitter (e.g.,DBS, VNS)?		
Did you ever undergo MRI in the past? If so, were there any problems		
Did you ever undergo TMS in the past? If so, were there any problems		
Do you need further explanation of NeuroStar TMS and its associated risks?		

Explain any ‘YES’ answers in the comment section below

Comments:

Attending Physician Review/Comments:

___ Physical Exam/Laboratory Tests Reviewed/Approved for Medical Clearance

___ Medical Clearance Pending Additional Data