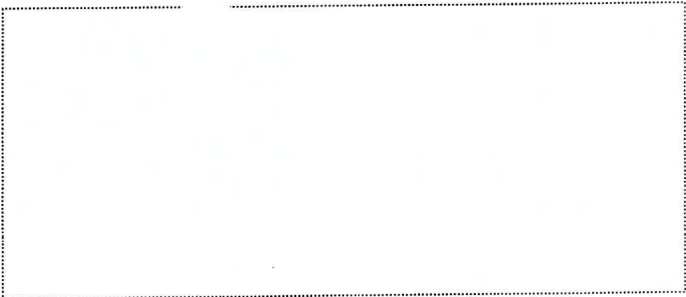


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TMS Patient Screening Form

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 microtransponder	<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) shunt	<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 If yes, please specify: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Age: _____ Weight (lbs): _____ Height: _____ 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 person completing this form: _____ Date: _____

Signature of physician or health care provider: _____ Date: _____