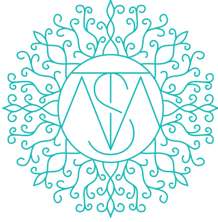

TMS Erina

CLEAR YOUR MIND

02 4314 7000 02 4314 7007
info@tmserina.com.au tmserina.com.au

Family Name ______________________

Given Names ______________________

Date of Birth | | | | | | | | |

Age | | Sex | |

TRANSCRANIAL MAGNETIC STIMULATION (TMS) ADULT SAFETY SCREEN

Please complete all information that you are able to fill out on all of the attached pages:

Date Adult Safety Screen completed: ____ /____ /____

Question	Answer
Have you undergone TMS in the Past?	☐ Yes ☐ No
If yes, were there any adverse reactions?	
Do you have epilepsy?	☐ Yes ☐ No
Have you ever had a convulsion or a seizure?	☐ Yes ☐ No
If yes, please describe:	
Does anyone in your family have epilepsy?	☐ Yes ☐ No
Have you ever had a fainting spell or syncope?	☐ Yes ☐ No
If yes, please describe the occasion(s):	
Have you ever had a stroke?	☐ Yes ☐ No
Have you ever had a head injury or neurosurgery?	☐ Yes ☐ No
If yes, was this associated with a concussion or loss of consciousness?	☐ Yes ☐ No
Have you ever had ear or facial surgery?	☐ Yes ☐ No
Have you had any illness which caused brain injury?	☐ Yes ☐ No
Have you ever had a retinal tear or retinal detachment?	☐ Yes ☐ No
If Yes, provide details:	

Handedness:

Are You (please tick): ☐ Left Handed ☐ Right Handed ☐ Mixed

TMS Erina

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Family Name ______________________

Given Names ______________________

Date of Birth | | | | | | | | |

Age [ ] Sex [ ]

TRANSCRANIAL MAGNETIC STIMULATION (TMS) ADULT SAFETY SCREEN

Please complete all information that you are able to fill out on all of the attached pages:

Question	
Do you have a cardiac pacemaker or intracardiac lines?	☐ Yes ☐ No
Do you have a medication infusion device?	☐ Yes ☐ No
Do you have an implanted neurostimulator? (eg: DBS, epidural / subdural / VNS?	☐ Yes ☐ No
Do you have any hearing problems or ringing in your ears?	☐ Yes ☐ No
Do you have cochlear implants?	☐ Yes ☐ No
Do you suffer from frequent or severe headaches?	☐ Yes ☐ No
Are you pregnant or is there any chance you might be?	☐ Yes ☐ No
Do you have any back or neck issues?	☐ Yes ☐ No
Are you taking any prescribed medication? If so, please list:	☐ Yes ☐ No

Name	Dose	How long did you take the medication for?

Please detail any medication changes in the past month: