V I T A L P S Y C H I A T R Y A S S O C I A T E S

Patient Name: _____

TMS Patient Screening Form

This section is to be filled out by the PATIENT/patient representative. Please indicate if have any of the following:

Aneurysm clips or coils ☐Yes ☐No
Wearable cardioverter defibrillator ☐Yes ☐No
Cardiac pacemaker or wires ☐Yes ☐No
Implanted insulin pump ☐Yes ☐No
Internal cardioverter defibrillator (ICD) ☐Yes ☐No
Programmable shunt or valve ☐Yes ☐No
Carotid or cerebral stents ☐Yes ☐No
Hearing aid ☐Yes ☐No
Deep brain stimulator ☐Yes ☐No
Cervical fixation devices ☐Yes ☐No
Metallic devices implanted in your head ☐Yes ☐No
Surgical clips, staples, or sutures ☐Yes ☐No
Dental implants ☐Yes ☐No
VeriChip microtransponder ☐Yes ☐No

Cochlear implant/ear implant ☐Yes ☐No
Wearable monitor (e.g., heart monitor) ☐Yes ☐No
CSF (cerebrospinal fluid) shunt ☐Yes ☐No
Bone growth stimulator ☐Yes ☐No
Eye implants ☐Yes ☐No
Wearable infusion pump ☐Yes ☐No
Cardiac stents, filters, or metallic valve ☐Yes ☐No
Radioactive seeds ☐Yes ☐No
Tattoo ☐ Yes ☐No
Portable glucose monitor ☐Yes ☐No
Vagus nerve stimulator (VNS) ☐Yes ☐No
Tracheostomy ☐Yes ☐No
Blood vessel coil ☐Yes ☐No
Medication patch/nicotine patch ☐Yes ☐No
Shrapnel, bullets, pellets, BBs, or other metal fragments ☐Yes ☐No
Other implanted metal or device ☐ Yes ☐No
If yes, please specify:_____

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 healthcare provider: _____ Date: _____