KATIE'S WAY

# Deep Transcranial Magnetic Stimulation (TMS)
# Pre-Treatment Questionnaire

**PATIENT NAME:**_____

(1) Do you have epilepsy, or have you ever had a convulsion or a seizure? _____

(2) Have you ever had a fainting spell or syncope? If yes, please describe on which occasion(s)? _____

(3) Have you ever had a head trauma that was diagnosed as a concussion or was associated with loss of consciousness? _____

(4) Do you have any hearing problems or ringing in your ears? ____

(5) Do you have cochlear implants? _____

(6) Are you pregnant or is there any chance that you might be? _____

(7) Do you have metal in the brain, skull or elsewhere in your body (e.g., splinters, fragments, clips, etc.)? If so, specify the type of metal. _____

(8) Do you have an implanted neurostimulator (e.g., DBS, epidural/subdural, VNS)? _____

(9) Do you have a cardiac pacemaker or intracardiac lines? _____

(10) Do you have a medication infusion device? _____

(11) Did you ever undergo TMS in the past? If so, were there any problems. _____

(12) Did you ever undergo MRI in the past? If so, were there any problems._____

(13) Do you have tattoos on or near your face and neck, or any new tattoos. _____

(14) Do you have a history of Alcohol Consumption or Drug Use?? _____

MEDICATION LIST: (Please list ALL PAST & PRESENT Medications. Use an extra sheet if needed. Kindly bring the bottles of your current Medications to your Initial Appointment. Thank you!)

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