Greater Lowell Psychiatric Associates, LLC **Date:**

73 Princeton St. Suite 203 (978) 256-6579
N. Chelmsford MA 01863-1559

Patient Name:________________

Patient DOB: _________________

TMS Adult Safety Screen Questions

Please circle either yes or no to the following questions:

1. Have you ever had an adverse reaction to TMS? **Yes or No**
2. Have you ever had a seizure? **Yes or No**
3. Have you ever had a stroke? **Yes or No**
4. Have you ever had a head injury or neurosurgery? **Yes or No**
5. Do you have metal in your head (outside your mouth) such as shrapnel, surgical clips, or fragments from metal work? **Yes or No**
6. Do you have any implanted devices such as cardiac pacemakers, medical pumps, or intracardiac lines? **Yes or No**
7. Do you suffer from frequent or severe headaches? **Yes or No**
8. Do you suffer from other brain-related condition? **Yes or No**
9. Have you had any illness that caused brain injury or damage? **Yes or No**
10. Are you taking any medications? **Yes or No**
11. For women of childbearing age: If you are sexually active are you *not* using reliable birth control? **Yes or No**
12. Does anyone in your family have epilepsy? **Yes or No**

If you answer yes to any questions, further exploration by a TMS Physician should be done.

Clinician Signature: _____________