JOHNS HOPKINS
MEDICINE
THE JOHNS HOPKINS HOSPITAL
600 NORTH WOLFE STREET
BALTIMORE, MD 21287

for addressograph plate

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DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

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	☐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 valves	☐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 If yes, please specify:_____	☐Yes	☐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: _____