Medical History Questionnaire

Welcome

This is your medical history form, to be completed prior to your visit. All information will be kept confidential. This information will be used for the evaluation of your health and readiness to begin treatment. The form is extensive, but please try to make it as accurate and complete as possible. Please take your time and complete it carefully and thoroughly, and then review it to be certain you have not left anything out. Your answers will help us design a comprehensive treatment program that meets your individual needs.

If you have questions or concerns, we will help you with those after this form is completed. We realize that some parts of the form will be unclear to you. Do your best to complete the form. Your questions will be thoroughly addressed afterwards. It might be helpful for you to keep a written list of questions or concerns as you complete the medical history form.

Name: _____

Date: _____

MEDICAL HISTORY AND SCREENING FORM

General Information

Participant:

Name _____

Address _____

Contact phone numbers _____

Birth date _____

Family Physician and/or Primary Health Care Provider:

Doctor/Other _____ Phone _____

Address _____ City _____

May I send a copy of your consultation to your physician or primary health care provider and consult with them as necessary?

□ Yes □ No Signature: _____

Are you Right or Left Handed? □ Left □ Right □ Ambidextrous

Do you have any of the following diagnoses?

Depression	□ Yes	□ No
Schizophrenia	□ Yes	□ No
Bipolar disorder	□ Yes	□ No
Post-traumatic Stress Disorder (PTSD)	□ Yes	□ No
Tinnitus	□ Yes	□ No
Diabetes	□ Yes	□ No
Hypertension	□ Yes	□ No
COPD or emphysema	□ Yes	□ No
Stroke	□ Yes	□ No
Heart disease	□ Yes	□ No
Cancer	□ Yes	□ No

Type of cancer _____

CURRENT MEDICATIONS	
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:	
Name of drug	**Dose (include strength & number of pills per day)**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

SURGICAL HISTORY	
Please list your surgeries:	
Name of surgery	**Date**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

ALLERGIES	
Please list your allergies:	
Name of Drug	**Reaction**
1.	
2.	
3.	
4.	
5.	

Do you have a cardiac pacemaker / defibrillator? □ Yes □ No

Do you have an aneurysm clip? □ Yes □ No

Do you have a vagal nerve stimulator? □ Yes □ No

Do you have a cochlear implant? □ Yes □ No

Do you have any other implanted device? □ Yes □ No

Do you have any metallic objects in your head? □ Yes □ No

Have you ever had brain surgery? □ Yes □ No

Have you ever had a seizure? □ Yes □ No If yes: Date_____

Have you ever had an MRI of your brain? □ Yes □ No If yes: Date_____

Have you had TMS before? □ Yes □ No

Marital Status: □ Married □ Divorced □ Separated □ Widowed □ Single

Do you smoke? □Yes □No Packs per day _____

Do you drink alcohol? □ Yes □ No Amount _____

Do you use street drugs? □ Yes □ No Type and Amount _____