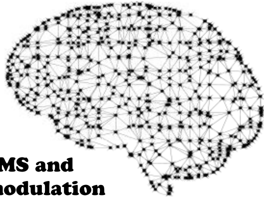


UCSF TMS Service
Medical Checklist

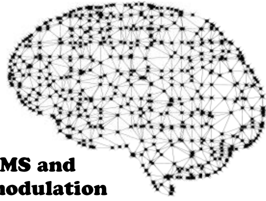
MRN: ___________________________

Patient Name: ____________________

Date of Service: __________________

Please indicate below any medical conditions you have EVER had in the PAST:

Medical Conditions	Occurrence			Year of Diagnosis	Comments
	Never	*Current*	*Past*		
Post-Traumatic Stress Disorder (PTSD)	☐	☐	☐		
Attention Deficit Hyperactivity Disorder (ADD/ADHD)	☐	☐	☐		
Migraines	☐	☐	☐		
Autism	☐	☐	☐		
Color Blindness	☐	☐	☐		
Mild Cognitive Impairment (MCI)	☐	☐	☐		
Alzheimer's	☐	☐	☐		
Dementia	☐	☐	☐		
Post-Concussion Syndrome (PCS)	☐	☐	☐		
Hearing Impairment (*please note if you wear hearing aids)	☐	☐	☐		
Depression	☐	☐	☐		
Diabetes	☐	☐	☐		
Epilepsy	☐	☐	☐		
Fibromyalgia	☐	☐	☐		
Multiple Sclerosis	☐	☐	☐		
Parkinson's Disease	☐	☐	☐		
Speech Difficulties	☐	☐	☐		
Stroke	☐	☐	☐		
Thyroid Disorder	☐	☐	☐		
Tinnitus (ringing in the ears)	☐	☐	☐		
Anemia	☐	☐	☐		
Arthritis	☐	☐	☐		
Asthma	☐	☐	☐		
Autoimmune Disorder	☐	☐	☐		
LOW Blood Pressure	☐	☐	☐		
HIGH Blood Pressure	☐	☐	☐		
Cancer	☐	☐	☐		
Chronic Fatigue	☐	☐	☐		



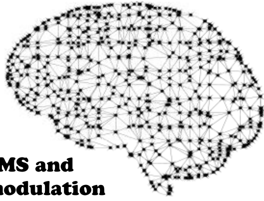
UCSF TMS Service
Medical Checklist

MRN: ____________________________

Patient Name: ____________________

Date of Service: __________________

Medical Conditions	Occurrence			Year of Diagnosis	Comments
	Never	*Current*	*Past*		
Chronic Pain	☐	☐	☐		
COPD (Emphysema/Chronic Bronchitis)	☐	☐	☐		
Glaucoma	☐	☐	☐		
Gout	☐	☐	☐		
Heart Disorder	☐	☐	☐		
Hepatitis	☐	☐	☐		
Immune System Disorder	☐	☐	☐		
Insomnia	☐	☐	☐		
Kidney and Urinary Problems	☐	☐	☐		
Liver Disease	☐	☐	☐		
Muscle Shaking (Tremors)	☐	☐	☐		
Muscular Dystrophy	☐	☐	☐		
Osteoporosis	☐	☐	☐		
Skin Disorder	☐	☐	☐		
Sleep Apnea	☐	☐	☐		
Synesthesia (letters/numbers perceived as colors)	☐	☐	☐		
Tumor	☐	☐	☐		
Other (please specify)	☐	☐	☐		



UCSF TMS Service Medical Checklist

MRN: ___________________________

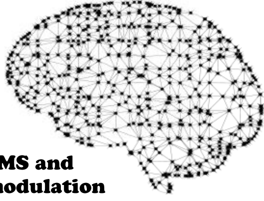
Patient Name: ___________________

Date of Service: __________________

Do you suffer from any known allergies?	☐ Yes	☐ No
Check all that applies:	☐ Seasonal	☐ Food
	☐ Pet	☐ Dust
	☐ Mold	☐ Skin (dermatitis)
	☐ Insect Sting	☐ Allergic Rhinitis
Family History - check if any member of your family (parent, sibling or grandparent) had any of the following:	☐ Cancer	☐ High Blood Pressure
	☐ Heart Disease	☐ Depression & Anxiety
	☐ Diabetes	☐ ADHD
	☐ Stroke	☐ Thyroid Disorder
	☐ Sleep Disorder	☐ Dementia
	☐ Obesity	☐ Does not apply

Have you ever had surgery? List date(s) and type of operation(s):

Do you **smoke?** (If so, please answer the questions below)	☐ Yes	☐ No
How often do you smoke?	☐ Never ☐ Occasionally	☐ Regularly ☐ Smoked & Quit
How many years have you been smoking?		
How many packs per day do you smoke?		



UCSF TMS Service Medical Checklist

MRN: ____________________________

Patient Name: ____________________

Date of Service: ___________________

	Yes	No
1. Have you been diagnosed with a concussion in the past?	☐	☐
a. # of concussions in the past:	☐	☐
b. Last date a concussion occurred:	☐	☐
c. Are you currently taking any medications for it?	☐	☐
2. Do you use any corrective visual aids (Contacts or Glasses)?	☐	☐
3. Have you been diagnosed with any type of Learning Disabilities? (e.g., reading disorder (dyslexia), writing disorder (dysgraphia), math disorder (dyscalculia), nonverbal learning disorder)	☐	☐
a. If so, please specify:		
4 . Have you been diagnosed with recurring headaches?	☐	☐
a. Are you currently taking any medications for it?	☐	☐
5. Has a headache limited your activities for a day or more in the last three months?	☐	☐
6. Are you nauseous or sick to your stomach when you have a headache?	☐	☐
7. Does light bother you when you have a headache?	☐	☐

Patient or Representative Signature ________________________________Date:__________Time:___________

If signed by someone other than the patient, please specify relationship to the patient: ___________________

Interpreter Signature ________________________________ID#:________Date:__________Time:___________

Physician Signature ____ Date:__________Time:___________