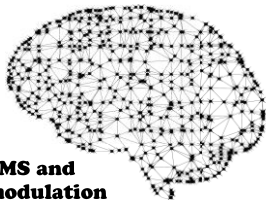


UCSF TMS and Neuromodulation Service

TMS Program Evaluation
Pre-Consultation Checklist

MRN: _____

Patient Name: _____

Date of Service: _____

Before you see the doctor, please go through this list and check all items that you currently have or have experienced within the past month:

General:	Yes	No
Weight loss or gain	☐	☐
Night sweats	☐	☐
Trouble sleeping	☐	☐
Fever or chills	☐	☐
Unexplained falls	☐	☐

Head:	Yes	No
Headache	☐	☐
Head injury	☐	☐
Sensitivity to light or sound	☐	☐

Eyes:	Yes	No
Redness	☐	☐
Blurry or double vision	☐	☐
Flashing lights	☐	☐
Spots or specks	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Pain	☐	☐
Last eye exam was: _____ (approximate date)		

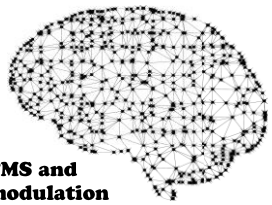
Skin:	Yes	No
Rashes	☐	☐
Lumps	☐	☐
Itching	☐	☐
Dryness	☐	☐
Color changes	☐	☐
Tattoos or permanent makeup	☐	☐
Hair and nail changes	☐	☐

Neck:	Yes	No
Lumps	☐	☐
Swollen glands	☐	☐
Pain	☐	☐
Stiffness	☐	☐

Ears:	Yes	No
Decreased hearing	☐	☐
Stuffiness	☐	☐
Earache	☐	☐
Ringing in ears	☐	☐
Drainage	☐	☐

Nose:	Yes	No
Stuffiness	☐	☐
Discharge	☐	☐
Itching	☐	☐
Hay fever	☐	☐
Nosebleeds	☐	☐
Sinus pain	☐	☐

Throat:	Yes	No
Toothache	☐	☐
Swallowing difficulties	☐	☐
Bleeding	☐	☐
Dry mouth	☐	☐
Sore throat	☐	☐
Hoarseness	☐	☐
Thrush	☐	☐
Non-healing sores	☐	☐
Last dental exam was: _____ (approximate date)		



UCSF TMS and Neuromodulation Service

TMS Program Evaluation
Pre-Consultation Checklist

MRN: _____

Patient Name: _____

Date of Service: _____

Breast:	Yes	No
Lumps	☐	☐
Pain	☐	☐
Soreness	☐	☐
Discharge	☐	☐
Breast-feeding	☐	☐
Last breast exam was: _____ (approximate date)		

Cardiovascular:	Yes	No
Chest pain or discomfort	☐	☐
Tightness	☐	☐
Shortness of breath with activity	☐	☐
Difficulty breathing when lying down	☐	☐
Swelling (edema)	☐	☐
Sudden awakening from sleep with shortness of breath	☐	☐
Palpitations	☐	☐
Faintness	☐	☐

Vascular:	Yes	No
Leg cramping	☐	☐
Calf pain with walking (Claudication)	☐	☐

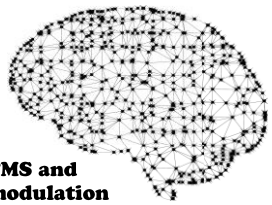
Respiratory:	Yes	No
Cough (dry or wet, productive)	☐	☐
Sputum (color & amount)	☐	☐
Coughing up blood	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
Painful breathing	☐	☐

Neurologic:	Yes	No
Dizziness	☐	☐
Poor balance	☐	☐
Speech problems	☐	☐
Paralysis	☐	☐
Seizures	☐	☐
Weakness	☐	☐
Numbness	☐	☐
Tingling	☐	☐
Tremor	☐	☐

Hematologic:	Yes	No
Ease of bruising	☐	☐
Ease of bleeding	☐	☐

Musculoskeletal:	Yes	No
Muscle or joint pain	☐	☐
Swelling or redness of joints	☐	☐
Stiffness	☐	☐
Back pain	☐	☐
Trauma	☐	☐
Misalignment	☐	☐

Gastrointestinal:	Yes	No
Heartburn	☐	☐
Abdominal pain	☐	☐
Nausea	☐	☐
Change in bowel habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Rectal bleeding	☐	☐
Yellow skin or eyes (Jaundice)	☐	☐



UCSF TMS and Neuromodulation Service

TMS Program Evaluation
Pre-Consultation Checklist

MRN: _____

Patient Name: _____

Date of Service: _____

Genital:	Yes	No
☐ **Male:**		
Hernia	☐	☐
Penile discharge	☐	☐
Masses or soreness	☐	☐
Erectile dysfunction	☐	☐
Itching, rashes, or sores	☐	☐
☐ **Female:**		
Vaginal dryness	☐	☐
Menses	☐	☐
Hot flashes	☐	☐
Vaginal discharge	☐	☐
Itching, rashes, or sores	☐	☐

Sexual Activity:	Yes	No
STD's	☐	☐
Pain with sex	☐	☐
Pregnant	☐	☐
Seeking Pregnancy	☐	☐
Birth Control Protection	☐	☐
Oral Contraception	☐	☐
Vaginal ring	☐	☐
IUD (non-hormonal)	☐	☐
IUD (hormonal)	☐	☐
Hormonal injection	☐	☐
Hormonal patch	☐	☐
Male or female condom	☐	☐
Withdrawal	☐	☐
Post-menopausal	☐	☐
Sterilization	☐	☐
Fertility awareness	☐	☐
Abstinence	☐	☐
Other form of protection:		

Urinary:	Yes	No
Urgency	☐	☐
Burning or pain	☐	☐
Blood in urine	☐	☐
Incontinence	☐	☐
Change in urinary strength	☐	☐
Catheter	☐	☐

Endocrine:	Yes	No
Fatigue	☐	☐
Heat or cold intolerance	☐	☐
Mood swings	☐	☐
Nausea with vomiting	☐	☐
Sweating	☐	☐
Frequent urination	☐	☐
Excessive thirst	☐	☐
Marked increase in appetite	☐	☐
Changes in libido	☐	☐

Psychiatric:	Yes	No
Nervousness	☐	☐
Low mood	☐	☐
Paranoia	☐	☐
Memory loss	☐	☐
Difficulty concentrating	☐	☐
Lack of energy	☐	☐
Irritability	☐	☐
Stress	☐	☐
Panic attacks	☐	☐
Claustrophobia	☐	☐
Desire or motive to engage in activities	☐	☐

UCSF TMS and Neuromodulation Service

TMS Program Evaluation
Pre-Consultation Checklist

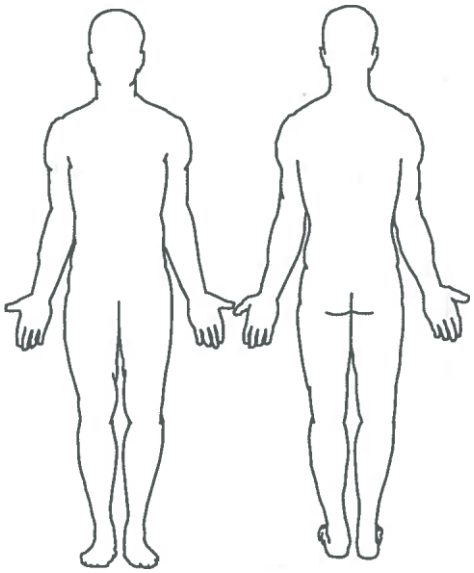
MRN: _____

Patient Name: _____

Date of Service: _____

Magnetic Field Precautions:	Yes	No
Aneurysm clips or coils	☐	☐
Metallic stents or filters	☐	☐
Surgical staples or sutures	☐	☐
Pin, screw, nail, wire, plate, etc.	☐	☐
Shunt (spinal or intraventricular)	☐	☐
Any metallic fragment or foreign body	☐	☐
Cochlear implant	☐	☐
Implanted cardiac defibrillator (ICD)	☐	☐
Pacemaker	☐	☐
Vagus nerve stimulator **(VNS)**	☐	☐
Spinal cord stimulator	☐	☐
Insulin or other Infusion pump	☐	☐
Any type of prosthesis	☐	☐
Joint replacement (hip, knee, etc.)	☐	☐
Other implants or metal:		

Please mark on the figures below the location of any implant or metal inside or on your body:



Please sign below to indicate you have thoroughly read and completed the checklist

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 _____ID#_____ Date _____Time _____