NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Patient Information

Patient Name: ______________________ Date of Birth: ______________

Do you or have you had any of the following?

Seizure	Yes ☐	No ☐	Hearing Loss	Yes ☐	No ☐
Head Trauma	Yes ☐	No ☐	Ringing in your ears	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Claustrophobia	Yes ☐	No ☐
Brain Tumor(s)	Yes ☐	No ☐	Restless Leg Syndrome	Yes ☐	No ☐
Severe Headaches	Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐
Eye Pain	Yes ☐	No ☐	Dizziness	Yes ☐	No ☐
Toothache	Yes ☐	No ☐			

Alcohol / Caffeine / Tobacco / Drugs

	Quantity	Frequency	Last Use
Alcohol			
Caffeine			
Tobacco			
Marijuana			

Other Drugs of Abuse

Drug	Quantity	Frequency	Last Use

Psychiatric History

Suicide Attempt(s)	Yes ☐	No ☐
Thoughts of suicide	Yes ☐	No ☐
Psychiatric Hospitalization(s)	Yes ☐	No ☐

Name of Hospital	Date

Have you ever had ECT? Yes ☐ No ☐

Date	Outcome	Unilateral / Bilateral
		Unilateral ☐ Bilateral ☐
		Unilateral ☐ Bilateral ☐
		Unilateral ☐ Bilateral ☐

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THE TMS CENTER OF NEW JERSEY
David Sikowitz, M.D., *Board Certified Psychiatrist*

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE (CONT'D)

Patient Name: ____________________

Prescription medications you are currently taking:

Prescription Medication	Dosage	Frequency

Vitamins, supplements or homeopathic medications you are currently taking:

Vitamins / Supplements / Homeopathic	Dosage	Frequency

List all medical problems you have been or are currently being treated for:

____
____
____
____
____

List all surgeries you have had:

Procedure	Date	Outcome

Allergies, including medications: No known allergies ☐

Allergy / Medication	Reaction

Date of last physical: ____________________

WOMEN

Are you pregnant? Yes ☐ No ☐

Date of L.M.P. ____________________

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THE TMS CENTER OF NEW JERSEY

David Sikowitz, M.D., *Board Certified Psychiatrist*

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE (CONT'D)

Patient Name: ______________________________

MEDICAL QUESTIONNAIRE

Do you have any implanted metal objects around the head?

Piercings: Yes ☐ No ☐ If yes, where? ____________ Removable? Yes ☐ No ☐

Plates: Yes ☐ No ☐ If yes, where? ____________

Staples / Screws: Yes ☐ No ☐ If yes, where? ____________

Stents: Yes ☐ No ☐ If yes, where? ____________

Dental Implants: Yes ☐ No ☐ If yes, where? ____________

Bullet Fragments: Yes ☐ No ☐ If yes, where? ____________

Shrapnel Fragments: Yes ☐ No ☐ If yes, where? ____________

Aneurysm Coils: Yes ☐ No ☐

Cochlear Implants: Yes ☐ No ☐

Ocular Implants: Yes ☐ No ☐

Deep Brain Stimulation Device: Yes ☐ No ☐

Do you have anything not mentioned above implanted in the head area? Yes ☐ No ☐

If yes, where? ____________ Removable? Yes ☐ No ☐

Do you have any of the following?

Pacemaker: Yes ☐ No ☐

Hearing Aid: Yes ☐ No ☐ Removable? Yes ☐ No ☐

Implantable Cardiac Defibrillator (I.C.D.): Yes ☐ No ☐

Wearable Cardiac Defibrillator (W.C.D.): Yes ☐ No ☐

Vagal Nerve Stimulator (V.N.S.): Yes ☐ No ☐

Spinal Cord Stimulator: Yes ☐ No ☐

Implantable Drug Pump: Yes ☐ No ☐

Insulin Pump: Yes ☐ No ☐

Do you have anything not mentioned above implanted on your body? Yes ☐ No ☐

If yes, where? ____________ Removable? Yes ☐ No ☐

SIGNATURE / AUTHORIZATION

I certify that the above is true and correct.

Signature of Patient or Responsible Party: ____________ Date: ________