



55 North Gilbert Street
Suite 2203
Tinton Falls, New Jersey 07701

(732) 740-7675 Telephone
(732) 842-0100 Fax
www.thetmscenterofnj.com

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

Page 1 of 3

Patient Information

Patient Name: _____ Date of Birth: _____

Do you or have you had any of the following?

Seizure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Hearing Loss	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Head Trauma	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Ringing in your ears	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stroke	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Claustrophobia	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Brain Tumor(s)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Restless Leg Syndrome	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Severe Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>	High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Eye Pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Dizziness	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Toothache	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

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 <input type="checkbox"/>	No <input type="checkbox"/>
Thoughts of suicide	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Psychiatric Hospitalization(s)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Name of Hospital	Date	

Have you ever had ECT?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Date	Outcome	Unilateral / Bilateral
		Unilateral <input type="checkbox"/> Bilateral <input type="checkbox"/>
		Unilateral <input type="checkbox"/> Bilateral <input type="checkbox"/>
		Unilateral <input type="checkbox"/> Bilateral <input type="checkbox"/>

Continued on next page



55 North Gilbert Street
 Suite 2203
 Tinton Falls, New Jersey 07701

(732) 740-7675 Telephone
 (732) 842-0100 Fax
 www.thetmscenterofnj.com

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. _____

Continued on next page



55 North Gilbert Street
Suite 2203
Tinton Falls, New Jersey 07701

(732) 740-7675 Telephone
(732) 842-0100 Fax
www.thetmscenterofnj.com

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE (CONT'D)

Page 3 of 3

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: _____