Medical History for Intervention Procedure

This patient is being evaluated for treatment with Transcranial Magnetic Stimulation, Spravato (Esketamine) or Intravenous Ketamine.

Patient Name: ________________________ DOB: ____________ Phone:_____________________________

Current Medical Diagnosis: ____

Please indicate if the patient was treated or is currently being treated for:

Medical Comorbidities	**Yes**	**No**
Allergies/hay fever		
Angina		
Asthma/ COPD		
Cardiac pacemaker		
Intracardiac lines/Supplemental O2		
Diabetes		
Epilepsy		
Fainting spells or syncope		
Head Trauma/concussion with or without LOC		
Heart attacks		
Kidney stones or other renal problems		
Hemodynamic Instability		
Intracranial HTN/Bleed		
Hepatic Disorders		

Medical Comorbidities	**Yes**	**No**
Hypertension		
Metal Implants		
Migraines		
MRI in the past		
Seizures		
Strokes/TIAs		
Syncope		
Thyroid		
Hypersensitivity to Ketamine/Esketamine/Excipients		
IV Ketamine/Spravato in the past		
TMS in the past		
AV malformations		
Intrathoracic/abdominal aneurysms		
Other		

Ketamine and esketamine (Spravato) are contraindicated in patients with:
Aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial, and peripheral arterial vessels) or arteriovenous malformation. History of intracerebral hemorrhage. Hypersensitivity to esketamine, ketamine, or any of the excipients. Pregnancy. If the patient had intolerance, please let us know what these are (e.g. nausea, dysgeusia, dissociation) please list these and we will address them with the patient.

Transcranial Magnetic Stimulation is contraindicated in patients with:
History of seizures. Ferromagnetic or magnetic sensitive metal objects implanted in the head or neck areas. Pacemakers, Vagus Nerve Stimulator, Cochlear implants, Pregnancy

Are there any medical contraindications to this patient for the following procedures (see below)?

Transcranial Magnetic Stimulation (TMS): [ ] Yes [ ] No

IV Ketamine/Spravato : [ ] Yes [ ] No

If Yes, explain:

******Please send completed form records@depressionmd.com or our fax number is 877-325-2241******

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NO MEDICATION RECONCILATION PRINTED NOTES WILL BE ACCEPTED

Current Medications:

Medication	Dose

____ ____

Medical Provider Name and Office (printed) **Signature**:

____________________ ____________________ ____________________________________

Date **Phone** **Email**

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