CARILION CLINIC

ECT Screening Questionnaire

Before you are able to receive ECT treatment, we need to make sure that it is safe for you to do so. To that end, we need information about the possible factors that could enhance your risk to experience unintentional adverse effects. Please fill out the questionnaire carefully and honestly. This form will subsequently be assessed by a physician or advanced care provider.

First and last name:_____

Screening questionnaire

1.	Do you have a history of problems with anesthesia?	Yes ☐	No ☐
2.	Do you have eye pain, visual changes or glaucoma?	Yes ☐	No ☐
3.	Do you have a history of blood clots (Deep Vein Thrombosis, Embolus)?	Yes ☐	No ☐
4.	Have you experienced chest pain in the past month?	Yes ☐	No ☐
5.	Do you have a heart condition?	Yes ☐	No ☐
6.	Do you have a history of hypertension or low blood pressure?	Yes ☐	No ☐
7.	Have you ever had a stroke or Transient Ischemic Attack (TIA)?	Yes ☐	No ☐
8.	Have you ever undergone surgery to your head or have a shunt?	Yes ☐	No ☐
9.	Have you ever had a head tumor or cancer?	Yes ☐	No ☐
10.	Have you ever lost consciousness without any known reason?	Yes ☐	No ☐
11.	Do you have asthma, bronchitis or any other breathing problem?	Yes ☐	No ☐
12.	Have you had hepatitis, liver disease, or jaundice?	Yes ☐	No ☐
13.	Do you have or have you ever had kidney disease?	Yes ☐	No ☐
14.	Do you have any bleeding problems?	Yes ☐	No ☐
15.	Have you ever (at present or in the past) suffered from a brain-related, neurological illness such as Epilepsy or Parkinson's?	Yes ☐	No ☐
16.	Do you suffer from frequent severe headaches?	Yes ☐	No ☐
17.	Do you have another chronic illness/disorder not yet listed above?	Yes ☐	No ☐
18.	Are you currently taking antibiotics?	Yes ☐	No ☐
19.	Do you take any herbals or complementary or alternative medicines?	Yes ☐	No ☐
20.	Are you taking any other supplements not mentioned above?	Yes ☐	No ☐
21.	(Women) Are you pregnant, or is there a chance that you might be?	Yes ☐	No ☐
22.	(Men) Do you take Viagra, Cialis, or other erectile dysfunction medicines?	Yes ☐	No ☐
23.	Does someone in your family have a psychiatric illness/disorder?	Yes ☐	No ☐
24.	Does someone in your family have Bipolar Disorder?	Yes ☐	No ☐
25.	Do you have sleeping problems such as Obstructive Sleep Apnea?	Yes ☐	No ☐
26.	Do you experience panic/anxiety attacks?	Yes ☐	No ☐
27.	Have you ever undergone TMS or Ketamine therapy?	Yes ☐	No ☐
28.	Do you averagely consume more than 3 alcoholic units a day?	Yes ☐	No ☐

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29.	Have you ever suffered from substance dependence or abuse?	Yes ☐	No ☐
30.	Are you using marijuana presently in the past 2 weeks?	Yes ☐	No ☐
31.	Have you used any recreational drugs during the past year? (Such as marijuana, ecstasy, cocaine, etc.)	Yes ☐	No ☐
32.	Are you allergic to latex (rubber) products?	Yes ☐	No ☐
33.	Do you have an Internal Cardiac Defibrillator (AICD) or Pacemaker?	Yes ☐	No ☐
34.	Do you have strong or frequent back pain?	Yes ☐	No ☐
35.	Do you have loose teeth or unstable dental problems?	Yes ☐	No ☐
36.	Do you have problems with urination (hesitancy, difficulty voiding)?	Yes ☐	No ☐
37.	Do you have any problems with your memory?	Yes ☐	No ☐
38.	Are you right handed or left handed?	Right ☐	Left ☐

Please comment on positive (yes) responses to the previous questions:

_____

_____

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I answered all questions to the best of my knowledge and belief:

Signature _____

Date: _____