CARILION CLINIC

VNS Screening Questionnaire

Before you are able to receive VNS 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.

First and last name:_____

Screening questionnaire

1.	Do you have a history of problems with anesthesia?	Yes ☐	No ☐
2.	Do you have sleeping problems such as obstructive sleep apnea?	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 such as heart failure, coronary artery disease, or atrial fibrillation?	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.	Do you have frequent sore throat or problems swallowing?	Yes ☐	No ☐
10.	Have you ever lost consciousness without any known reason?	Yes ☐	No ☐
11.	Do you have asthma, COPD, frequent shortness of breath, frequent cough 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 Seizure Disorder?	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.	Do you experience frequent hoarseness or changes in your voice?	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 a history of laryngospasm, which is an abnormal muscle tone of the vocal cords leading to difficulty with speaking or breathing?	Yes ☐	No ☐
26.	Do you experience panic/anxiety attacks?	Yes ☐	No ☐
27.	Have you ever undergone TMS, ECT or Ketamine therapy?	Yes ☐	No ☐

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28.	Do you averagely consume more than 3 alcoholic units a day?	Yes ☐	No ☐
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 ☐

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

_____
_____
_____
_____
_____
_____
_____

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

Signature _____

Date: _____