

TMS CHECKLIST



Have you ever:

- 1. Had TMS before? _____ Yes No
- 2. Had an adverse reaction to TMS? _____ Yes No
- 3. Had a seizure? _____ Yes No
- 4. Lost consciousness for unknown reasons? _____ Yes No
- 5. Had a stroke? _____ Yes No
- 6. Had a serious head injury? _____ Yes No
- 7. Had surgery to your head? _____ Yes No
- 8. Had any brain related neurological illnesses? _____ Yes No
- 9. Had any illnesses that may have caused brain injury? _____ Yes No
- 10. Had frequent or severe headaches? _____ Yes No
- 11. Do you have metal in your head (e.g., surgical clips, shrapnel)? _____ Yes No
- 12. Do you have implanted devices (e.g., pacemakers, medical pumps, deep brain stimulators)? _____ Yes No
- 13. Do you have a heart disease? _____ Yes No
- 14. Are you taking any medications? _____ Yes No
- 15. Are you pregnant, or not sure if you are pregnant? _____ Yes No
- 16. Does anyone in your family have epilepsy? _____ Yes No
- 17. Do you need further explanation of TMS or its risks? _____ Yes No

For every YES answer, please describe below in detail:

Item / Description

Subject signature _____ Date ___ / ___ / 2009

Investigator signature _____ Date ___ / ___ / 2009