

## TMS SCREENING FORM

Subject Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female

Handedness: Left-Handed  Right-Handed

Please answer these questions carefully and discuss with the experimenter if your answer to any of the following is positive.

Yes  No  1. Do you have any implants in your body? (pacemaker, medication pump, metallic plate in the skull, cochlear (ear) implant, brain stimulator, etc)

Yes  No  2. Do you have any history of seizure or epilepsy?

Yes  No  3. Do you have any history of migraine headaches?

Yes  No  4. Do you have any history of any other neurological condition or neurosurgery? Please explain.

Yes  No  5. Are you taking any medications? If so please list them (especially important are drugs that may lower seizure threshold such as tricyclic antidepressants and neuroleptics).

Yes  No  6. Do you have any metallic objects in your head (metal fragments in eye, skull, etc)  
[Please remove any metallic objects you may have in your hair (hair pins, etc).]

Yes  No  7. Female subjects: Any chance you are pregnant?

By signing below please confirm that you have accurately read and answered all questions in this document. Please ask us if you have any questions.

Signature of TMS Subject: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of investigator: \_\_\_\_\_

Date: \_\_\_\_\_