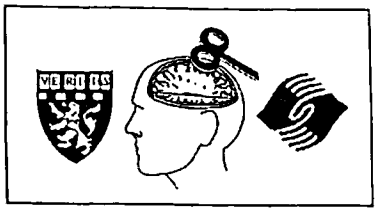

LABORATORY FOR MAGNETIC BRAIN STIMULATION
BETH ISRAEL DEACONESS MEDICAL CENTER
330 Brookline Ave., Kirstein Building KS 454
TEL: 1-617-667 02 03 • FAX: 1-617-975 53 22
Director: Alvaro Pascual-Leone, MD, PhD
Administrator: Mark Thivierge

Subject Initials: ___ IRB Study #: ___

Date: ___/___/___ ☐ AM ☐ PM
Month Day Year

Investigator Name: _____

TMS-Screening Questionnaire

Have you ever:

Had TMS before?	☐ Yes	☐ No
Had an adverse reaction to TMS?	☐ Yes	☐ No
Had a seizure?	☐ Yes	☐ No
Had an unexplained spell of loss of consciousness?	☐ Yes	☐ No
Had a stroke?	☐ Yes	☐ No
Had a serious head injury?	☐ Yes	☐ No
Had a surgery to your head?	☐ Yes	☐ No
Had any brain-related, neurological illnesses?	☐ Yes	☐ No
Had any illness that may have caused brain injury?	☐ Yes	☐ No
Do you suffer from frequent or severe headaches?	☐ Yes	☐ No
Do you have any metal in your head (outside the mouth) such as shrapnel, surgical clips, or fragments from welding?	☐ Yes	☐ No
Do you have any implanted medical devices such as cardiac pacemakers, or medical pumps?	☐ Yes	☐ No
Are you taking any medications?	☐ Yes	☐ No
Are you pregnant, or are you sexually active and not sure whether you might be pregnant?	☐ Yes	☐ No
Does anyone in your family have epilepsy?	☐ Yes	☐ No
Do you need any further explanation of TMS or its associated risks?	☐ Yes	☐ No

FOR ANY 'YES' RESPONSE, PLEASE PROVIDE DETAILED INFORMATION

_____
_____
_____
_____
_____
_____
_____

Subject Signature

Date: ___ ___ / ___ ___ / ___ ___
Month Day Year

Investigator Signature

Date: ___ ___ / ___ ___ / ___ ___
Month Day Year