Participant ID: ________

Center for Advanced Brain Imaging
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TRANSCRANIAL MAGNETIC STIMULATION SCREENING FORM

Transcranial Magnetic Stimulation (TMS) uses brief magnetic pulses to stimulate the brain cells near the scalp. There is a potential for the pulses to interact with nearby metal and/or electrical devices, thus we restrict any metal or electrical devices within one foot of the TMS wand. There is evidence that the TMS can induce fainting and, in rare cases, cause seizures. Therefore, participants with any history of epilepsy or seizure will be excluded. In addition, the system is loud, and participants will be provided hearing protection.

Yes	*No*	
☐	☐	Have you had an adverse reaction to Transcranial Magnetic Stimulation?
☐	☐	Have you ever had a seizure (epilepsy)?
☐	☐	Has anyone in your family been diagnosed with epilepsy?
☐	☐	Have you ever had a Electroencephalogram (EEG)?
☐	☐	Have you ever had a stroke?
☐	☐	Have you ever had a head injury (including Neurosurgery)?
☐	☐	Do you suffer from frequent or severe headaches?
☐	☐	Do you have any metal in your head such as shrapnel, surgical clips, or fragments from welding or metal work?(outside of your mouth)
☐	☐	Do you have any implanted devices such as cardiac pacemakers, medical pumps, or intra-cardiac lines?
☐	☐	Have you had any brain-related conditions?
☐	☐	Have you ever had any illness that caused brain injury?(i.e. meningitis, aneurysm, brain tumor)
☐	☐	Have you had unstable severe disease such as cardiologic, pulmonary, renal, endocrinal (hyperthyroidism or hypothyroidism), gastrointestinal, or others?
☐	☐	Are you currently taking any medication? If yes, please list.____
☐	☐	Do you have a latex allergy?
☐	☐	If you are woman of childbearing ages; do you suspect that you might be pregnant?
☐	☐	Do you need any further explanation of TMS and its associated risks?
☐	☐	If any item was marked "yes"' please provide a comment here:____

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: ______________________________ Date (MM/DD/YYYY) ________________

Form Completed By: ☐ Participant ☐ Relative

______________________________ ______________________________

If relative, print your name State your relationship to participant

Notes to any checked items: *June 2010*

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For Experimenter Use Only:
Name of Project & PI: ______________________
Researcher(s):______________________
Person obtaining screening, Date, & Time: ______________