Code Participant: __ __ Date: __ __ / __ __ / __ __
Day Month Year

Investigator name: _____

Questionnaire TMS

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 any brain-related, neurological injury or illnesses?	☐ 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
▪ Do you suffer from frequent or severe headaches?	☐ Yes	☐ No
▪ Are you taking any medications?	☐ Yes	☐ No
▪ Have you recently taken any psycho-active drug or alcohol?	☐ Yes	☐ No
▪ Are you sleep deprived?	☐ 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

_____
_____
_____
_____

SIGNATURES

Participant: _____ Date: __ __ / __ __ / __ __

Investigator: _____ Date: __ __ / __ __ / __ __
Day Month Year