# MARTINOS CENTER TMS SCREENING FORM vs. 02/28/2018

Name _____ Date _____

MGH # _____ Gender_____ Date of Birth _____

Race/Ethnicity _____ Principal Investigator _____

**Have you ever (for every YES answer, please describe):**

1. Had TMS before? _____ ☐ No ☐ Yes: _____
2. Had an adverse reaction to TMS? _____ ☐ No ☐ Yes: _____
3. Had metal in head (*e.g.*, surgical clips, shrapnel)?_____ ☐ No ☐ Yes: _____
4. Do you have implanted devices (*e.g.*, pacemakers, medical pumps, brain stimulators)?_____ ☐ No ☐ Yes: _____
5. Had a seizure or been diagnosed with epilepsy? _____ ☐ No ☐ Yes: _____
6. Does anyone in your family have epilepsy? _____ ☐ No ☐ Yes: _____
7. Had a fainting spell or syncope? _____ ☐ No ☐ Yes: _____
8. Had a stroke? _____ ☐ No ☐ Yes: _____
9. Had a head injury resulting in unconsciousness? _____ ☐ No ☐ Yes: _____
10. Had surgery to your head? _____ ☐ No ☐ Yes: _____
11. Had any brain related (neurological) illnesses? _____ ☐ No ☐ Yes: _____
12. Had any illnesses that may have caused brain injury? _ ☐ No ☐ Yes: _____
13. Had frequent or severe headaches? _____ ☐ No ☐ Yes: _____
14. Do you have a heart disease? _____ ☐ No ☐ Yes: _____
15. Do you have hearing problems or ringing in the ears? _ ☐ No ☐ Yes: _____
16. Are you taking any medications? (please list) _____ ☐ No ☐ Yes: _____
17. Have you had any alcohol yesterday or today? _____ ☐ No ☐ Yes: _____
18. Have you smoked today?_____ ☐ No ☐ Yes: _____
19. Are you sleep deprived? _____ ☐ No ☐ Yes: _____
20. Do you need further explanation of TMS or its risks? _ ☐ No ☐ Yes: _____

**Pregnancy screening questions for women of childbearing potential:**

21. Do you believe that you could be pregnant? _____ ☐ No ☐ Yes: _____
22. Are you currently trying to become pregnant? _____ ☐ No ☐ Yes: _____
23. Are you using reliable contraception? _____ ☐ No ☐ Yes: _____
24. When did your last period start? _____ Date____ / ___ / _____

**Assessment of Risk of Falls. Please check the appropriate box:**

- How are you feeling right now? □ Weak □ Dizzy □ Light-headed □ Fine □ Other: _____
- Recently, have you had any falls? □ Yes □ No
- Do you need help to walk? □ Yes □ No

If **Yes**, what type of help do you need to walk?

□ Crutches □ Walker □ Cane □ Companion to help you □ Other: _____

I have received a signed copy of the informed consent document for this study _____ (initials)

Subject signature _____ Date ___ / ___ / _____

Investigator signature _____ Date ___ / ___ / _____

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To be filled out by investigator:

IRB Protocol Number _____ IRB Expiration Date _____ Rescan (circle): Yes No