JH TASS

TASS

Transcranial Magnetic Stimulation Adult Safety Screening Questionnaire

Note: A positive screen is any 'Yes' answer and indicates further investigation by the clinician (but not indicating exclusion from TMS).

1. Have you ever had an adverse reaction to TMS? * ☐ Yes ☐ No

2. Have you ever had a seizure? * ☐ Yes ☐ No

3. Have you ever had an EEG? * ☐ Yes ☐ No

4. Have you ever had a stroke? * ☐ Yes ☐ No

5. Have you ever had a head injury (including neurosurgery)? * ☐ Yes ☐ No

6. Do you have any metal in your head (outside of mouth) such as shrapnel, surgical clips, or fragments from welding or metal work? * ☐ Yes ☐ No

7. Do you have any implanted devices such as pace makers, medical pumps, or intracardiac lines? * ☐ Yes ☐ No

8. Do you suffer from frequent or severe headaches? * ☐ Yes ☐ No

9. Have you ever had any other brain-related conditions? * ☐ Yes ☐ No

10. Have you ever had any illness that caused brain injury? * ☐ Yes ☐ No

11. Are you taking any medications? * ☐ Yes ☐ No

12. If you are a woman of childbearing age, are you sexually active, and if so, are you not using a reliable birth control method? * ☐ Yes ☐ No

13. Does anyone in your family have epilepsy? * ☐ Yes ☐ No

PATIENT SIGNATURE *