



**Center for Advanced Brain Imaging**  
**Georgia State University and Georgia Institute of Technology**  
 831 Marietta St, Atlanta GA 30332, USA  
 Phone (404) 385-8619 FAX (404) 385-8620

### 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

<input type="checkbox"/>	<input type="checkbox"/>	Have you had an adverse reaction to Transcranial Magnetic Stimulation?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a seizure (epilepsy)?
<input type="checkbox"/>	<input type="checkbox"/>	Has anyone in your family been diagnosed with epilepsy?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had and Electroencephalogram (EEG)?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a stroke?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a head injury (including Neurosurgery)?
<input type="checkbox"/>	<input type="checkbox"/>	Do you suffer from frequent or server headaches?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any metal in your head such as shrapnel, surgical clips, or fragments from welding or metal work?(outside of your mouth)
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any implanted devices such as cardiac pacemakers, medical pumps, or intra-cardiac lines?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any brain-related conditions?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any illness that caused brain injury?(i.e. meningitis, aneurysm, brain tumor)
<input type="checkbox"/>	<input type="checkbox"/>	Have you had unstable severe disease such as cardiologic, pulmonary, renal, endocrinal (hyperthyroidism or hypothyroidism), gastrointestinal, or others?
<input type="checkbox"/>	<input type="checkbox"/>	Are you currently taking any medication? If yes, please list. _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a latex allergy?
<input type="checkbox"/>	<input type="checkbox"/>	If you are woman of childbearing ages; do you suspect that you might be pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Do you need any further explanation of TMS and its associated risks?
<input type="checkbox"/>	<input type="checkbox"/>	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

**For Experimenter Use Only:**

Name of Project & PI: \_\_\_\_\_

Researcher(s): \_\_\_\_\_

Person obtaining screening, Date, & Time: \_\_\_\_\_