Screening Questionnaire for Transcranial Magnetic Stimulation (TMS)

Please circle as appropriate:

1. Do you have epilepsy or have you ever had a convulsion or a seizure? Y / N

2. Have you ever had a fainting spell or syncope? Y / N

   If yes, please give further information ……..

   ……

3. Have you ever had a head trauma that was diagnosed as a concussion or was associated with loss of consciousness? Y / N

4. Do you have any hearing problems or ringing in your ears? Y / N

5. Do you have cochlear implants? Y / N

6. Are you pregnant or is there any chance that you might be? Y / N

7. Do you have metal in the brain, skull or elsewhere in your body (e.g., splinters, fragments, clips, etc.)? If so, specify the type of metal. Y / N

   ……

8. Do you have an implanted neurostimulator? Y / N

   (e.g., DBS, epidural/subdural, VNS)

9. Do you have a cardiac pacemaker or intracardiac lines? Y / N

10. Do you have a medication infusion device? Y / N

11. Are you taking any medications? (please list) Y / N

    ……

12. Did you ever undergo TMS in the past? If so, were there any problems. Y / N

13. Did you ever undergo MRI in the past? If so, were there any problems. Y / N

(Safety of TMS Consensus group; Rossi et al. 2009)

14. Have you received any medication or other treatment for fibromyalgia in the past? Y / N

If yes, please give details:

What treatment/medication? ……

When/for how long? ……

Did it help? ……

Side effects? ……

Patient Signature:

_____

Print Name:

_____

Date:

_____

(Safety of TMS Consensus group; Rossi et al. 2009)