TMS Patient Questionnaire

☐ yes ☐ no Do you have epilepsy or have you ever had a convulsion or a seizure?

☐ yes ☐ no Have you ever had a head trauma that was diagnosed as a concussion or was associated with loss of consciousness?

☐ yes ☐ no Do you have any hearing problems or ringing in your ears?

☐ yes ☐ no Do you have cochlear implants?

☐ yes ☐ no Are you pregnant or is there any chance that you might be?

☐ yes ☐ no Do you have metal in the brain, skull or elsewhere in your body (e.g., splinter, fragments, clips, etc.)? If so, specify the type of metal.

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☐ yes ☐ no Do you have a cardiac pacemaker or intracardial lines?

☐ yes ☐ no Are you taking any medications? (please list)

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☐ yes ☐ no Did you ever undergo TMS in the past? If so, were there any problems?

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☐ yes ☐ no Have you been diagnosed as having major depression by a psychiatrist?

☐ yes ☐ no Have you been tried and failed at least 4 antidepressants?

☐ yes ☐ no Have you been diagnosed with schizophrenia or psychosis?

☐ yes ☐ no Have you ever been diagnosed with Alzheimer's disease or dementia?

? yes ? no Can you commit to coming daily Monday through Friday 5 days a week for
6 weeks?

? yes ? no Do you have reliable transportation or someone who can bring you?