UCONN | UNIVERSITY OF CONNECTICUT

BRAIN IMAGING RESEARCH CENTER

TMS SCREENING FORM

Name:_____

Please read the following questions carefully. It is very important for us to know if you have any **metal devices** or **metal parts** anywhere in your body. If you do not understand a question, please ask us to explain! If you answer yes to any question, please contact the principal investigator.

Part I: Exclusions for cortical TMS

1. Yes ☐ No☐ Do you have epilepsy or have you ever had a convulsion or a seizure that was not related to a fever?
2. Yes ☐ No☐ Do you have a heart pacemaker or intracardiac lines?
3. Yes ☐ No☐ Have you ever had a head trauma that was diagnosed as a concussion or was associated with loss of consciousness?
4. Yes ☐ No☐ Do you have implants in your ear (like cochlear implants)?
5. Yes ☐ No☐ Do you have an implanted neurostimulator (e.g., deep brain stimulator (DBS), epidural/subdural, vagus nerve stimulator (VNS))?
6. Yes ☐ No☐ Have you ever had a stroke or lesion (such as a tumor) in your brain?
7. Yes ☐ No☐ Have you ever had metal removed from your eyes by a doctor?
8. Yes ☐ No☐ Do you have metal in the brain, skull or neck (e.g., splinters, fragments, clips, implants etc.)?
   If so, specify the location and type of metal._____
9. Yes ☐ No☐ Do you think there is any possibility that you might be pregnant?
   Date of last menstrual period _____

Part II: Cautions for cortical TMS

10. Yes ☐ No☐ Have you ever had a fainting spell or syncope? If yes, please describe on which occasion(s)?
11. Yes ☐ No☐ Do you have a medication infusion device?
12. Yes ☐ No☐ Do you use a hearing aid?
13. Yes ☐ No☐ Have you ever had migraine headaches?
14. Yes ☐ No☐ Have you ever had brain surgery?
15. Yes ☐ No☐ Did you ever undergo TMS in the past?
    If so, describe any problems:_____
16. Yes ☐ No☐ Did you ever undergo MRI in the past?
    If so, describe any problems:_____
17. Yes ☐ No☐ Have you ever had any surgery? Please list all _____
18. Yes ☐ No☐ Are you taking any medications or have you stopped taking any medications in the last 2 weeks?
    (please list)_____
19. Yes ☐ No☐ Have you had more than 2 cups of coffee/caffeinated beverages in the last 12 hours?
    How much caffeine do you usually consume on an average day? _____ beverages

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Participant signature: _____ **Date:** _____

Investigator signature:_____ **Date:** _____

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Exclusionary drugs and medications:

For all drugs and medications listed below, a participant is considered to be currently affected by a substance or risk for withdrawal when the time since the last dose is less than 6.64 times the formulation half-life. Exclude participants unless in special circumstances if they have consumed any of the following medication within this time-frame. For alcohol, they must not have consumed alcohol within the past 3 days.

Current usage

imipramine, amitriptyline, doxepine, nortriptyline, maprotiline, chlorpromazine, clozapine, foscarnet, ganciclovir, ritonavir, amphetamines, cocaine, MDMA (ecstasy), phencyclidine (PCP, angel's dust), ketamine, gamma-hydroxybutyrate (GHB), alcohol, theophylline, mianserin, fluoxetine, fluvoxamine, paroxetine, sertraline, citalopram, reboxetine, venlafaxine, duloxetine, bupropion, mirtazapine, fluphenazine, pimozide, haloperidol, olanzapine, quetiapine, aripiprazole, ziprasidone, risperidone, chloroquine, mefloquine, imipenem, penicillin, ampicillin, cephalosporins, metronidazole, isoniazid, levofloxacin, cyclosporin, chlorambucil, vincristine, methotrexate, cytosine arabinoside, carmustine (BCNU), lithium, anticholinergics, antihistamines, sympathomimetics

Recent discontinuation (possible withdrawal)

alcohol, barbiturates, benzodiazepines, meprobamate, chloral hydrate

*Verbally ask***:**

1. "When was the last time you consumed alcohol?" (must be >72 hours)
2. "Have you recently taken any of the following substances: amphetamines, cocaine, MDMA, (ecstasy), phencyclidine (PCP, angel's dust), ketamine, gamma-hydroxybutyrate (GHB)?"