



Screening Forms



Screening questionnaire for Transcranial Magnetic Stimulation (TMS)

(as suggested by the Safety of TMS Consensus group; Rossi et al. 2009)

1. Do you have epilepsy or have you ever had a convulsion or a seizure?
2. Have you ever had a fainting spell or syncope? If yes, please describe on which occasion(s)?
3. Have you ever had a head trauma that was diagnosed as a concussion or was associated with loss of consciousness?
4. Do you have any hearing problems or ringing in your ears?
5. Do you have cochlear implants?
6. Are you pregnant or is there any chance that you might be?
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.
8. Do you have an implanted neurostimulator (e.g., DBS, epidural/subdural, VNS)?
9. Do you have a cardiac pacemaker or intracardiac lines?
10. Do you have a medication infusion device?
11. Are you taking any medications? (please list)
12. Did you ever undergo TMS in the past? If so, were there any problems.
13. Did you ever undergo MRI in the past? If so, were there any problems.

**SCREENING QUESTIONNAIRE FOR
TRANSCRANIAL ELECTRICAL STIMULATION (TES)**

		YES	NO
1	Do you have metal (except titanium) or electronic implants in the brain/skull (e.g., splinters, fragments, clips, cochlear implants, deep brain stimulation etc.)? If yes, please specify the type of metal and the location _____		
2	Do you have metal or any electronic device at other sites in your body, such as a cardiac pacemaker or traumatic metallic residual fragments? If yes, please specify the device and the location _____		
3	Did you ever have surgical procedures involving your head or spinal cord? If yes, please specify the locations _____		
4	Have you ever had a head trauma followed by impairment of consciousness?		
5	Do you have skin problems, such as dermatitis, psoriasis or eczema? If yes, please specify the location _____		
6	Do you have epilepsy or have you ever had convulsions, a seizure?		
7	Did you ever have fainting spells or syncope?		
8	Are you pregnant or is there any chance that you might be?		
9	Are you taking any medications? If yes, please specify: _____		
10	Did you ever undergo transcranial electric or magnetic stimulation in the past? If yes, were there any adverse events? Please specify: _____		

An affirmative answer to one or more of questions do not represent an absolute contraindication to TES, but the risk-benefit ratio should be carefully balanced by the Principal Investigator of the research project or by the responsible (treating) physician.

Name _____ Surname _____

Date _____ Signature _____