Appendix A: TMS Safety Questionnaire

ABSOLUTE CONTRAINDICATIONS

TMS is contraindicated if the answer to any of these questions is YES.

1. Do you have any electronic or magnetic implants (e.g., cochlear implant, cortical stimulator, deep brain stimulator, ventriculoperitoneal shunt, cardiac pacemaker, defibrillator, medication pump, nerve or spinal cord stimulator, or any similar device)?	YES ☐ NO ☐
2. Do you have any metal implants in your head (e.g., aneurysm clips, bullet fragments, surgical hardware) other than dental work?	YES ☐ NO ☐
3. Have you had a skull fracture or serious head injury (e.g., involving loss of consciousness or hospitalization)?	YES ☐ NO ☐
4. Have you ever had a stroke?	YES ☐ NO ☐
5. Have you experienced a prior TMS-related serious adverse event?	YES ☐ NO ☐
6. Do you have epilepsy or have you ever had a convulsion or a seizure?	YES ☐ NO ☐
7. Do you have a family history of epilepsy?	YES ☐ NO ☐
8. Have you ever had febrile seizures?	YES ☐ NO ☐
9. Have you ever had brain surgery?	YES ☐ NO ☐
10. Do you have any implanted ferromagnetic materials in your body?	YES ☐ NO ☐
11. Are you pregnant or is there any chance that you might be?	YES ☐ NO ☐

CONSIDERATIONS

These are not necessarily contraindications to TMS but further discussion should occur to determine TMS eligibility.

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1. Have you ever had a fainting spell or syncope? If yes, please describe. YES ☐ NO ☐

2. Do you experience recurring headaches? *There is a low risk of mild, transient headache after TMS.* YES ☐ NO ☐

3. Do you experience tinnitus (ringing in ears) or hyperacusis (sensitivity to sound), or wear hearing aids? *Hearing protection should especially be provided if YES.* YES ☐ NO ☐

4. Do you have any metal in your body? If yes, specify type of metal and location. YES ☐ NO ☐

5. Are you taking any medications, especially those that affect brain excitability such as antidepressants, antipsychotics, stimulants, or benzodiazepines? (please list) YES ☐ NO ☐

6. Have you undergone TMS in the past? If so, were there any problems? YES ☐ NO ☐

7. Have you undergone MRI in the past? If so, were there any problems? YES ☐ NO ☐

8. Have you been diagnosed with any psychiatric condition (e.g., depression, bipolar disorder, schizophrenia)? YES ☐ NO ☐

9. Have you been diagnosed with any neurological condition (e.g., cerebrovascular disease, dementia, increased intracranial pressure, history of repetitive or severe head trauma, or primary or secondary tumors in the central nervous system.)? YES ☐ NO ☐

10. Do you currently use or have a history of using recreational drugs or substances (e.g., alcohol, cannabis, stimulants)? YES ☐ NO ☐

11. Do you have a history of sleep disorders or are you currently sleep-deprived? YES ☐ NO ☐

12. Is there any other medical condition or concern you think we should know about before administering TMS? YES ☐ NO ☐