

1	Have you ever had an adverse reaction to rTMS?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2	Have you ever had a seizure?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3	Have you ever had an EEG?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4	Have you ever had a stroke?	<input type="checkbox"/> No <input type="checkbox"/> Yes
5	Have you ever had a head injury (including neurosurgery)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
6	Do you have any metal in your head (outside of the mouth) such as shrapnel, surgical clips, or fragments from welding or metalwork?	<input type="checkbox"/> No <input type="checkbox"/> Yes
7	Do you have any implanted devices such as cardiac pacemakers, medical pumps, or intracardiac lines?	<input type="checkbox"/> No <input type="checkbox"/> Yes
8	Do you suffer from frequent or severe headaches?	<input type="checkbox"/> No <input type="checkbox"/> Yes
9	Have you ever had any other brain-related condition?	<input type="checkbox"/> No <input type="checkbox"/> Yes
10	Have you ever had any illness that caused brain injury?	<input type="checkbox"/> No <input type="checkbox"/> Yes
11	Are you taking any medications?	<input type="checkbox"/> No <input type="checkbox"/> Yes
12	If you are woman of childbearing age, are you sexually active, and if so, are you <i>not using</i> a reliable method of birth control?	<input type="checkbox"/> No <input type="checkbox"/> Yes
13	Does anyone in your family have epilepsy?	<input type="checkbox"/> No <input type="checkbox"/> Yes
14	Do you need further explanation of rTMS and its associated risks?	<input type="checkbox"/> No <input type="checkbox"/> Yes
15	If any item was marked 'yes', please provide a comment here:	