1. Do you have epilepsy or have you ever had a convulsion or a seizure?

**□Y □N**

1. Have you ever had a fainting spell or syncope? If yes, please describe on which occasion(s)?

**□Y □N**

1. Have you ever had a head trauma that was diagnosed as a concussion or was associated with loss of consciousness?

**□Y □N**

1. Do you have any hearing problems or ringing in your ears?

**□Y □N**

1. Do you have cochlear implants?

**□Y □N**

1. Are you pregnant or is there any chance that you might be?

**□Y □N**

1. 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.

**□Y □N**

1. Do you have an implanted neurostimulator (e.g., DBS, epidural/subdural, VNS)?

**□Y □N**

1. Do you have a cardiac pacemaker or intracardiac lines?

**□Y □N**

1. Do you have a medication infusion device?

**□Y □N**

1. Are you taking any medications? Medications that could potentially lower your seizure threshold?

**□Y □N**

1. Did you ever undergo TMS in the past? If so, were there any problems.

**□Y □N**

1. Did you ever undergo MRI in the past? If so, were there any problems.

**□Y □N**

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Participant Signature Date

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Research Staff Signature Date