If you agree to take part in this study, please answer the following questions. The information you provide is for screening purposes only and will be kept completely confidential.

**CIRCLE or CROSS OUT**

Have you ever suffered from any neurological or psychiatric conditions? . . . . . . . . . . . . YES / NO
If YES please give details (nature of condition, duration, current medication, etc)

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Have you ever suffered from epilepsy or febrile convulsions in infancy? . . . . . . . . . . . . YES / NO

Have you ever fainted? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . YES / NO

If YES when did this (last) happen and what caused it:

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Does anyone in your immediate or distant family suffer from epilepsy? . . . . . . . . . . . . . YES / NO
If YES please state your relationship to the affected family member.

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Do you suffer from migraine? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . YES / NO

Have you ever undergone a neurosurgical procedure (including eye surgery)? . . . . . . YES / NO
If YES please give details.

Do you currently have any of the following fitted to your body? . . . . . . . . . . . . . . . . . . . YES / NO

Heart pacemaker

Cochlear implant

Medication pump

Surgical clips

Are you currently taking any unprescribed or prescribed medication? . . . . . . . . . . . . . YES / NO
If YES please give details.

. . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Are you currently undergoing anti - malarial treatment? . . . . . . . . . . . . . . . . . . . . . . . . YES / NO

Have you drunk more than 3 units of alcohol in the last 24 hours? . . . . . . . . . . . . . . . . YES / NO

Have you drunk alcohol already today? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . YES / NO

Have you had more than one cup of coffee, or other sources of caffeine,
in the last hour? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . YES / NO

Have you used recreational drugs in the last 24 hours? . . . . . . . . . . . . . . . . . . . . . . . . YES / NO

Did you have very little sleep last night? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . YES / NO

Have you already participated in a TMS experiment today? . . . . . . . . . . . . . . . . . . . . . YES / NO

Have you participated in more than a TMS experiment in the last 6 months? . . . . . . . . YES / NO

Are you taking any prescribed drugs (prescribed by your GP or a hospital)? . . . . . . . . YES / NO

Is there any chance that you could be pregnant? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . YES / NO

Are you left or right handed? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Left / Right

Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Signed: ............................................................................Date: ….................................

Name (in block letters): ..................................................................……….....................

**ERN\_09-417 v.1.0 Approved by UoB Ethics Committee (July 2009)
ERN\_09-417 v.2.0 Amended (May 2011)**