

Brain Imaging and Analysis Center

Part I: For all individuals entering the scanner room

Name _____ Birth Date _____
Last name first name M.I. City _____
Address _____
State _____ Zip Code _____ Phone (H)(_____) _____ (W)(_____) _____

1. Have you had any previous MRI studies or been in a MR scanner? No Yes
If yes, please list (most recent first):
Body part _____ Date _____ Facility location _____
2. Have you ever worked with metal (grinding, fabricating, etc.) or ever had an injury to the eye involving a metallic object (e.g. metallic slivers, shavings, foreign body)? No Yes
If yes, please describe: _____
3. Have you ever had surgery or other invasive medical procedure? (If yes, explain on back.) No Yes

Some of the following items may be hazardous to your safety or may interfere with the MRI examination. Do you have any of the following?

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac Pacemaker or defibrillator | <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial limb or prosthesis? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Insulin or infusion pump | <input type="checkbox"/> Yes <input type="checkbox"/> No Bone/joint screw, nail, wire, plate |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cochlear, otologic, or ear implant | <input type="checkbox"/> Yes <input type="checkbox"/> No Wire sutures or surgical staples |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing aid | <input type="checkbox"/> Yes <input type="checkbox"/> No Any implant held in place by a magnet (e.g., dental) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Any implanted metal (e.g., clamps, valves, clips, shunts, catheters) | <input type="checkbox"/> Yes <input type="checkbox"/> No Transdermal delivery system (Nitro) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Body piercing(s)? | <input type="checkbox"/> Yes <input type="checkbox"/> No Colored contact lenses |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tattoos or permanent makeup (e.g., eyeliner, lips) | <input type="checkbox"/> Yes <input type="checkbox"/> No Any metal fragments (e.g., shrapnel) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tissue expanders (plastic surgery) | |

Other, please explain: _____

Before you may enter the scanner room, you must remove all metallic objects.

- | | |
|--|--|
| <input type="checkbox"/> All contents of pockets, including back pockets | <input type="checkbox"/> Shoes that contain any metal (e.g., steel-tipped) |
| <input type="checkbox"/> Wrist watch, any bracelets | <input type="checkbox"/> Hearing aids or other electronic devices |
| <input type="checkbox"/> Hair pins, clips, weaves, fasteners | <input type="checkbox"/> Pagers, cell phones, PDAs |
| <input type="checkbox"/> Pins or badges on shirt | <input type="checkbox"/> Dentures or removable retainer |
| <input type="checkbox"/> Belt with metal (e.g., buckle) | <input type="checkbox"/> Necklaces, chains |

Note: You are required to wear earplugs or earphones during the MRI examination.

Signature of Person Completing Form _____ Date _____
Form completed by: Self Parent/guardian Other relative Physician page 1/2

Part II: For all individuals entering the scanner bore

1. Please list any surgeries or other invasive medical procedures:

2. Are you currently taking or have you recently taken any medication? No Yes

If yes, please list _____

3. Do you have anemia or any diseases that affect your blood? No Yes

If yes, please describe _____

4. Do you have a history of stroke, seizures, brain tumor, head trauma, or other neurological disorder? No Yes

If yes, please describe _____

5. Do you wear glasses or contact lenses? No Yes

If yes, please specify prescription (if known) _____

6. Do you have a breathing disorder (e.g., asthma, apnea) or heart condition? No Yes

7. Are you claustrophobic? No Yes

8. Are you wearing any clothing with metal wires, such as a bra with underwire? No Yes

(If yes, please remove before entering scanner room)

9. Do you have an IUD or a diaphragm containing metal? No Yes

10. Are you pregnant, experiencing a late menstrual period, or undergoing fertility treatment? No Yes

11. Do you currently have a fever or other acute illness? No Yes

Height _____ Weight _____ Handedness _____

Signature of Person Completing Form

Signature of Person Screening Subject/Patient

Date