Experiment: ______________________________ Date of Experiment: _______________

Brain Imaging and Analysis Center

Part I: For all individuals entering the scanner room

Name____ Birth Date ____________________
Last name first name M.I.

Address____ City_________________________

State_______ Zip Code_____________ Phone (H)(_____)__________ (W)(_____)_________

Email:____

1. Have you ever had an injury to the eye involving a metallic object (e.g. metallic slivers, shavings, foreign body)? ❑ No ❑ Yes
   If yes, please describe:____
2. Have you ever worked with metal (grinding, fabricating, etc.) ❑ No ❑ Yes
   If yes, please describe:____
3. Have you ever had eye surgery ❑ No ❑ Yes
   If yes, please describe:____
4. 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_____________
   If yes, did you have any problems?____

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?

❑ Yes ❑ No Cardiac Pacemaker or defibrillator
❑ Yes ❑ No Insulin or infusion pump
❑ Yes ❑ No Cochlear, otologic, or ear implant
❑ Yes ❑ No Any implanted metal clamps, valves, clips, shunts, or catheters.
❑ Yes ❑ No Any metal fragments (e.g., shrapnel)
❑ Yes ❑ No Tissue expanders (plastic surgery)
❑ Yes ❑ No Any implant held in place by a magnet (e.g., dental)
❑ Yes ❑ No Artificial limb or prosthesis
❑ Yes ❑ No Body piercing(s)
❑ Yes ❑ No Transdermal delivery system
❑ Yes ❑ No Hearing aid
❑ Yes ❑ No Colored contact lenses
❑ Yes ❑ No Tattoos or permanent makeup
❑ Yes ❑ No Dental Work other than fillings
❑ Yes ❑ No Bone/joint screw, nail, plate
❑ Yes ❑ No Wire sutures or surgical staples

Other, please explain:____

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

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

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

MRI Exam Number_____________

Part II: For all individuals entering the scanner bore

1. Are you claustrophobic? ❑ No ❑ Yes

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

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

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

5. Please list any surgeries or other invasive medical procedures:
____
____

6. Are you currently taking or have you recently taken any medication? ❑ No ❑ Yes
*If yes, please list*____

7. Do you have anemia or any diseases that affect your blood? ❑ No ❑ Yes
*If yes, please describe*____

8. Do you have a history of stroke, seizures, brain tumor, head trauma, or other neurological disorder? ❑ No ❑ Yes
*If yes, please describe*____

9. Do you wear glasses or contact lenses? ❑ No ❑ Yes
*If yes, please specify prescription (if known)*____

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

11. Are you wearing any clothing with metal wires, such as a bra with underwire? ❑ No ❑ Yes
(If yes, please remove before entering scanner room)

Height__________________ Weight_________________ Handedness_____________________

________________________________ ______________________________ ____________
Signature of Person Completing Form | Signature of Person Screening Subject/Patient | Date

Form completed by: ❑ Self ❑ Parent/guardian ❑ Other relative ❑ Physician