# MRI Screening Form

Date: _____/_____/_____ By: _____

Subject: _____

Study: _____ PI: _____

ID#: _____

Sex: Female Male Age: _____ DOB: _____/_____/_____

Weight: _____

Height: ____'____"

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*Yes* *No*

___ ___ **Do you have corrected vision?**
Do you know your vision rating or prescription?_____

___ ___ **Do you wear contact lens?**

___ ___ **Do you use transdermal patches (nicotine) or any type of medicated adhesive?**
Type? _____

___ ___ **Have you ever had an MRI scan?**
When? _____
Why? _____

___ ___ **Have you ever had surgery or a similar invasive procedure?**
When? _____
Type? _____

___ ___ **Have you ever had heart surgery?**
When? _____
Type? _____
___ ___ Do you have a Pacemaker?
___ ___ Do you have an implanted cardiac defibrillator?
___ ___ Do you have an artificial heart valve or stent?
___ ___ Do you have cardiac pace wires?

___ ___ **Have you ever had head or brain surgery?**
When? _____
Type? _____

___ ___ **Have you ever had eye surgery?**
___ ___ Do you have lens implants?

___ ___ **Do you wear dentures?**

___ ___ **Have you ever had ear surgery?**
___ ___ **Do you have a cochlear implant?**
___ ___ **Do you wear a hearing aid?**

*Yes* *No*

___ ___ **Have you ever had back surgery?**
When? _____
Type? _____

___ ___ **Do you have any implanted devices of any type?**
___ ___ Breast/Penile?
___ ___ Electrodes?
___ ___ Pumps (e.g., drug infusion device)?
___ ___ Bone or socket?
___ ___ Neurostimulators/Biostimulator?

___ ___ **Did you have a colonoscopy or endoscopy in the last 8 weeks?**

___ ___ **Do you have any dental or orthodontic implants (fillings are O.K.)?**
Type? _____
___ ___ **Do you have any type of prosthesis?**
Type? _____
___ ___ **Do you have any type of orthopedic implant (e.g., pins, rods, screws, nails)?**
Type? _____

___ ___ **Do you have any permanent cosmetics (e.g., eyeliner)?**
___ ___ **Do you have any tattoos on your upper body?**
Where/Extent? _____
___ ___ **Do you have any body piercing(s)?**
Where? _____

___ ___ **Do you have a history of any metal in your body?**
___ ___ **Have you every worked as an occupational metal grinder?**
Description: _____
___ ___ **Have you ever worked with metal as a hobby?**
Description: _____
___ ___ Did you routinely wear safety glasses?

___ ___ **Have you ever sought medical attention for metal in your eyes?**
___ ___ **Have you ever had metal fragments removed from your eyes?**
___ ___ **Have you ever been struck by a gun shot, B.B. or shrapnel?**

___ ___ **Do you have any physical disabilities?**
Type? _____
___ ___ **Do you have any involuntary motor disorders?**
Type? _____
___ ___ **Have you ever experienced claustrophobia?**
When? _____

___ ___ **Do you or have you used acupressure magnets / magnet therapy?**
When? _____

___ ___ **Do you have any back problems that would prevent you from lying still for up to 2 hours?**

**<u>Female Subjects</u>**
___ ___ **Are you or is there a chance you are pregnant?**
___ ___ **Do you have an intrauterine device (IUD)?**

****ANY QUESTIONABLE CONDITIONS <u>MUST</u> BE APPROVED BY THE MR TECHNICIAN****