

Subject Screening Form

Please answer the questions below thoroughly and honestly.

Thank you!

Date filled out (today's date)

Body part to be scanned

- Brain
- Other

Other body part to be scanned

Physical Information

gender

- male
 - female
-

Birth Date

Height
(round to nearest height in feet' inches")

- 4'0"
- 4'1"
- 4'2"
- 4'3"
- 4'4"
- 4'5"
- 4'6"
- 4'7"
- 4'8"
- 4'9"
- 4'10"
- 4'11"
- 5'0"
- 5'1"
- 5'2"
- 5'3"
- 5'4"
- 5'5"
- 5'6"
- 5'7"
- 5'8"
- 5'9"
- 5'10"
- 5'11"
- 6'0"
- 6'1"
- 6'2"
- 6'3"
- 6'4"
- 6'5"
- 6'6"
- 6'7"
- 6'8"
- 6'9"
- 6'10"
- 6'11"
- 7'0"
- 7'1"
- 7'2"
- 7'3"
- 7'4"
- 7'5"
- 7'6"
- 7'8"
- 7'9"
- 7'10"
- 7'11"

Weight (pounds)

(please provide weight rounded to nearest number. For instance, if you weigh 185.4 pounds, enter 185. If you weigh 87.6 kilograms, enter 88.)

Medical History

Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind?

Yes No

Date of most recent surgery

(Best estimate)

Briefly describe or simply name the procedure

Add another surgery?

Yes No

Date of second most recent surgery

(Best estimate)

Briefly describe or simply name the procedure

Add another surgery?

Yes No

Date of third most recent surgery

(Best estimate)

Briefly describe or simply name the procedure

Have you had a prior MRI study or examination?

Yes No

Approximate date of most recent MRI

(Use your best estimate)

What body part was scanned?

At which facility were you scanned?

Add another MRI?

Yes No

Approximate date of second most recent MRI

(Use your best estimate)

What body part was scanned?

At which facility were you scanned?

Add another MRI?

Yes No

Approximate date of third most recent MRI

(Use your best estimate)

What body part was scanned?

At which facility were you scanned?

Have you experienced any problem related to a previous MRI examination or MR procedure?

Yes
 No

Please describe the problem here.

Have you had an injury to the eye involving a metallic object or fragment (e.g. metallic slivers, shavings, foreign body, etc.)? Yes
 No

Please describe the injury here.

Have you ever been injured by a metallic object/foreign body (e.g., BB, bullet, shrapnel, etc.)? Yes
 No

Please describe the injury here.

Have you ever used a welding tool to join metal parts? Yes
 No

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

Please list all recently taken medications here.

Are you allergic to any medication? Yes
 No

Please list here the medications to which you are allergic.

Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? Yes
 No

Please describe asthma, allergic reaction, or respiratory disease here.

Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease or seizures? Yes
 No

Please describe here any problems that fit that description.

Are you post menopausal? Yes
 No

Are you pregnant? Yes
 No

Has it been more than 28 days since your last menstrual period?

- Yes
- No

Please describe

Are you taking any type of fertility medication or are you having fertility treatments?

- Yes
- No

Please describe

Are you currently breast feeding?

- Yes
- No

Please indicate if you have had any of the following:

Aneurysm clip(s) Yes
 No

Cardiac pacemaker Yes
 No

Implanted cardioverter defibrillator (ICD) Yes
 No

Electronic implant or device Yes
 No

Magnetically-activated implant or device Yes
 No

Neurostimulation system Yes
 No

Spinal cord stimulator Yes
 No

Internal electrodes or wires Yes
 No

Bone growth/bone fusion stimulator Yes
 No

Cochlear, otologic, or other ear implant Yes
 No

Radiation seeds or implants Yes
 No

Swan-Ganz or thermodilution catheter Yes
 No

Insulin or other infusion pump Yes
 No

Can the pump be removed for the scan? Yes
 No

Implanted drug infusion device Yes
 No

Please describe _____

Any type of prosthesis (eye, penile, etc.) Yes
 No

Please describe _____

Heart valve prosthesis Yes
 No

Eyelid spring or wire Yes
 No

Artificial or prosthetic limb Yes
 No

Please describe _____

Metallic stent, filter, or coil Yes
 No

Shunt (spinal or intraventricular) Yes
 No

Please describe _____

Vascular access port and/or catheter Yes
 No

Medication patch (Nicotine, Nitroglycerine) Yes
 No

Patch must be removed. Please describe _____

Any metallic fragment or foreign body Yes
 No

Please describe _____

Wire mesh implant Yes
 No

Tissue expander (e.g., breast) Yes
 No

Surgical staples, clips, or metallic sutures Yes
 No

Please describe _____

Joint replacement (hip, knee, etc.) Yes
 No

Bone/joint pin, screw, nail, wire, plate, etc. Yes
 No

Please describe

IUD, diaphragm, pessary, other semi permanent birth control

- Yes
 No

Type

- Mirena
 Paraguard
 Diaphragm
 Pessary
 Implanon
 I don't know
 Other

Other, please describe

Dentures or partial plates

- Yes
 No

Tattoo or other permanent makeup (including eyeliner)

- Yes
 No

Was this tattoo preformed in the US?

- Yes
 No

Was this tattoo preformed in the last 20 years?

- Yes
 No

Please describe where on the body. Also please describe the size.

Body piercing jewelry

- Yes
 No

Please describe where on the body. Also please describe the size.

Hearing aid

- Yes
 No

Breathing problem or motion disorder

- Yes
 No

Claustrophobia

- Yes
 No

Are you comfortable being scanned? The bore of the magnet is about 70 centimeters in diameter.

- Yes
 No

Any other implant not referenced here

- Yes
 No

Please describe

Please list here all other implants and/or devices

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo (please sign)

Print name

Form completed by

- Self
- Other

Relationship to subject

Principal investigator

LEVEL 2 ONLY

This form has been reviewed and the above subject signed has been deemed safe to undergo the MR procedure.

LEVEL 2 ONLY

Level 2 print name
