University of Texas Imaging Research Center MRI Research Subject Screening Form

Date:___ /___ /___ (Month Day Year)　　Exam Number: ______________

Principal Investigator: ________________________________　　Level 2 User: ________________________________

Name: ________________________________ (Last　First　Middle Initial)　　Age:________ Height: ________ Weight ________lbs

Date of Birth:___ /___ /___ (Month Day Year) Gender: ❑ Male ❑ Female　　Body part to be scanned: ________________________

Address:________________________________ (Street)　　Phone number: ________________________

____________________ (City) ______ (State) ____________ (Zip)

---

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ❑Yes ❑No
   If yes, please indicate the date and type of surgery:

   Date:___ /___ /___ (Month Day Year) Type of surgery: ____

   Date:___ /___ /___ (Month Day Year) Type of surgery: ____

2. Have you had a prior MRI imaging study or examination? ❑Yes ❑No

   If yes, please specify:

   Body Part:________________________ Date:___ /___ (Month Year) Facility:____________________
   Body Part:________________________ Date:___ /___ (Month Year) Facility:____________________
   Body Part:________________________ Date:___ /___ (Month Year) Facility:____________________

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ❑Yes ❑No
   If yes, please describe:____
4. Have you had an injury to the eye involving a metallic object or fragment ❑Yes ❑No
   (e.g., metallic slivers ,shavings, foreign body, etc.)?
   If yes, please describe:____
5. Have you ever been injured by a metallic object/foreign body (e.g., BB, bullet, shrapnel, etc.)? ❑Yes ❑No
   If yes, please describe:____
6. Are you currently taking or have you recently taken any medication or drug? ❑Yes ❑No
   If yes, please list:____
7. Are you allergic to any medication? ❑Yes ❑No
   If yes, please list:____
8. 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
9. 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
   If yes, please describe:____

For female participants only: It is crucial that we find out whether there is any chance that you are pregnant.

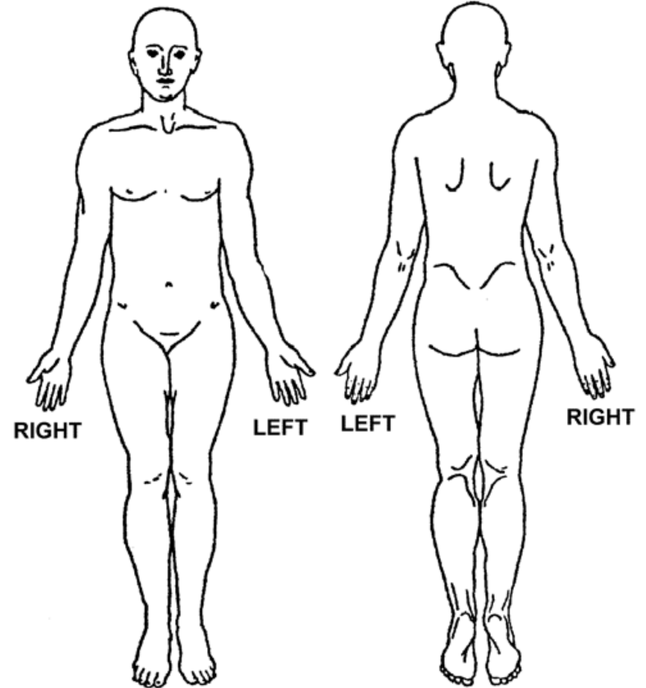
10. Are you post menopausal? ❑Yes ❑No
11. Are you pregnant? ❑Yes ❑No
12. Do any of the following conditions apply:
    Has it been more than 28 days since your last menstrual period? ❑Yes ❑No
    Are you taking any type of fertility medication or are you having fertility treatments? ❑Yes ❑No
13. Are you currently breast feeding? ❑Yes ❑No

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the researcher BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

- ❑Yes ❑No 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 Insulin or other infusion pump
- ❑Yes ❑No Implanted drug infusion device
- ❑Yes ❑No Any type of prosthesis (eye, penile, etc.)
- ❑Yes ❑No Heart valve prosthesis
- ❑Yes ❑No Eyelid spring or wire
- ❑Yes ❑No Artificial or prosthetic limb
- ❑Yes ❑No Metallic stent, filter, or coil
- ❑Yes ❑No Shunt (spinal or intraventricular)
- ❑Yes ❑No Vascular access port and/or catheter
- ❑Yes ❑No Radiation seeds or implants
- ❑Yes ❑No Swan-Ganz or thermodilution catheter
- ❑Yes ❑No Medication patch (Nicotine, Nitroglycerine)
- ❑Yes ❑No Any metallic fragment or foreign body
- ❑Yes ❑No Wire mesh implant
- ❑Yes ❑No Tissue expander (e.g., breast)
- ❑Yes ❑No Surgical staples, clips, or metallic sutures
- ❑Yes ❑No Joint replacement (hip, knee, etc.)
- ❑Yes ❑No Bone/joint pin, screw, nail, wire, plate, etc.
- ❑Yes ❑No IUD, diaphragm, or pessary
- ❑Yes ❑No Dentures or partial plates
- ❑Yes ❑No Tattoo or permanent makeup
- ❑Yes ❑No Body piercing jewelry
- ❑Yes ❑No Hearing aid *(Remove before entering MR system room)*
- ❑Yes ❑No Other implant ________________________
- ❑Yes ❑No Breathing problem or motion disorder
- ❑Yes ❑No Claustrophobia

Please mark on the figures below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the experimenter if you have any questions or concerns BEFORE you enter the MR system room

NOTE: You are required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

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.

Signature of person completing form: ____________________ (Signature) Date: ___ / ___ / ___ (Month Day Year)

Form completed by: ❑Subject ❑Relative ____________________ (Printed Name) ____________________ (Relationship to subject)

Form reviewed by: ____________________ (Signature) ____________________ (Printed Name)