Waisman Brain Imaging Core MRI Screening Form

Date: _____/_____/_____ Administered by: _____

Subject (include middle initial): _____

Study / ID#: _____ PI: _____

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

Weight: _____

Yes *No*

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

___ ___ **Do you wear contact lenses?**

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

___ ___ **Have you ever had a MRI scan?**
Date & Description:_____

___ ___ **Have you ever had surgery or a similar invasive procedure?**
Date & Description:_____

___ ___ **Have you ever had heart surgery?**
Date & Description:_____

___ ___ **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?**

___ ___ **Do you have an IVC (inferior vena cava) filter?**

___ ___ **Have you ever had head or brain surgery?**
Date & Description:_____

___ ___ **Do you have brain aneurysm clips or coils?**

___ ___ **Do you have a VP (ventriculoperitoneal) shunt?**

___ ___ **Have you ever had eye surgery? (Lasik is O.K.)**
Date & Description:_____

___ ___ **Do you have lens implants?**

___ ___ **Do you wear dentures?**

___ ___ **Have you ever had ear surgery?**

___ ___ **Do you have a cochlear implant?**

Yes	*No*	
___	___	**Do you wear a hearing aid?**
___	___	**Have you ever had back surgery?** Date & Description:_____
___	___	**Do you have any implanted devices of any type?** Description:_____
___	___	**Do you have breast or penile implants?**
___	___	**Do you have implanted electrodes?**
___	___	**Do you have a pump or shunt implanted? (e.g., drug infusion device)?**
___	___	**Do you have neurostimulator or biostimulators implanted?**
___	___	**Did you have a colonoscopy or endoscopy in the last 8 weeks? (If so, was anything removed?)** Date & Description:_____
___	___	**Do you have any dental or orthodontic implants? (Fillings are O.K.)** Date & Description:_____
___	___	**Do you have any type of prosthesis?** Date & Description:_____
___	___	**Do you have any type of orthopedic implant (e.g., pins, rods, screws, nails)?** Date & Description:_____
___	___	**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) that can't be removed?** Where? _____
___	___	**Do you have a history of any metal in your body?**
___	___	**Have you every worked as an occupational metal grinder or worked with metal as a hobby?**
___	___	**Do you have metal in your body from an accident?** Description:_____
___	___	**Do you have metal in your body from a surgery?** Description:_____
___	___	**Have you ever sought medical attention for metal in your eyes or had metal fragments removed from your eyes?** Description:_____
___	___	**Have you ever been struck by a gun shot, B.B. or shrapnel? (If BB, did it break the skin?)**
___	___	**Have you ever experienced claustrophobia?**
___	___	**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)? (Mirena, Paragard, Nexplanon are O.K.)** Description:_____

****ANY QUESTIONABLE CONDITIONS MUST BE APPROVED BY THE MR TECHNICAN****