Participant ID: _____
For Internal Use Only

McCausland Center for Brain Imaging
MRI Participant Screening Document

You must properly answer **ALL** the questions on this form to be considered for scanning in the MRI. If you choose not to answer any of the questions, **DO NOT SIGN** this document and inform the researcher that you wish to withdraw from the experiment.

HEIGHT _____ ft _____ in WEIGHT _____ lbs Date of Birth _____ / _____ / _____

1) Participant History

____Yes ____ No Have you ever done metal grinding, welding or machine shop work (job, hobby or student)?

____Yes ____ No Have you ever had an eye injury involving metal objects, or had metal removed from your eye(s) (including metal shavings, slivers, and bullets)?

____Yes ____ No Are you claustrophobic?

____Yes ____ No Do you experience vertigo or other vestibular abnormalities?

2) Participant History

____Yes ____ No Do you have sickle cell anemia?

____Yes ____ No Do you have a medical history of cancer (your history, not family history)?

____Yes ____ No Are you pregnant, possibly pregnant, and/or breast-feeding?
(Date of last menstrual period? _____ / _____ / _____)

3) Do you have any of the following in or on your body?

____Yes ____ No Cardiac Wires or Defibrillator

____Yes ____ No Venous Filters, Baskets or Stents

____Yes ____ No Joint Replacements

____Yes ____ No Fractured bones repaired with metal

____Yes ____ No Implanted Catheter

____Yes ____ No Penile Prosthesis

____Yes ____ No Ear Implant

____Yes ____ No Eye Implants

____Yes ____ No Dental Implants

____Yes ____ No Other Implanted Devices (pacemaker, pain pump, bone stimulator, tissue expander, IUD, etc.)

____Yes ____ No Bullets, BBs, Pellets, Metal Fragments of any kind

Participant ID: _____
For Internal Use Only

4) Do you have any of the following in or on your body?

____Yes ____ No Orthodontic Braces or Permanent Retainer

____Yes ____ No Permanent Makeup (eyeliner, etc.) or Tattoo

Date of Tattoo: _____

Location of Tattoo Parlor: _____

5) Do you have any of the following in or on your body?

____Yes ____ No Artificial limbs

____Yes ____ No Removable dental work

____Yes ____ No Hearing aid (must be removed before entering scan room)

____Yes ____ No Body piercing jewelry

____Yes ____ No Medication patches (including nicotine)

____Yes ____ No Underwire Bra

6) List <u>all</u> past surgical procedures (e.g. Heart Surgery or Brain Surgery):

_____
_____
_____
_____
_____

7) List <u>all</u> allergies (e.g. Latex or Medications):

_____
_____
_____
_____
_____

8a) Have you had an MRI before? ____Yes ____ No

8b) Have you had any clinical scans of your brain, head, and/or neck? ____Yes ____ No

The possible hazards of an MRI scan have been explained to me, and I understand that I can withdraw at this point for any reason, and that I do not have to disclose that reason to the experimenter.

Your signature below indicates that you understand this screening form and attest to its accuracy.

_____ _____
Participant signature **Date**

_____ _____
Witness **Date**