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
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 all past surgical procedures (e.g. Heart Surgery or Brain Surgery):

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

7) List all 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