P.I. _________

Participant

fMRI Safety Screening Form

Name: ______________________________ Phone #: ______________________________

DOB: ______/_______/________ Email: ________________________________

Age: ______ Handedness: (R) / (L) / (A)

Gender: (M) / (F) Race: _________________________________

Weight: ______lbs Native Language: ______________________

Height: ____ft ____in Education (last yr completed): ____________

Please answer the following questions.

Have you ever had a MRI before?	**Y** / **N**
If yes, did you experience any problems with the procedure?	
Have you ever had surgery?	**Y** / **N**
If yes, please describe:	
Have you ever been injured by a metallic object or foreign body (e.g. shrapnel, bullet, BB, etc.)?	**Y** / **N**
If yes, was the projectile removed? Please describe:	

Have you ever done any work with metals (e.g. welding, grinding, etc.)?	Y / N
If yes, did you always wear protective eyewear?	Y / N
Have you been informed of the potential threat to your safety if you have metal in your eyes?	Y / N
Are you confident that your eyes are not at risk?	Y / N
Is there any possibility that you are currently pregnant?	Y / N
Have you recently experienced dizziness, loss of balance or loss of consciousness?	Y / N
Do you have sinus problems?	Y / N
Are you at all claustrophobic?	Y / N
Do you have any breathing problems or motion disorders?	Y / N

Please indicate if you have any of the following...

Aneurysm clip	Y / N
Cardiac pacemaker	Y / N
Implanted Cardioverter Defibrillator (ICD)	Y / N
Electronic implant or device	Y / N
Magnetically activated implant or device	Y / N
Neurostimulation system	Y / N
Spinal cord stimulator	Y / N
Internal electrodes or wires	Y / N
Bone growth/Bone fusion stimulator	Y / N
Cochlear, otologic or other ear implant	Y / N
Insulin or other infusion pump	Y / N
Implanted drug infusion device	Y / N
Any type of prosthesis (eye, penile, etc.)	Y / N
Heart valve prosthesis	Y / N
Eyelid spring or wire	Y / N
Artificial or prosthetic limb	Y / N
Metallic stint, filter or coil	Y / N
Permanent orthodontic retainer	Y / N
Shunt (spinal or intraventricular)	Y / N
Vascular access port and/or catheter or vena cava umbrella	Y / N
Radiation seeds or implants	Y / N
Swan-Ganz or thermodilution catheter	Y / N
Medication patch (nicotine, nitroglycerin, birth control)	Y / N
Any metallic fragment or foreign body	Y / N
Wire mesh implant	Y / N
Tissue expander (e.g. breast)	Y / N
Surgical staples, clips, or metallic sutures	Y / N
Joint replacement (hip, knee, etc.)	Y / N
Bone/ Joint pin, screw, nail, wire, plate, etc.	Y / N

Please indicate if you have any of the following...

Tubal ligation with titanium	Y / N
Are you using an IUD?	Y / N
If yes, what kind?	
Braces, Dentures, or Partial Plates	Y / N
Tattoo above the belly button or permanent make-up	Y / N
Body piercing jewelry	Y / N
Hearing aid	Y / N
Other implant	Y / N
If yes, please describe:	
Colored contact lenses	Y / N
Hairpiece/ wig/ toupee	Y / N
Aneurysm	Y / N
Seizures	Y / N
Other neurological disease or disorder (ex. Stroke, Parkinson's, etc...)	Y / N
Severe and active hearing impairment	Y / N
Meniere's disease	Y / N
Hearing loss/ Tinnitus	Y / N
Are you confident that you are not wearing clothing containing silver microfiber threads, typically used in exercise, anti-odor, and anti-microbial clothing? For example: Lululemon, Athleta, Omniheat, Columbia, etc	**Y / N**
Are you wearing magnetic eyelashes?	**Y / N**

Do you have any questions or concerns pertaining to your participation and safety?

____

____

____

____

____

Please be advised that you must remove all make up and all metal objects (underwire bra, jewelry, piercings, etc.)

Signature	**Date**
Screener Signature	**Session ID**