

UCSB BRAIN IMAGING CENTER MAGNET SCREENING FORM

Date ____/____/____

Subject Number _____

Name _____ Age _____ Height _____ Weight _____
Last name First name Middle Initial

Date of Birth ____/____/____ Male Female
month day year

Address _____ Telephone (home) (____) ____-____

City _____

State _____ Zip Code _____

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

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

3. Have you experienced any problem related to a previous MRI examination or MR procedure? No Yes
If yes, please describe: _____

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? No Yes

If yes, please describe: _____

5. Have you ever done any welding, grinding or cutting of metal in your lifetime? No Yes

6. Did you wear safety protection for your eyes? No Yes

7. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? No Yes
If yes, please describe: _____

For Female Volunteers:

8. Are you currently pregnant or is there any possibility that you may be pregnant (e.g., late menstrual period)? No Yes

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If you have any question regarding an implant, device, or possible metal object, please discuss this with the MRI Technologist or Researcher BEFORE entering the MRI room.

Please indicate if you have any of the following:

- Yes No Dentures or partial plates
- Yes No Head or Neck Tattoo or Permanent Makeup
- Yes No Body piercing jewelry
- Yes No IUD or diaphragm
- Yes No Electronic implant or device

If yes, which of the following apply:

- Magnetically-activated implant or device
- Cardiac pacemaker
- Implanted cardioverter defibrillator (ICD)
- Aneurysm clip(s)
- Neurostimulation system
- Spinal cord stimulator
- Internal electrodes or wires
- Bone growth/bone fusion stimulator
- Cochlear, otologic, or other ear implant
- Insulin or infusion pump
- Implanted drug infusion device
- Any type of prosthesis (eye, penile, etc.)
- Heart valve prosthesis
- Eyelid spring or wire
- Artificial or prosthetic limb
- Metallic stent, filter, or coil
- Shunt (spinal or intraventricular)
- Vascular access port and/or catheter
- Wire mesh implant
- Surgical staples, clips, or metallic sutures
- Joint replacement (hip, knee, etc.)
- Bone/joint pin, screw, nail, wire, plate, etc.
- Radiation seeds or implants

- Yes No Medication patch (Nicotine, Nitroglycerine)
- Yes No Any metallic fragment or foreign body
- Yes No Hearing aid **(Remove before entering MR system room)**

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have 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 _____ Date ____/____/____
Signature

Form Completed By _____
Print name Relationship to person entering magnet room

Form Information Reviewed By _____
Print name Signature