UCSB BRAIN IMAGING CENTER MAGNET SCREENING FORM

Date ____/____/_____ Subject ID (place sticker here):

Name _____
First name Last name Middle Initial

Date of Birth_____/_____/_____ Age _____ Height _____ Weight _____

Sex (Assigned at birth) Male ❒ Female ❒

Gender _____

Address _____

City _____ State _____

Zip Code _____

Email Address _____

Phone Number (_____) _____ - _____

❒ Hispanic or Latino
❒ Not Hispanic or Latino

❒ White
❒ Native American / Alaskan Native
❒ Asian
❒ Native Hawaiian / Pacific Islander
❒ Black
❒ More than one race

1. Have you ever had a surgery/operation (e.g. arthroscopy, endoscopy, etc.) of any kind? ❒ No ❒ Yes
   If yes, please describe _____
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? ❒ 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
5. Have you ever done any welding, grinding, or cutting of metal in your lifetime? ❒ No ❒ Yes
   5a. Did you wear safety protection for your eyes? ❒ No ❒ Yes
6. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? If yes, please describe _____ ❒ No ❒ Yes
8. Are you wearing any silver or copper material lined clothing? (Lululemon, Under Armor, etc.) ❒ No ❒ Yes
9. **Do you have any other type of implant in your body not covered by the above list?** ❒ No ❒ Yes
   If yes, type of implant _____
10. Do you have a history of migraines? ❒ No ❒ Yes

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

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:

❒ No ❒ Yes Dentures, partial plates, or dental retainers
❒ No ❒ Yes Head or Neck Tattoo or Permanent Makeup
❒ No ❒ Yes Body piercing jewelry
❒ No ❒ Yes IUD, diaphragm, or pessary
❒ No ❒ Yes Electronic implant or device

❒ No ❒ Yes Implanted cardioverter defibrillator (ICD)
❒ No ❒ Yes Magnetically activated implant or device
❒ No ❒ Yes Neurostimulation system
❒ No ❒ Yes Internal electrodes or wires
❒ No ❒ Yes Cochlear, otologic, or other ear implant
❒ No ❒ Yes Implanted drug infusion device
❒ No ❒ Yes Heart valve prosthesis
❒ No ❒ Yes Artificial or prosthetic limbs
❒ No ❒ Yes Shunt (spinal or intraventricular)
❒ No ❒ Yes Surgical staples or metallic structures
❒ No ❒ Yes Bone/joint pin, screw, nail, wire, plate, etc.
❒ No ❒ Yes Radiation seeds or implants

❒ No ❒ Yes Cardiac pacemaker
❒ No ❒ Yes Aneurysm clip(s)
❒ No ❒ Yes Spinal cord stimulator
❒ No ❒ Yes Bone growth/bone fusion stimulator
❒ No ❒ Yes Insulin or infusion pump
❒ No ❒ Yes Any type of prosthesis (eye, penile, etc.)
❒ No ❒ Yes Eyelid spring or wire
❒ No ❒ Yes Metallic stent, filter, or coil
❒ No ❒ Yes Vascular access port and/or catheter
❒ No ❒ Yes Wire mesh implant
❒ No ❒ Yes Joint replacement (hip, knee, etc.)
❒ No ❒ Yes Tissue expander (e.g., breast)

❒ No ❒ Yes Medication patch (Nicotine, Nitroglycerine, Contraceptive, Menopause, any transdermal patch)
❒ No ❒ Yes Any metallic fragment or foreign body
❒ No ❒ Yes Any transdermal patch
❒ No ❒ Yes External glucose / blood sugar monitor?
❒ No ❒ Yes Are you here for an MRI scan?
❒ No ❒ Yes Hearing issues (loss, sensitivity, previous excessive noise exposure, or use of hearing aid)
If yes, please describe (and remove hearing aid before entering MR system room):
_____
❒ No ❒ Yes Tinnitus (ringing, clicking, buzzing in one or both ears that may be constant or may come and go)
If yes, please describe (frequency/duration): _____

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.

You will be required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

Signature of Person Completing Form _____ Date ____/_____/____
Signature

Signature Form Completed by _____ _____
Print Name Relationship to person entering MRI (self, parent, etc.)

Form Information Reviewed by _____ Date ____/_____/____