MRI Contraindications Screening Sheet

Date: ________________

Subject ID: (to be completed by investigator; do not write subject name)__________________________

Gender:  M   F

Do you have any metal in your body? __________________________________________________________

1. Do you have any metal plates__, pins__, wires__, screws__, a joint replacement__, or anything that might have been inserted during an operation? If yes, describe: ______________________________

2. Do you have an artificial limb? Yes  No  If yes, is it removable? Yes  No

3. Have you had heart or blood vessel surgery? Yes  No  If yes, do you have any of the following: pacemaker__, cerebral arteriogram__, stent__, or any metal implants related to the heart or blood vessel surgery__?

4. Have you ever worked with metals, e.g. metallurgy, metal shaving, welding, soldering, etc.? If yes, describe: ____________________________________________________________

5. Have you ever been injured as a result of metal work? Yes  No

6. Have you ever been wounded by anything metal, e.g. a bullet, shrapnel, metal filing? If yes describe: ____________________________________________________________

7. Do you have hearing problems? Yes  No  If yes, do you have any of the following: Hearing aid__, removable  non-removable, cochlear implant__, ear surgery___________________?

8. Have you ever had heart or blood vessel surgery? Yes  No  If yes, do you have any of the following: pacemaker__, cerebral arteriogram__, stent__, or any metal implants related to the heart or blood vessel surgery__?

9. Do you have tattoos or permanent cosmetics (lipstick, lip liner, eye liner)? Yes  No

10. Do you have any piercings? Yes  No

11. Do you wear colored contacts? Yes  No  If yes, do you also have non-colored contacts? Yes  No

12. Do you have dental bridges or dental plates? Yes  No  If yes, are they removable? Yes  No

13. Do you have metal caps? Yes  No  Approximately how many? ______

14. Do you have any non-removable metal in your mouth besides fillings? Yes  No  If yes, describe: ____________________________________________________________

15. Do you have fillings? Yes  No  If so, how many? ______

16. Have you ever been told you can’t have a MRI or fMRI for any reason? Yes  No  If yes, what was the reason? ____________________________________________

17. Have you ever been claustrophobic or afraid of small spaces? If yes, describe:

Women only:

1. Are you pregnant? Yes  No

2. Do you have an IUD? Yes  No

3. Results of pregnancy test______________________

Signature of person administering screening: ____________________________________________