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HEALTHEmotions
RESEARCH INSTITUTE
UNIVERSITY OF WISCONSIN

# HealthEmotions Research Institute - MRI Screening Form

Date:____/____/____ Administered by: _____

Subject (include middle initial): _____

Study / ID#:_____ PI: _____

Sex: Female Male Age:_____ Weight:_____ Date of Birth: ____/____/____

| *Yes* | *No* | |
|---|---|---|
| ☐ | ☐ | **Do you have corrected vision?** Do you know your vision rating or prescription? _____ |
| ☐ | ☐ | **Do you wear contact lenses?** |
| ☐ | ☐ | **Do you use transdermal patches (nicotine) or any type of medicated adhesive?** |
| ☐ | ☐ | **Have you ever had a MRI scan?** Date & Description: _____ |
| ☐ | ☐ | **Have you ever had surgery or a similar invasive procedure?** Date & Description: _____ |
| ☐ | ☐ | **Have you ever had heart surgery?** Date & Description: _____ |
| ☐ | ☐ | **Do you have a Pacemaker?** |
| ☐ | ☐ | **Do you have an implanted cardiac defibrillator?** |
| ☐ | ☐ | **Do you have cardiac pacing wires?** |
| ☐ | ☐ | **Do you have implanted electrodes, retained leads, or wires?** |
| ☐ | ☐ | **Do you have an artificial heart valve or stent?** |
| ☐ | ☐ | **Do you have an IVC (inferior vena cava) filter?** |
| ☐ | ☐ | **Have you ever had head or brain surgery?** Date &Description: _____ |
| ☐ | ☐ | **Do you have brain aneurysm clips or coils?** |
| ☐ | ☐ | **Do you have a VP (ventriculoperitoneal) shunt?** |
| ☐ | ☐ | **Have you ever had eye surgery? (Lasik is O.K.)** Date &Description: _____ |
| ☐ | ☐ | **Do you have lens implants?** |
| ☐ | ☐ | **Do you wear dentures?** |
| ☐ | ☐ | **Have you ever had ear surgery?** |
| ☐ | ☐ | **Do you have a cochlear implant or stapes prosthesis?** |
| ☐ | ☐ | **Do you wear a hearing aid?** |
| ☐ | ☐ | **Have you ever had back surgery?** Date & Description: _____ |
| ☐ | ☐ | **Do you have any implanted devices of any kind?** Description: _____ |

| Yes | No | |
|---|---|---|
| ☐ | ☐ | **Do you have breast or penile implants?** |
| ☐ | ☐ | **Do you have tissue expanders?** |
| ☐ | ☐ | **Do you have implanted electrodes?** |
| ☐ | ☐ | **Do you have a pump or shunt implanted? (e.g., drug infusion device)?** |
| ☐ | ☐ | **Do you have neurostimulator or biostimulators implanted?** |
| ☐ | ☐ | **Did you have a colonoscopy or endoscopy in the last 8 weeks? (If so, was anything removed?)** Date & Description: _____ |
| ☐ | ☐ | **Do you have any dental or orthodontic implants? (Fillings are O.K.)** Date & Description: _____ |
| ☐ | ☐ | **Do you have any type of prosthesis?** Date & Description: _____ |
| ☐ | ☐ | **Do you have any type of orthopedic implant (e.g., pins, rods, screws, nails)?** Date & Description: _____ |
| ☐ | ☐ | **Do you have any permanent cosmetics (e.g., eyeliner) or have you ever had hair extensions or weaves?** |
| ☐ | ☐ | **Do you have any tattoos on your upper body?** Where/Extent? _____ |
| ☐ | ☐ | **Do you have any body piercing(s) that can't be removed? Do you have any permanent jewelry?** Where? _____ |
| ☐ | ☐ | **Do you have a history of any metal in your body?** |
| ☐ | ☐ | **Have you ever worked as an occupational metal grinder or worked with metal as a hobby?** |
| ☐ | ☐ | **Do you have metal in your body from an accident?** Description: _____ |
| ☐ | ☐ | **Do you have metal in your body from a surgery?** Description: _____ |
| ☐ | ☐ | **Have you ever sought medical attention for metal in your eyes or had metal fragments removed from your eyes?** Description: _____ |
| ☐ | ☐ | **Have you ever been struck by a gun shot, B.B. or shrapnel? (If BB, did it break the skin?)** |
| ☐ | ☐ | **Have you ever experienced claustrophobia?** |
| ☐ | ☐ | **Do you have sleep apnea or trouble breathing when you sleep?** |
| ☐ | ☐ | **Do you have any back problems that would prevent you from lying still for up to 2 hours?** |
| | | **Day of Scan (Adult):** |
| ☐ | ☐ | **Did you or will you take medicine for claustrophobia? If yes, do you or will you have a driver?** |
| ☐ | ☐ | **Have you ingested alcohol or other drugs in the last 4 (four) hours?** |
| | | **Day of Scan (Adolescent):** |
| ☐ | ☐ | **Have you taken medication that affects your ability to play a video game or do schoolwork?** |
| | | **Female Subjects:** |
| ☐ | ☐ | **Are you or is there a chance you are pregnant?** |
| ☐ | ☐ | **Do you have an intrauterine device (IUD)? If yes, was the procedure done in the United States?** Description: _____ |

****ANY QUESTIONABLE CONDITIONS MUST BE APPROVED BY THE MRI TECHNICAN****