

Yes No

Do you wear a hearing aid?

Have you ever had back surgery?

Date & Description: _____

Do you have any implanted devices of any type, including implantable birth control?

Description: _____

Do you have breast or penile implants?

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)?

Do you have any tattoos on your upper body?

Where/Extent? _____

Do you have any body piercing(s) that can't be removed?

Where? _____

Do you have a history of any metal in your body?

Have you every 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 any back problems that would prevent you from lying still for up to 2 hours?

Female Subjects:

Are you or is there a chance you are pregnant?

Do you have an intrauterine device (IUD)? (Mirena & Skyla are O.K.)

Description: _____

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