



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 | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have corrected vision? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you know your vision rating or prescription? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear contact lenses? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use transdermal patches (nicotine) or any type of medicated adhesive? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a MRI scan? |
| | | Date & Description: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had surgery or a similar invasive procedure? |
| | | Date & Description: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had heart surgery? |
| | | Date & Description: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a Pacemaker? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have an implanted cardiac defibrillator? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have cardiac pacing wires? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have implanted electrodes, retained leads, or wires? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have an artificial heart valve or stent? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have an IVC (inferior vena cava) filter? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had head or brain surgery? |
| | | Date & Description: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have brain aneurysm clips or coils? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a VP (ventriculoperitoneal) shunt? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had eye surgery? (Lasik is O.K.) |
| | | Date & Description: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have lens implants? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear dentures? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had ear surgery? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a cochlear implant or stapes prosthesis? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear a hearing aid? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you even had back surgery? |
| | | Date & Description: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 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)?
- 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 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: _____