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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?** 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: _____