UCSB BRAIN IMAGING CENTER MAGNET SCREENING FORM

Date ____/____/_______ Subject ID (place sticker here):

Name ________________________________ ________________________________

First name Last name Middle Initial

Date of Birth ____/____/_______ Age ______ Height ______ Weight ______

Sex (Assigned at birth)   Male ☐    Female ☐

Gender ______________________

Address ________________________________________________________________

City ________________________________ State ______

Zip Code ______

Email Address ____________________________________________________________

Phone Number (_______) _______ - _______

1. Have you ever had a surgery/operation (e.g. arthroscopy, endoscopy, etc.) of any kind? If yes, please describe __________________________________________

   ☐ No ☐ Yes

2. Have you had a prior diagnostic imaging study or examination with MRI?

   ☐ No ☐ Yes

3. Have you experienced any problem related to a previous MRI examination? If yes, please describe __________________________________________

   ☐ No ☐ Yes

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)

   ☐ No ☐ Yes

5. Have you ever done any welding, grinding, or cutting of metal in your lifetime?

   5a. Did you wear safety protection for your eyes?

   ☐ No ☐ Yes

6. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? If yes, please describe __________________________________________

   ☐ No ☐ Yes

8. Are you wearing any silver or copper material lined clothing? (Lululemon, Under Armor, etc.)

   ☐ No ☐ Yes

9. Do you have any other type of implant in your body not covered by the above list? If yes, type of implant ________________________________

   ☐ No ☐ Yes

10. Do you have a history of migraines?

    ☐ No ☐ Yes

For Female Volunteers: Are you currently pregnant or is there any possibility that you may be pregnant? (e.g., late menstrual period)

    ☐ No ☐ Yes
If you have any question regarding an implant, device, or possible metal object, please discuss this with the MRI Technologist or Researcher BEFORE entering the MRI room.

Please indicate if you have any of the following:

- □ No  □ Yes  Dentures, partial plates, or dental retainers
- □ No  □ Yes  Head or Neck Tattoo or Permanent Makeup
- □ No  □ Yes  Body piercing jewelry
- □ No  □ Yes  IUD, diaphragm, or pessary
- □ No  □ Yes  Electronic implant or device
- □ No  □ Yes  Implanted cardioverter defibrillator (ICD)
- □ No  □ Yes  Magnetically activated implant or device
- □ No  □ Yes  Neurostimulation system
- □ No  □ Yes  Internal electrodes or wires
- □ No  □ Yes  Cochlear, otologic, or other ear implant
- □ No  □ Yes  Implanted drug infusion device
- □ No  □ Yes  Heart valve prosthesis
- □ No  □ Yes  Artificial or prosthetic limbs
- □ No  □ Yes  Shunt (spinal or intraventricular)
- □ No  □ Yes  Surgical staples or metallic structures
- □ No  □ Yes  Bone/joint pin, screw, nail, wire, plate, etc.
- □ No  □ Yes  Radiation seeds or implants
- □ No  □ Yes  Cardiac pacemaker
- □ No  □ Yes  Aneurysm clip(s)
- □ No  □ Yes  Spinal cord stimulator
- □ No  □ Yes  Bone growth/bone fusion stimulator
- □ No  □ Yes  Insulin or infusion pump
- □ No  □ Yes  Any type of prosthesis (eye, penile, etc.)
- □ No  □ Yes  Eyelid spring or wire
- □ No  □ Yes  Metallic stent, filter, or coil
- □ No  □ Yes  Vascular access port and/or catheter
- □ No  □ Yes  Wire mesh implant
- □ No  □ Yes  Joint replacement (hip, knee, etc.)
- □ No  □ Yes  Tissue expander (e.g., breast)
- □ No  □ Yes  Medication patch (Nicotine, Nitroglycerine, Contraceptive, Menopause, any transdermal patch)
- □ No  □ Yes  Any metallic fragment or foreign body
- □ No  □ Yes  Any transdermal patch
- □ No  □ Yes  Are you here for an MRI scan?
- □ No  □ Yes  Hearing issues (loss, sensitivity, previous excessive noise exposure, or use of hearing aid)
  
  If yes, please describe (and remove hearing aid before entering MR system room):
  __________________________________________________________________________________
- □ No  □ Yes  Tinnitus (ringing, clicking, buzzing in one or both ears that may be constant or may come and go)
  
  If yes, please describe (frequency/duration): ________________________________________________

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

You will be required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

Signature of Person Completing Form ______________________________ Date ____/____/____

Signature Form Completed by __________________________ Date ____/____/____

Print Name __________________________ Relationship to person entering MRI (self, parent, etc.)

Form Information Reviewed by __________________________ Date ____/____/____

Print Name