UCSB BRAIN IMAGING CENTER MAGNET SCREENING FORM

Revised 10/13/2021

Date___/___/______ Subject ID (place sticker here): ______

Name____________________________________

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 or operation (e.g., arthroscopy, endoscopy, etc.) of any kind? □ 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? □ NO □ YES

6. Did you wear safety protection for your eyes? □ NO □ YES

7. 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? (e.g., Lululemon, Under Armor) □ 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

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 or partial plates
- No [ ] Yes [ ] Head or Neck Tattoo or Permanent Makeup
- No [ ] Yes [ ] Body piercing jewelry
- No [ ] Yes [ ] IUD or diaphragm
- No [ ] Yes [ ] Electronic implant or device

**If yes, which of the following apply:**

- Magnetically-activated implant or device
- Implant cardioverter defibrillator (ICD) Aneurysm clip(s)
- Neurostimulation system
- Internal electrodes or wires
- Cochlear, otologic, or other ear implant
- Implanted drug infusion device
- Heart valve prosthesis
- Artificial or prosthetic limbs
- Shunt (spinal or intraventricular)
- Surgical staples, clips, or metallic sutures
- Bone/joint pin, screw, nail, wire, plate, etc.
- Medication patch (Nicotine, Nitroglycerine, Contraceptive, any transdermal patch)
- Any metallic fragment or foreign body
- Any transdermal patch
- Hearing issues (loss, sensitivity to loud noises, history of tinnitus, job with high noise exposure, use of hearing aid) If yes, please describe: ____________________________
- Tinnitus (e.g., ringing, clicking, buzzing in one or both ears that may be constant or may come and go) If yes, please describe (record 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.

**NOTE:** You may be advised or 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

Signature Form Completed by __________________________

Print Name __________________________ Relationship to person entering MRI

Form Information Reviewed by __________________________