The MR suite contains a very strong magnet. Some metal objects can interfere with your scan or even be dangerous. Before you are allowed to enter, we must know if you have any metal objects in your body or have experienced any of the conditions listed below. Please answer the following:

<table>
<thead>
<tr>
<th>Metal fragments in your eye</th>
<th>Tissue expander (Breast)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac pacemaker</td>
<td>Aneurysm clip</td>
</tr>
<tr>
<td>Any type of internal electrode(s) Pacing wires, Cochlear Implant, etc...</td>
<td>Implanted insulin pump</td>
</tr>
<tr>
<td>Swan-Ganz catheter</td>
<td>Halo vest or metallic cervical fixation device</td>
</tr>
<tr>
<td>Hearing aid</td>
<td>Any type of intravascular coil, filter or stent</td>
</tr>
<tr>
<td>Implanted drug injection device</td>
<td>Any type of foreign body, shrapnel or bullet</td>
</tr>
<tr>
<td>Heart valve prosthesis</td>
<td>Any type of ear implant</td>
</tr>
<tr>
<td>Penile prosthesis</td>
<td>Any type of surgical clip or staple</td>
</tr>
<tr>
<td>Vascular access port</td>
<td>Intraventricular shunt</td>
</tr>
<tr>
<td>Artificial limb or joint</td>
<td>Dentures or braces</td>
</tr>
<tr>
<td>Diaphragm (in place), IUD</td>
<td>Latex allergies</td>
</tr>
<tr>
<td>Neurostimulator</td>
<td>Wire mesh</td>
</tr>
<tr>
<td>Any type of electronic, mechanical or magnetic implant</td>
<td>Implanted cardiac defibrillator</td>
</tr>
<tr>
<td>Any implanted orthopedic items (e.g. pins, rods, screws, nails, clips, plates, wire, etc...)</td>
<td>Medication patch</td>
</tr>
<tr>
<td>Tattoo or tattooed makeup, such as eyeliner</td>
<td>Amateur or prison tattoo</td>
</tr>
<tr>
<td>Sickle cell anemia/Parkinson/Dementia/Alzheimer’s</td>
<td>Epilepsy/seizure</td>
</tr>
</tbody>
</table>

**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. Do not enter the MR environment if you have any questions or concerns regarding an implant, device, or object. Consult with the MR Technologist BEFORE entering the MR environment if you have any concerns. The MR system is Always on.
### Magnetic Resonance Screening Form

If you are female: Do you suspect that you are pregnant?

- [ ] Yes
- [ ] No
- [ ] N/A

Have you ever had surgery?

- [ ] Yes
- [ ] No

If you have had surgery, were any metal, metallic, and/or medical devices implanted?

- [ ] Yes
- [ ] No

Have you ever been injured by any metallic foreign body (e.g., bullet, BB, shrapnel, etc)?

- [ ] Yes
- [ ] No

Have you ever had an eye injury involving a metal object, such as metallic slivers, shavings, foreign body, etc.?

- [ ] Yes
- [ ] No

**Date of Birth (MM/DD/YYYY)**  **Weight (Pounds)**  **Height (Feet, Inches)**

**IMPORTANT INSTRUCTIONS FOR YOUR SAFETY**

*Before entering the MR environment you must remove all metallic objects including hearing aids, dentures, removable partial plates, keys, beeper, mobile phone, eyeglasses, hair pins, barrettes, jewelry, body piercing, watch, safety pins, paper clips, money clips, credit cards, bank cards, magnetic strip cards, coins, pens, pocketknife, nail clipper, tools, shoes, clothing with metal fasteners (excluding pants & bra).*

I attest that the above information is correct to the best of my knowledge. I have read and understand the 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.

Signature of Person Completing Form:  ____________________________

Date (MM/DD/YYYY):  ____________________________

Form Completed by:  [ ] Participant  [ ] Relative

If relative, print your name:  ____________________________

State your relationship to participant:  ____________________________

For Office Use Only

Notes on any checked items:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

For Experimenter Use Only:

Name of Project:  ____________________________

Principal Investigator:  ____________________________

Researcher(s):  ____________________________

Person obtaining screening:  ____________________________

Screening date & time:  ____________________________