PARTICIPANTS WITH ANY HISTORY OF IMPLANTS MUST BE APPROVED BY THE MRI SAFETY OFFICER BEFORE A MRI SCAN MAY BE PERFORMED WITHOUT EXCEPTION.

UCDAVIS IMAGING RESEARCH CENTER PRE-MRI SCREENING FORM

Date _____/_____/_____ | **Principal Investigator:** _____

Name _____ Height _____ Weight _____
Last name First name M.I.

Birth Date _____

1. Have you ever had surgery or similar invasive procedure in which medical devices may have been implanted? No ☐ Yes ☐
   If yes, please list:
   Type:_____ Date: _____/____/_____
   Type:_____ Date: _____/____/_____

2. Have you had any previous MRI imaging studies? No ☐ Yes ☐
   If yes, please list:

Body part	Date	Facility Location
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____
_____	_____/_____/_____	_____

3. Have you ever worked with metal (grinding, fabricating, etc.) or ever had an injury to the eye involving a metallic object (e.g., metallic slivers, shavings, shrapnel, foreign body)? No ☐ Yes ☐
   If yes, please describe: _____

For female subjects only:

4. Are you pregnant, or is there a possibility that you are pregnant? (if unsure, please notify MRI operator or Principal Investigator) No ☐ Yes ☐
5. Are you breast feeding? No ☐ Yes ☐ 6. Date of last menstrual period: _____/____/_____
7. Are you taking any type of fertility medication or having fertility treatments? No ☐ Yes ☐
8. Are you taking oral contraceptives or receiving hormone treatment? No ☐ Yes ☐

9. Are you currently taking or have you recently taken any medication? No ☐ Yes ☐
   If yes, please list: _____
10. Do you have anemia or any diseases that affect your blood, or a history of renal disease? No ☐ Yes ☐
    If yes, please list: _____
11. Do you have a history of seizure disorder or epilepsy? No ☐ Yes ☐
12. Do you have any drug allergies? No ☐ Yes ☐
    If yes, please list: _____
13. Have you ever had asthma, allergic reaction, respiratory disease, or any type of reaction to a contrast medium or dye used for an MRI or CT examination? No ☐ Yes ☐
    If yes, please describe: _____

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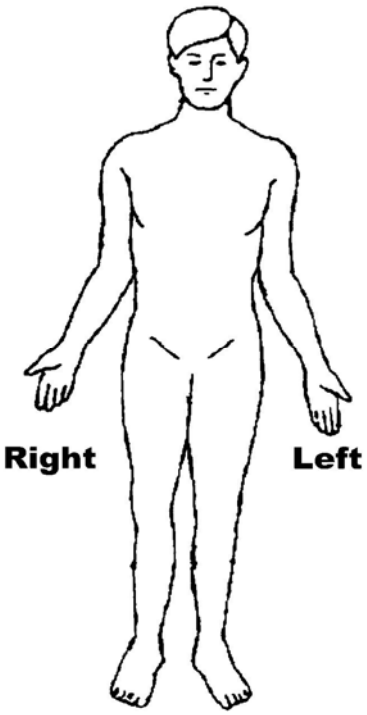
Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following. Do you have any of the following:

Yes ☐	No ☐	Dental Hardware (e.g. metal crowns, braces, retainers)
Yes ☐	No ☐	Cardiac pacemaker
Yes ☐	No ☐	Implanted cardiac defibrillator
Yes ☐	No ☐	Aneurysm clip(s)
Yes ☐	No ☐	Carotid artery vascular clamp
Yes ☐	No ☐	Neurostimulator
Yes ☐	No ☐	Insulin or infusion pump
Yes ☐	No ☐	Implanted drug infusion device
Yes ☐	No ☐	Bone growth/fusion stimulator
Yes ☐	No ☐	Cochlear, otologic, or implant
Yes ☐	No ☐	Any type of prosthesis (eye, penile, etc.)
Yes ☐	No ☐	Heart valve prosthesis
Yes ☐	No ☐	Artificial limb or joint
Yes ☐	No ☐	Electrodes (on body, head, or brain)
Yes ☐	No ☐	Intravascular stents, filters, or coils
Yes ☐	No ☐	Shunt (spinal or intraventricular)
Yes ☐	No ☐	Vascular access port and/or catheter
Yes ☐	No ☐	Swan-Ganz catheter
Yes ☐	No ☐	Any implant held in place by a magnet
Yes ☐	No ☐	Transdermal Patch Delivery System (e.g. Nicotine,) (**Remove before MRI)**
Yes ☐	No ☐	IUD or diaphragm
Yes ☐	No ☐	Tattooed makeup (eyeliner, lips, etc.)
Yes ☐	No ☐	Body piercing(s) (**Remove before MRI)**
Yes ☐	No ☐	Any metal fragments (including bullets, shrapnel)
Yes ☐	No ☐	Internal pacing wires
Yes ☐	No ☐	Aortic clip
Yes ☐	No ☐	Metal or wire mesh implants
Yes ☐	No ☐	Wire sutures or surgical staples
Ye ☐	No ☐	Harrington rods (spine)
Yes ☐	No ☐	Metal rods in bones
Yes ☐	No ☐	Joint replacement_____
Yes ☐	No ☐	Bone/joint in, screw, nail, wire, plate
Yes ☐	No ☐	Hearing aid **(Remove before MRI)**
Yes ☐	No ☐	Dentures **(Remove before MRI)**
Yes ☐	No ☐	Breathing disorder
Yes ☐	No ☐	Movement disorder
Yes ☐	No ☐	Claustrophobia
Yes ☐	No ☐	Anxiety

Other, please explain _____

Please mark on the figure below, the location of any implant or metal inside of or on your body.



Before your MRI, please **remove all metallic objects** including keys, hair pins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife, & clothing with metal in the material.

NOTE: YOU ARE REQUIRED TO WEAR EARPLUGS OR EARPHONES DURING THE MRI EXAMINATION.

_____ Date_____/_____/_____

Signature/Printed name of Person Completing Form

Form completed by: ☐ Patient/Subject ☐ Relative: _____

Name & relationship to patient

☐ Physician or other: _____

Name & relationship to patient

_____/_____ Date_____/_____/_____

Signature/Printed name of Person Reviewing Form