

Athinoula A. Martinos Imaging Center
Subject / Volunteer Screening Form
 (This form is to be used for imaging only)

Name: _____ Date: _____

Date of Birth: _____ Weight: _____

Race/Ethnicity: _____ Gender: _____

Type of Exam: _____ Principal Investigator: _____

I have / had / am	YES	NO	IF YES, Please Explain
History of Head Trauma	_____	_____	_____
Surgical Aneurysm Clips	_____	_____	_____
Cardiac Pacemaker	_____	_____	_____
Prosthetic Heart Valve	_____	_____	_____
Neurostimulator	_____	_____	_____
Implanted Pumps	_____	_____	_____
Cochlear Implants	_____	_____	_____
Metal rods, Plates, Screws	_____	_____	_____
Previous Surgery	_____	_____	_____
IUD	_____	_____	_____
Hearing Aid, Dentures	_____	_____	_____
Injury to eye (metal??)	_____	_____	_____
Pregnant	_____	_____	_____
Currently breast feeding	_____	_____	_____
Meniere's Disease	_____	_____	_____
Tattoos	_____	_____	_____
Nicotine Patch (or other foil backed patch)	_____	_____	_____
Dental Implants / Braces	_____	_____	_____

I have received a copy of the informed consent document(s) for this study: _____
 (initial)

All subjects **MUST** wear either ear plugs or headphones during any imaging

I hereby agree to have a nuclear magnetic resonance study.

Signature: _____ Date: _____

Witnessed by: _____ Date: _____

To be filled out by investigator: IRB Protocol # _____ IRB Expiration Date: _____ Rescan _____
