

**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: \_\_\_\_\_

<b>I have / had / am</b>	<b>YES</b>	<b>NO</b>	<b>IF YES, Please Explain</b>
History of Head Trauma / Surgery	_____	_____	_____
Surgical Aneurysm Clips	_____	_____	_____
Cardiac Pacemaker	_____	_____	_____
Prosthetic Heart Valve	_____	_____	_____
Neurostimulator	_____	_____	_____
Implanted Pumps	_____	_____	_____
Cochlear Implants	_____	_____	_____
Metal rods, Plates, Screws	_____	_____	_____
Previous Surgery	_____	_____	_____
Intrauterine Device (IUD)	_____	_____	_____
Hearing Aid, Dentures	_____	_____	_____
Injury to eye (metal?)	_____	_____	_____
Pregnant	_____	_____	_____
Body Piercings	_____	_____	_____
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 _____
---