Cornell Magnetic Resonance Imaging Facility
MRI Safety Questionnaire for Research Subject

Month Day Year Last First Middle Initial

Date _ _ /_ _ /_ _ **Name** _____ **Gender** ___

Height_____ **Weight** _____ **Age**_____ **Are you aged 11 or older? Y/N**

Email _____ **Phone Number** _____ **Subject ID #** _____

Please read the following questions carefully. It is very important for us to know if you have any metal devices or parts anywhere in or on your body. Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR environment. If you do not understand a question, please ask us to explain.

Do not enter the MR system room or MR environment if you have any questions or concerns regarding an implant, device, or object. Consult the MRI Technologist or Researcher BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Remove ALL METALLIC OBJECTS before entering the MR environment, including hearing aids, dentures, partial plates, belts/buckles, keys, beeper, wallet/money clips, cell phone, eyeglasses, colored contact lenses, hairpins/barrettes/safety pins, jewelry/piercings, wigs/hairpiece/extensions, watch, underwire bra, pocket knife, radio relays, or stethoscopes. If your clothing has metal on it (large zippers, studs, buckles) we can provide you with alternate clothing for the period you are in the MR scanner. Also remove EVERYTHING from your pockets, especially metal (e.g., coins, clips, pens/pencils, pins) and magnetic strip cards (e.g., credit cards, bank cards, bus cards, store cards).

Yes ☐ No ☐ Do you read and understand English?

Yes ☐ No ☐ Have you ever had surgery (so we know if you may have an implant or device)?
If yes (you have had surgery): Have you had an MRI examination since your last surgery? Yes ☐ No ☐

Yes ☐ No ☐ Have you ever had a previous MRI examination?
If yes (you have had an MRI examination): Date (month/year): ____/_____.
Research ☐ or Clinical ☐?
Were there any complications during the scan? Yes ☐ No ☐
If yes, please describe:
_____ (continue on back)
If yes (you have had an MRI examination): Have you had any surgery since your last MRI scan? Yes ☐ No ☐
If yes, please describe:
_____ (continue on back)
If yes (you have had an MRI examination): Have you had any problem related to a previous MRI examination? Yes ☐ No ☐

Yes ☐ No ☐ Do you have any vision, hearing or mobility limitations (e.g. glasses or contacts)?
If yes, please describe:
_____ (continue on back)

Yes ☐ No ☐ Do you suffer from claustrophobia, or anxiety in small or confined places?

Yes ☐ No ☐ Do you experience breathing problems or a motion disorder like tics or restless legs?

Please indicate if you have any of the following **IN YOUR BODY**:

Yes ☐ No ☐ Past injury to the eye involving a metallic object or fragment

Yes ☐ No ☐ Past injury from shrapnel, bullets or metal

Yes ☐ No ☐ Past work with metal (e.g. in a machine shop)

Yes ☐ No ☐ Any metallic fragment or foreign body

Please indicate if you currently have any of the following **IMPLANTS or PROSTHESES**:

- Yes ☐ No ☐ Aneurysm clip(s) from brain surgery
- Yes ☐ No ☐ Carotid artery vascular clamp
- Yes ☐ No ☐ Heart valve prosthesis
- Yes ☐ No ☐ Cochlear or other ear implant
- Yes ☐ No ☐ Eye implant or eyelid spring or wire
- Yes ☐ No ☐ Artificial or prosthetic limb
- Yes ☐ No ☐ Metallic stent, filter or coil
- Yes ☐ No ☐ Vascular access port, catheter or shunt (tube to drain fluid)
- Yes ☐ No ☐ Radiation seeds or implants
- Yes ☐ No ☐ Wire mesh implant
- Yes ☐ No ☐ Tissue expander (e.g., breast)
- Yes ☐ No ☐ Surgical staples, clips, or metallic sutures
- Yes ☐ No ☐ Joint replacement (hip, knee, etc.)
- Yes ☐ No ☐ Bone/joint pin, screw, nail, wire, plate, etc.
- Yes ☐ No ☐ Implanted medication delivery device
- Yes ☐ No ☐ Any type of prosthesis (eye, penile, etc.)
- Yes ☐ No ☐ Do you have any metal or metallic implants in your body that are not listed?
  If yes, describe: _____

For **FEMALE** Participants:

- Yes ☐ No ☐ Are you using a metal IUD right now?
- Yes ☐ No ☐ Is there any possibility that you might be pregnant?
- Yes ☐ No ☐ Have you had a hysterectomy (uterus removed) or are you post-menopausal?

Please indicate if you **HAVE** or **ARE WEARING**: *(if possible, remove before entering MR system room)*

- Yes ☐ No ☐ Dentures with metal components, tooth fillings, partial plates
- Yes ☐ No ☐ Medication patch (Nicotine, Nitroglycerine)
- Yes ☐ No ☐ Tattoo or permanent makeup
- Yes ☐ No ☐ Braces or permanent retainers
- Yes ☐ No ☐ Body piercing jewelry
- Yes ☐ No ☐ Hearing aid
- Yes ☐ No ☐ Hair extensions/ wig/ hairpiece
- Yes ☐ No ☐ Heavy makeup or eyeliner
- Yes ☐ No ☐ Colored contact lenses

Please indicate if you currently have any of the following **MEDICAL DEVICES**:

- Yes ☐ No ☐ Cardiac pacemaker
- Yes ☐ No ☐ Implanted heart defibrillator or prosthetic heart valve
- Yes ☐ No ☐ Electronic implant or device
- Yes ☐ No ☐ Magnetically-activated implant or device
- Yes ☐ No ☐ Neurostimulation system (nerve stimulators also called TENS or "wires")
- Yes ☐ No ☐ Bone growth/bone fusion stimulator
- Yes ☐ No ☐ Internal electrodes or wires
- Yes ☐ No ☐ Insulin or other infusion pump

I agree 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.

Your Signature _____ Date _____

Your Name (printed) _____

Signature of Parent/Legal Guardian _____ Date _____

Parent/Legal Guardian Name (printed) _____

Signature of Screener _____ Date _____

Screener Name (printed) _____