



# MAGNETIC RESONANCE SCREENING FORM

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**For Office Use Only**  
ID No.:

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Last name First name M.I.

Birthdate \_\_\_\_\_ Phone (H) (\_\_\_\_\_) (W) (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Physician's name & address \_\_\_\_\_ Phone \_\_\_\_\_

1. Have you ever had surgery or other invasive procedures? Yes No If yes, please list below.  
Type: \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Type: \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

2. Have you had any previous MRI studies? Yes No If yes, please list below.  
Area of Body Date Facility Name & Location  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

3. Have you ever worked as a machinist, metal worker, or in any profession or hobby grinding metal? Yes No  
had an injury to the eye involving a metallic object (e.g. metallic slivers, shavings, or foreign body)? Yes No

4. Are you pregnant, possibly pregnant or breast feeding? Yes No

5. Do you have Sickle Cell Anemia or Thalassemia? Yes No

**The MRI room 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 in your body or have experienced any of the conditions listed below. Please check the correct answer from each of the following:**

- |     |    |  |     |    |   |
|-----|----|--|-----|----|---|
| Yes | No | Cardiac pacemaker  | Yes | No | Shrapnel, buckshot, or bullets                      |
| Yes | No | Implanted cardiac defibrillator  | Yes | No | Tattooed eyeliner or eyebrows                       |
| Yes | No | Aneurysm clip or brain clip  | Yes | No | Body piercing(s)                                    |
| Yes | No | Carotid artery vascular clamp  | Yes | No | Metal fragments (eye, head, ear, skin)              |
| Yes | No | Neurostimulator  | Yes | No | Internal pacing wires                               |
| Yes | No | Insulin or infusion pump   | Yes | No | Aortic clips  |
| Yes | No | Spinal fusion stimulator   | Yes | No | Metal or wire mesh implants                         |
| Yes | No | Cochlear, otologic, ear tubes or ear implant   | Yes | No | Wire sutures or surgical staples                    |
| Yes | No | Prosthesis (eye/orbital, penile, etc.)   | Yes | No | Harrington rods (spine)                             |
| Yes | No | Implant held in place by a magnet  | Yes | No | Bone/joint pin, screw, nail, wire, plate            |
| Yes | No | Heart valve prosthesis   | Yes | No | Wig, toupee, or hair implants                       |
| Yes | No | Artificial limb or joint   | Yes | No | Hearing aid ( <b>Remove before scan</b> )           |
| Yes | No | Other implants in body or head   | Yes | No | Dentures or retainers ( <b>Remove before scan</b> ) |
| Yes | No | Electrodes (on body, head or brain)  | Yes | No | Asthma or breathing disorders                       |
| Yes | No | Intravascular stents, filters, or  | Yes | No | Seizures or motion disorders                        |
| Yes | No | Shunt (spinal or intraventricular)   | Yes | No | Hospitalization for mental or neurological illness  |
| Yes | No | Vascular access port or catheters  | Yes | No | Head Trauma   |
| Yes | No | IUD or diaphragm   | Yes | No | Migraine Headache                                   |
| Yes | No | Transdermal delivery system or other types of foil patches (e.g. Nitro, Nicotine, Birth control, etc.) | Yes | No | Panic attack  |
|     |    |  | Yes | No | Stroke  |

Please remove **all metallic objects** before MR examination 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. Ear protection is required during the MRI examination.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form; and I have had the opportunity to ask questions regarding the information on this form.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date \_\_\_\_\_