MGH-NMR Center Patient / Volunteer Screening Form

(This form to be used for imaging only)

Name _____ D.O.B_____ Date _____

Race/Ethnicity _____Weight _____ Gender ____ Volunteer / Patient _____

Type of Exam _____ Principal Investigator _____

Assessment of Risk for Falls

1.)How are you feeling right now?

weak, dizzy, light headed, fine other_____

2.)Recently, have you had any falls Yes No

3.)Do you need help to walk? Yes No

If **yes,** what type of help do you need to walk? crutches a walker cane

a companion to help you other_____

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	____	____	_____
Transdermal patches	____	____	_____

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 Number_____ IRB Expiration Date_____ Rescan_____