**Screening Form**

Full Name:

Date of Birth:

Address:

General Practitioner contact details (address) :

Male / Female **Age: …………………**

Are you pregnant? **Yes No N/A**

**Section 1: Technical Questions**

|  |  |  |  |
| --- | --- | --- | --- |
| Aneurysm clips or coils | **Yes No** | Wearable cardioverter defibrillator | **Yes No** |
| Cardiac pacemaker or wires | **Yes No** | Implanted insulin pump | **Yes No** |
| Internal cardioverter defibrillator (ICD) | **Yes No** | Programmable shunt or valve | **Yes No** |
| Carotid or cerebral stents | **Yes No** | Hearing aid | **Yes No** |
| Deep brain stimulator | **Yes No** | Cervical fixation devices | **Yes No** |
| Metallic devices implanted in your head | **Yes No** | Surgical clips, staples, or sutures | **Yes No** |
| Dental implants | **Yes No** | VeriChip microtransponder | **Yes No** |
| Cochlear implant/ear implant | **Yes No** | Wearable monitor (e.g., heart monitor) | **Yes No** |
| CSF (cerebrospinal fluid) shunt | **Yes No** | Bone growth stimulator | **Yes No** |
| Eye implants | **Yes No** | Wearable infusion pump | **Yes No** |
| Cardiac stents, filters, or metallic valves | **Yes No** | Radioactive seeds | **Yes No** |
| Vagus nerve stimulator (VNS) | **Yes No** | Portable glucose monitor | **Yes No** |
| Blood vessel coil | **Yes No** | Tracheostomy | **Yes No** |
| Medication patch/nicotine patch | **Yes No** | Other implanted metal or device  If yes, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

Have you ever had complication from an MRI? ……….…………

**Section 2: Clinical Questions.**

1. Are you affected by Depression/Anxiety (please specify - Unipolar etc)? …………………………
2. How many months and/or years? .………………………….
3. Are you currently taking medication for depression/Anxiety? **Yes** **No**
4. Please specify brand/name of medication for clinical depression/Anxiety? ………………………………………………………………………………………
5. How many different medications for depression/Anxiety taken? ………………………………………………………………………………………
6. Do you have epilepsy? **Yes**  **No** …………………….
7. Have you experienced a seizure within the last 12 months? **Yes** **No**
8. How long did the episode last?...... …………………………….
9. Do you suffer from migraines and/or continuous headaches? ………………………………………………………………………………
10. Do you suffer from Insomnia? **Yes** **No**

…………………………………………………………………………………..

1. Daily alcohol intake:
2. Daily Caffeine intake:
3. Drug Abuse:
4. Are you currently on any other medication other than anti-depressants? Please specify. ……………………………………………………………………………….

**Other relevant information:** …………………………………………………………………………………………………………………………………………………………………………………………………………………………

Signature of person filling this form:

…………………..……………………………………. Date:………………….