Section A:

Screening for magnetic resonnance imaging (MRI) study.

In order to ensure the safety of everyone having access to the area of Functional Neuroimaging Unit, it is of the utmost importance that this questionnaire be completed correctly. All information contained in this document is confidential.

A1.

A2. **Laste name:**

A3. **First name:**

A4. **floor(((strtotime(date("Y-m-d")) - strtotime(birthdate)) / 86400) / 365)**

A5. **Have you had a head surgery?**

If yes, please specify the type of surgery and the date (comments).

Yes ☐

No ☐

A6.

A7. **Have you had a chest or hearth surgery?**

If yes, please specify the type of surgery and the date (comments).

Yes ☐

No ☐

A8.

A9. Have you had an abdomen or pelvis surgery?

If yes, please specify the type of surgery and the date (comments).

Yes ☐

No ☐

A10.

A11. Have you had an arm or hand surgery?

If yes, please specify the type of surgery and the date (comments).

Yes ☐

No ☐

A12.

A13. Have you had a leg or foot surgery?

If yes, please specify the type of surgery and the date (comments).

Yes ☐

No ☐

A14.

A15. Have you had a spine surgery?

If yes, please specify the type of surgery and the date (comments).

Yes ☐

No ☐

A16.

A17. Have you had a eye surgery?

If yes, please specify the type of surgery and the date (comments).

Yes ☐

No ☐

A18.

A19. Have you had a another surgery?

If yes, please specify the type of surgery and the date (comments).

Yes ☐

No ☐

A20.

A21. Are you carrying any of the following:

	Yes, can not be removed	Yes, can be removed	No
Pacemaker? Epicardial wires?	☐	☐	☐
Aneurysm clips, Stent?	☐	☐	☐
Filter or catheter in a blood vessel?	☐	☐	☐
Artificial heart valve?	☐	☐	☐
Cochlear implant ? Hearing aid?	☐	☐	☐
Neurostimulator or Bone growth stimulator?	☐	☐	☐
Metal foreign body (ex: bullets, shrapnel, metal fragments)?	☐	☐	☐
Implanted insulin pumps?	☐	☐	☐
Orthopedic implant (ex: screws, plate, pins)?	☐	☐	☐
Tattoos or permanent make-up?	☐	☐	☐
Piercing?	☐	☐	☐
Implants magnetic or non-magnetic?	☐	☐	☐
Diaphragm or IUD?	☐	☐	☐
Dental work (ex. braces, caps, crowns, dentures)?	☐	☐	☐
Ocular implants?	☐	☐	☐
Transdermic patch (ex : nitroglycerine patch)?	☐	☐	☐

A22. **You answered: Yes, can not be removed to one or more of the following questions, enter any additional information that may help the staff of the Functional Neuroimaging Unit to assess whether you can pass the magnetic resonance examination security. For example, the type of implant or device, the manufacturer and the model if you know them, the year of implantation.**

A23. **Others :**

A24. **Do you suffer from claustrophobia ?**

Yes ☐

No ☐

A25. **Have you ever been injured by metal objects ?**

Eg: car accident, work accident, war wounds.

Yes ☐

No ☐

A26. **Have you ever been a:**

	Yes	No
Mechanist ?	☐	☐
Welder ?	☐	☐

A27. Do you have any respiratory or motor disorder ?

Yes ☐

No ☐

A28. Have you ever had previous magnetic resonance imaging test ?

Yes ☐

No ☐