Subject last name:______________________________ First name: ________________________________

Date of birth:______________________
dd / mm / yy

Sex: F ☐ / M ☐

Previous surgery?	NO	YES	If yes indicate the type
Head			
Heart			
Eyes			
Abdomen			
Extremities			
Spine			

Others:____

Do you have a:	NO	YES		Specify type
Cardiac Pacemaker / Defibrillator				
Cochlear implant or implanted hearing aid				
Implanted insulin pump			***If yes, must be removed for scan***	
Coloured contact lenses			***If yes, must be removed for scan***	
Transdermal delivery system (e.g. patch)			***If yes, must be removed for scan***	
Body piercing			***If yes, must be removed for scan***	
IUD				
Foreign metallic objects (e.g. bullets or metal splinters)				
Permanent make-up / tattoos				
Ocular implants or devices			▶	______
Cardiac valve prosthesis			▶	______
Neurostimulator			▶	______
Artificial limb or joint			▶	______
Implanted orthopedic device			▶	______
Penile implant			▶	______
Aneurysm Clip			▶	______
Filter, catheter or stent in a blood vessel			▶	______
Shunt (programmable)			▶	______

	NO	YES
Are you pregnant?		
Have you ever been injured by a metallic piece? (e.g. in your eyes)		
Have you ever undergone Magnetic Resonance Imaging? If yes when: ____________________		
Do you suffer from claustrophobia?		

____ ____________________
Subject signature Date (dd-mm-yy)

____ ____________________
Physician / Researcher signature Date (dd-mm-yy)