Martinos Center Patient / Subject MEG Screening Form (Must be used before any MEG recording)

| Name | | Date of | ate of Birth | | | Date | | |
|--|--|---|--|--|---|--------------------|----------|--|
| MGH # | Gender | Race/Ethnicity | | | Principal Investigator | | | |
| Assessment of Risk of falls | | | | | | | | |
| Please answer these questions to he | elp us know your r | ink for fal | ls. Selec | t your answe | r and mark | the box: | | |
| 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? | | □YI | ES □N | IO | | | | |
| If Yes, what type of help do ye | ou need to walk | ? □cru | itches | $\Box a$ walker | □a cane | □a companion to h | nelp you | |
| | | □Ot | her: | | *************************************** | | | |
| In a separate consent procedure, I ha using a de-magnetizer to remove or sbody. I understand that incomplete o | significantly reduce | the magne | tization o | f my body, I n | need to inform | | | |
| I have / had | Y | ES | | NO | If Ye | es, Please Explain | | |
| Vagal Nerve Stimulator | | | | | *************************************** | | | |
| Cochlear Implant | | | | | | | | |
| Other Neurostimulator | | growing database consistences | | | | | | |
| Surgical Clip | | *************************************** | | | *************************************** | | | |
| Cardiac Pacemaker | | angananan angan peryan angan angan | | | | | | |
| Prosthetic Heart Valve | # ordered | delitropological materials | | entre risulti dell'infrazzoni scori colo | ridda tinde oprille valen djælen videns op | | | |
| Metal Rod, Plate or Screw | water | ppe college of the change | | rentral contrassion describe | Martin de commission en actui au descrit | | | |
| Other implanted Medical Dev | ice | | | municipal designation of the second s | ARTHOUGH SQUARE CONTRACTOR AND AND A | | | |
| Hearing Aid, Dentures | | | | the former disknown constraints are as | | | | |
| Previous Injury or Surgery that may have left any metal in my | | | | | Austriany and discount resolution of charge | | | |
| Previous Head Trauma | | | | | AND THE PERSON NAMED IN COLUMN TWO | | | |
| Dental Work (fillings, wires, root canals, et I hereby agree to have a MEG study. | | | | | - Marie Construction of the Construction | | | |
| Signature | and the second of the control of the | | | D | ate | | | |
| Witnessed By | | | | D | ate | | | |
| I have received a signed copy of the | informed consent d | ocument fo | or this stu | dy (ini | tial) | | | |
| To be filled out by investigator: If | RB Protocol Numbe | г | | _ IRB Expira | ation Date | Rescan Yes | No | |