BROOKHAVEN NATIONAL LABORATORY
Occupational Medicine Clinic (OMC)

Static Magnetic Fields Questionnaire

NAME: ________________________________  CHART #: _______________________

This form is to be completed by anyone working in a static magnetic field. The purpose of this questionnaire is the detection of medical devices, conditions or procedures that may result in adverse effects in a magnetic field.

Please check any of the following items relevant to your health. These will be discussed with you and clarified by the OMC physicians at the time of your routine examination at the OMC. You may use the space at the bottom of this form to write in details.

Have you had any surgery other than dental surgery?  ____ Yes  ____ No
If yes, date and type of surgery: ________________________________

Have you had a diagnostic MRI in the past year?  ____ Yes  ____ No
If yes, date and reason: ________________________________

Have you served as an experimental subject at a BNL MRI in the past year?  ____ Yes  ____ No

Have you ever entered the MRI ring as an employee (non-subject)?  ____ Yes  ____ No
If yes, approximate date(s) (month/year): ________________________________

Have you experienced the following: dizziness/vertigo, metallic taste, nausea or flashing lights (visuales), when exposed to static magnetic fields?  ____ Yes  ____ No
If yes, explain: ________________________________

Please check any that may apply to you:

___ Cardiac Pacemaker/Defibrillator  ___ Insulin Pump
___ Surgical clips (aneurysm, brain, cardiac, vascular, other)
___ Neurostimulators (Tens Unit)
___ Joint replacement, joint prosthesis, or fractured bones treated with metal rods, metal plates, pins, screws, nails, or plates
___ Bod Piercings
___ Tattoos
___ Spinal fusion performed using metal rods, metal plates, pins, screws, or other metallic instrumentation
___ Shrapnel injury
___ Surgery involving insertion of a metal mesh
___ Work grinding metal silvers or fragments
___ Eye surgery or metal chip in the eye
___ Shunts
___ Cochlear implantation surgery
___ Heart Valve
___ Hearing aid
___ Other ferromagnetic implants or other internal devices (explain below)
___ IUD (intrauterine device)
___ Diagnostic medical MRI studies in the past

If you have any changes in your medical history, you must notify the OMC.

Signature of employee/contractor: ________________________________  Date: ________________