BROOKHAVEN NATIONAL LABORATORY
Occupational Medicine Clinic (OMC)

Static Magnetic Fields Questionnaire

NAME: ______________________________ **CHART #:** ____________________

This form to be completed 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 (visuals), when exposed to static magnetic fields? ____ Yes ____ No
If yes, explain: ______________________

Please check any that may apply to you:

___ Cardiac Pacemaker/Defibrillator

___ Surgical clips (aneurysm, brain, cardiac, vascular, other)

___ Joint replacement, joing prosthesis, or fractured bones treated with metal rods, metal plates, pins, screws, nails, or plates

___ Spinal fusion performed using metal rods, metal plates, pins, screws, or other metallic instrumentation

___ Surgery involving insertion of a metal mesh

___ Eye surgery or metal chip in the eye

___ Cochlear implantation surgery

___ Hearing aid

___ IUD (intrauterine device)

___ Insulin Pump

___ Neurostimulators (Tens Unit)

___ Bod Piercings

___ Tattoos

___ Shrapnel injury

___ Work grinding metal silvers or fragments

___ Shunts

___ Heart Valve

___ Other ferromagnetic implants or other internal devices (explain below)

___ 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: ______________