BROOKHAVEN NATIONAL LABORATORY
Occupational Medicine Clinic (OMC)

Medical Protocol for Static Magnetic Fields

NAME: CHART #:

This form to be completed by BNL employee. 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? Y/N (If yes, date _____ reason _____.)

Have you served as an experimental subject at a BNL MRI in the past year? Y/N

Have you ever entered the MRI ring as an employee (non-subject)? Y/N

If yes, approximate date(s) (month/year) _____

Have you experienced the following: dizziness/vertigo, metallic taste, nausea or flashing ilghts (visuals), when exposed to static magnetic fields? Y/N (If yes, explain _____.)

Please check any that may apply to you:

_____ Cardiac Pacemaker/Defibrillator

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

_____ Joint replacement, joint 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 chips in the eye

_____ Cochlear implantation surgery

_____ Hearing aid

_____ IUD (Intrauterine Device)

_____ Insulin Pump

_____ Neurostimulators (Tens Unit)

_____ Body Piercings/Tattoos

_____ Shrapnel injury

_____ Work grinding metal slivers or fragments

_____ Shunts

_____ Heart Valve

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

_____ Diagnostic medical MRI studies in the past

Any cancers diagnosed? _____

Any adverse reproductive outcomes (self/partner) spontaneous abortions/stillbirths or birth defects?
_____

Details of above checked items:
_____

Signature of employee: _____ Date: _____

Reviewed by OMC Physician:

Signature_____ Date: _____