

Name: _____ Date: _____ Study: _____

IRB#: _____ Time in Magnet: _____ Operator: _____

Thank you for participating in our study. As described in our consent form, some persons have reported various sensations in the magnet. We would appreciate it if you could answer the following questions about your experience.

1. Did you experience any unusual sensations while in the magnet?

No _____ Yes _____

If yes, please describe _____

when: _____

for how long: _____

2. Please check the following where applicable,

Did you experience:	<u>Yes</u>	<u>No</u>	<u>Uncertain</u>
a) nervousness	_____	_____	_____
b) double vision	_____	_____	_____
c) sleepiness	_____	_____	_____
d) vertigo	_____	_____	_____
e) lightheadedness	_____	_____	_____
f) metallic taste	_____	_____	_____
g) warmth	_____	_____	_____
h) cold	_____	_____	_____
i) other	_____	_____	_____

Please describe _____

3. Please tell us how we can make the experience more comfortable.

4. Would you like to participate in another MRI study here at the CMRR?
