Please answer the medical history questions below. Note that a "Yes" response to any of the following may preclude a subject from having a 3T scan.

	Yes	No			
Aneurysm clip	____	____			
Pacemaker/stimulator	____	____			
Ear Implant	____	____			
Heart Valve Replaced	____	____			
Other Implant	____	____			
Hx of Metal Work	____	____			
Hx of Metal in eyes	____	____			
Bullets, Shrapnel	____	____			
Dentures/braces/wigs	____	____			
Tattoos/Piercing	____	____			
Cardiac/Respiratory	____	____			
Strokes/Seizures	____	____	Left	or	Right
Liver/Kidney dz	____	____	Left	or	Right
Cancer	____	____			
Brain surgery	____	____	Left	or	Right
Diabetes/high BP	____	____			
Claustrophobia	____	____			
Prior MRI	____	____	Where_________		

Onset of Symptoms (date/time):
____

Indicate below any items of medical history not listed above which may be of concern to you.