



Pre-Imaging Visit Questionnaire

When booking an appointment, a small number of participants may have forgotten about events that make them unable to take part in the Imaging study.

In order to ensure that you are able to take part, we would be grateful if you could fill in this form. If you think your answer to any of these questions differ to what you indicated when booking your appointment, please contact the Participant Resource Centre on 0800-0-276-276 (Monday to Saturday 8am to 7pm).

It is not essential to bring this document with you on the day of your appointment, but it may be helpful to do so if you have a long or complicated medical history. A final check of your eligibility to take part will be completed at the assessment centre.

(1) Do you have, or have you ever had, a heart pacemaker or defibrillator? Yes / No

If yes, write further details below:

(2) Operations: Please list any operations you have had to your **heart, head / brain, eyes, ears, spine.**

(3) Have you ever had any surgery or procedures involving your blood vessels, stomach, bowel, intestines or joints? E.g. Coronary artery stents, coils or clips, hip or knee replacements, breast implants. Yes / No

If yes, write further details below:

(4) Do you have any electronic or magnetically-activated implants or devices attached to your body? E.g. vascular access ports, infusion pumps, or vascular catheters. Yes / No

If yes, write further details below:

(5) Have you had any surgery in the last 6 weeks, or are you due to have surgery/procedures before your set appointment date? Yes / No

If yes, write further details below:

(6) Have you ever had any metal go into your eyes or other parts of your body, regardless of how long ago it was? This is the most common event that participants forget. Please take a moment to think back regarding this question. Yes / No

If yes, write further details below:

(7) Have you had a scan or x-ray in the last 2 weeks that involved taking a contrast medium? Yes / No

If yes, write further details below:

(8) Women only

a. Do you have a contraceptive IUD (coil) implanted? Yes / No

If yes, please write type below:

Women < 60 years (i.e. born after 1953):

b. Is there any chance you could be pregnant? Yes / No

c. Would you be willing to take a pregnancy test to check whether you are pregnant or not? Yes / No

Please remember to bring this completed form to your imaging assessment visit.