



Center for Advanced Brain Imaging
Georgia State University and Georgia Institute of Technology
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HEALTH SCREENING FORM

Name		Phone Number
Date of Birth	Age	Gender

Ethnic Category:

[] American Indian/Alaska Native [] Asian
 [] Black/African American [] Hispanic/Latino
 [] Native Hawaiian/Other Pacific Islander [] Caucasian

HANDEDNESS

What hand do you normally use? (Put "+" in the column if you usually use that hand, "++" if you always use that hand, or one "+" in each column if you use both hands equally.)
 Experimenter: Score 1 for L++, 2 for L+, 3 for + in each column, 4 for R+, and 5 for R++ (> = 20 ok).

Activity	Left	Right
Writing a message		
Drawing a picture		
Using a toothbrush		
Throwing a ball		
Using a pair of scissors		

Do you have any immediate family members who write with their left hand? [] No [] Yes

EYESIGHT

Indicate which you use: <input type="checkbox"/> Glasses <input type="checkbox"/> Bifocals <input type="checkbox"/> Reading glasses <input type="checkbox"/> Contacts <input type="checkbox"/> None (normal vision)	If you know your prescription, please write it here.	Is the prescription for one eye much stronger than the other? <input type="checkbox"/> No <input type="checkbox"/> Yes
	<i>Left</i>	Do you have astigmatism? <input type="checkbox"/> No <input type="checkbox"/> Yes
	<i>Right</i>	Are you color blind? <input type="checkbox"/> No <input type="checkbox"/> Yes

LANGUAGE / EDUCATION

Is English your first language? <input type="checkbox"/> No <input type="checkbox"/> Yes If not, what language is?	List all other languages that you speak:	Starting with elementary school, how many years of education have you had?
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GENERAL HEALTH

How would you rate your general health? <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent	List any serious medical conditions that you have had, and list all of your current medications.
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For Experimenter Use Only:

Principal Investigator _____
 Experimental ID _____
 Subject ID _____
 Screen Date _____
 MRI Date & Time _____