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:	If you know your prescription, please write it here.	Is the prescription for one eye much stronger than the other?
[ ] Glasses		[ ] No [ ] Yes
[ ] Bifocals		
[ ] Reading glasses	*Left*	Do you have astigmatism?
[ ] Contacts		[ ] No [ ] Yes
[ ] None (normal vision)	*Right*	Are you color blind?
		[ ] No [ ] Yes

LANGUAGE / EDUCATION

Is English your first language?	List all other languages that you speak:	Starting with elementary school, how many years of education have you had?
[ ] No [ ] Yes		
If not, what language is?		

GENERAL HEALTH

How would you rate your general health?	List any serious medical conditions that you have had, and list all of your current medications.
[ ] Poor [ ] Fair	
[ ] Good [ ] Excellent	

For Experimenter Use Only:
Principal Investigator_____
Experimental ID_____
Subject ID_____
Screen Date_____
MRI Date & Time_____