FORM 1 – TO BE FILLED IN AT THE START OF YOUR WORK

Time (hh:mm) [___:___]

1. Do you experience any of the symptoms (listed in the table below) at this moment (so before you started your work at the scanner)?

○ No → Please continue to question 3
○ Yes → Please indicate in the table which symptoms you are presently experiencing

	Symptoms that you experienced
- Tinnitus or sensation of head ringing	○
- Earache	○
- Headache	○
- Concentration problems	○
- Tiredness or sleepiness	○
- Nausea	○
- Vomiting	○
- Involuntary muscle contractions	○
- Palpitation	○
- Tingling sensation in the body, please specify body part:	○
- Sensation of glowing, burning or irritated skin	○
- Suddenly feeling warm or hot, hot flashes	○
- Itchy, watery or red eyes	○
- Seeing black spots or having a temporary loss of vision	○
- Seeing light spots or light flashes	○
- Blurred or double vision	○
- Sensation of dizziness or vertigo	○
- Feeling lightheaded or weightless	○
- Feeling of instability when standing, walking or moving	○
- A metallic taste	○
- A strange smell sensation	○
- Other, please specify:	○

2. Do you have any idea what caused these symptoms?

3. How many alcoholic consumptions did you consume during the past 24 hours?
Please report the number of glasses. (NB: one serving glass of wine, beer or spirit equals 1 glass; a bottle of beer equals 1,5 glasses)

___ glasses

4. Comments

FORM 2 – TO BE FILLED IN AT THE END OF YOUR WORK

Time (hh:mm) [___:___]

1.a Did you enter the MRI scanner room (i.e. the room in which the scanner is placed)?

○ No → Please continue to question 3
○ Yes

1.b At which scanner(s) did you work during this shift? Please report scanner name/number (e.g. "MRI 2") and field (in Tesla).

.....

2. How many times were you in the scanner room during image acquisition?*
Count the total number of *times*, not the number of procedures!
*Acquisition: The moment when the image is acquired; when the scan is being performed.

___ times

3. Did you use any disinfectants (e.g. alcohol) during your work day?

○ No
○ Yes

4. Did you use any cleaning agents during your work day?

○ No
○ Yes → Please specify which type of cleaning agents:

○ Cleaning agents that have a strong chemical smell or vapour, such as products containing bleach or volatile compounds)
○ Cleaning agents that do *not* have a strong chemical smell or vapour, such as products made of soap (hand soap, detergent)

5. How do you consider the workload during this work day?

○ Light
○ Moderate
○ Heavy

6. How tiring do you consider this work day to have been?

○ Hardly tiring
○ A little tiring
○ Very tiring

7. Did you experience any of the symptoms (listed in the table below) during your work shift?

○ No → Please continue to question 10
○ Yes → Please indicate which symptoms you have experienced and their approximate duration

	Symptoms that you experienced		Duration (minutes):				
			< 1	< 5	< 15	< 60	> 60
- Tinnitus or sensation of head ringing	○	→	○	○	○	○	○
- Earache	○	→	○	○	○	○	○
- Headache	○	→	○	○	○	○	○
- Concentration problems	○	→	○	○	○	○	○
- Tiredness or sleepiness	○	→	○	○	○	○	○
- Nausea	○	→	○	○	○	○	○
- Vomiting	○	→	○	○	○	○	○
- Involuntary muscle contractions	○	→	○	○	○	○	○
- Palpitation	○	→	○	○	○	○	○
- Tingling sensation in the body, please specify body part:	○	→	○	○	○	○	○
- Sensation of glowing, burning or irritated skin	○	→	○	○	○	○	○
- Suddenly feeling warm/hot, hot flashes	○	→	○	○	○	○	○
- Itchy, watery or red eyes	○	→	○	○	○	○	○
- Seeing black spots or having a temporary loss of vision	○	→	○	○	○	○	○
- Seeing light spots or light flashes	○	→	○	○	○	○	○
- Blurred or double vision	○	→	○	○	○	○	○
- Sensation of dizziness or vertigo	○	→	○	○	○	○	○
- Feeling lightheaded or weightless	○	→	○	○	○	○	○
- Feeling of instability when standing, walking or moving	○	→	○	○	○	○	○
- A metallic taste	○	→	○	○	○	○	○
- A strange smell sensation	○	→	○	○	○	○	○
- Other, please specify:	○	→	○	○	○	○	○

8. Do you have any idea what caused these symptoms?

9. Did you feel that one or more of these symptoms hampered/affected your work activities in some way?

○ No
○ Yes → By which of the above listed symptoms was your work affected and in what manner?

10. Comments