GeoScan and Remote Geo Smoking Study: Neural and Behavioral Correlates of Smokers' Exposure to Retail Environments

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GeoRemote FMRI Screening Survey

This screening survey is to determine your eligibility to participate in an optional in-person scanning session (2 hours, including the 1-hour fMRI scan, for up to $95 via ClinCard) at the University of Pennsylvania. Out-of-pocket travel/parking expenses for this session can be reimbursed for up to $75 total. You can read more about this optional component of the study here [LINK TO CONSENT ADDENDUM FOR MRI].

We expect this screening survey to take you less than 5 minutes to complete. The screening survey includes a series of questions to determine whether it is safe and feasible for you to enter an MRI scanner. Additionally, this screening survey has questions about any diagnoses, medicines, and drugs that could change your brain activity.

As with all of the information collected for this study, there is always a risk of an unintentional breach of confidentiality. However, the information collected during this session will be held to the same rigorous standards of confidentiality and data security, which were explained in the main consent document [LINK TO FULL CONSENT] that you signed at your first appointment. This includes the protection of a Certificate of Confidentiality from the National Institutes of Health, which means that no authority will have a legal means of accessing your responses or any other personally sensitive data without your permission.

Your participation in this screening survey is completely voluntary. If you are not interested in the in-person scanning session and/or do not want to complete this survey, select “No” below.

Please indicate whether you consent to participate in our online screening survey:

- ○ Yes, I wish to complete the online screening survey for this research study. I have read and understood the information above.
- ○ No, I do not wish to complete this online screening survey. (Selecting this response will let the researchers know that you do <u>not</u> want to participate in the optional in-person scanning session).

Question	**Answer Options**
Screening	
Study Eligibility	
How many cigarettes do you smoke on a typical day?	___
Are you currently enrolled or have plans to enroll in a smoking cessation program within the next 3 months?	Yes No
Are you currently using or have plans to use nicotine substitutes or smoking cessation treatments within the next 3 months?	Yes No

Apart from nicotine products like cigarettes, have you ever received a diagnosis of or treatment for substance abuse (e.g., alcohol, opioids including heroin, cocaine, marijuana, or stimulants)? One example of a common substance abuse treatment is a prescription for methadone.	Yes (if yes, is this an active problem; if not active, how long ago did it resolve; within the last 5 years, over 5 years ago) No Prefer not to answer
COVID-19 Questions	
By clicking on the checkbox below, I understand that my in-person appointment may be rescheduled or canceled by the study team in the event that I do not meet the COVID-19 screening requirements necessary to enter the testing facilities, including but not limited to: (1) Reporting any COVID-19 related symptoms (2) Reporting any recent positive COVID-19 test (3) Reporting any recent interactions with others who have tested positive for COVID-19	[checkbox, "I have read and understand that my participation in this study is contingent upon the screening procedures required by the testing facilities."]
fMRI Eligibility	
Is English your native language?	Yes No
Are you right or left handed?	Left Right
Are you currently pregnant or breastfeeding?	Yes No
Is it likely that you have ferromagnetic metal in your body? This would include anything that might set off a metal detector. Examples include bullet shrapnel, metal shavings (e.g., from welding without protection), or any implant that may be attracted to	Yes No

or damaged by magnets.

Please do not count dental fillings.

Do you have any metal of an unverifiable origin in your body?	Yes No
Do you have any non-removable piercings?	Yes No
Do you have any silver-colored or gold dental fillings in your teeth?	Yes No
Do you have a non-removable retainer or braces?	Yes No
Over the past 2 weeks, have you used any of the following drugs? Benzodiazepines, Amphetamines, Methamphetamines, Cocaine, MDMA, Methadone, Barbiturates, PCP, Heroin, Oxycodone, Opiates (e.g., morphine, heroin), Buprenorphine	Yes No Prefer not to answer
Do you plan to use any of the above drugs over the next 6 weeks?	Yes No Prefer not to answer
Have you had an MRI scan before?	No If yes: What was the date of the last MRI you had? What body part was the MRI for? Did you have any problems? Yes (If yes, provide additional information) No
Are you claustrophobic (that is, do you get anxious in small spaces)?	Yes No
Do you have any major mental health diagnoses? Common examples include major depression, anxiety disorders, bipolar affective disorder, schizophrenia or psychosis, ADHD, and dementia.	Yes No Prefer not to answer

Have you been hospitalized for a psychiatric condition in the last year?	Yes No
Do you have a history of stroke, seizures, brain tumor, or other neurological disorders?	Yes (if yes, provide additional information) No
Do you have a history of head trauma or traumatic brain injury (e.g., concussion, gunshot wound to head)?	Yes (if yes, select all that apply): Non-penetrative trauma (e.g., concussion) Penetrative trauma that cracks the skull (e.g., gunshot wound to head) No
Do you wear glasses and/or contacts?	Yes No
Do you own contact lenses that you can use instead of glasses?	Yes No
Do you know your prescription for your glasses or are you able to easily access it within a day or two?	Yes No
What is the prescription for your RIGHT EYE? (negative: harder to see distant objects) (positive: harder to read/see things up close)	[text entry] (ex. -5.25)
What is the prescription for your LEFT EYE? (negative: harder to see distant objects) (positive: harder to read/see things up close)	[text entry] (ex. -4.75)
How much do you weigh?	__ lbs
How tall are you?	__ ft, __ in

fMRI Session Questionnaire Examples

- If a participant tests positive for any drug on the urine drug test, we will ask how long ago they used the drug and at what dosage.
- During the last 6 months, how often did you usually have any kind of drink containing alcohol? (By a drink we mean the equivalent of a 12 oz can or glass of beer, a 5 oz glass of wine, or a drink containing 1 shot of liquor).
    - Every day
    - 5-6 times a week
    - 3-4 times a week
    - Twice a week
    - Once a week
    - 2-3 times a month
    - Once a month

    - 3-5 times in the past 6 months
    - 1-2 times in the past 6 months
    - I did not drink alcohol in the last 6 months, but I did drink in the past
    - I never drank any alcohol in my life
- During the 6 months, how many alcoholic drinks did you have on a typical day when you drank alcohol?
    - 25 or more drinks
    - 19-24 drinks
    - 16-18 drinks
    - 12 - 15 drinks
    - 9-11 drinks
    - 7-8 drinks
    - 5-6 drinks
    - 3-4 drinks
    - 2 drinks
    - 1 drink
    - 0 drinks