



THE MOUNT SINAI HEALTH SYSTEM

Mount Sinai Hospital
 Mount Sinai West
 Mount Sinai Beth Israel
 New York Eye and Ear Infirmary at Mount Sinai
 Mount Sinai Outpatient Faculty Practices
 Mount Sinai Queens
 Mount Sinai St. Luke's
 Mount Sinai Brooklyn

Name: JEFFREY EPSTEIN

Date of Birth: 01/20/1953 Gender: M

Medical Record Number (if known): _____

Requesting Physician: _____

Today's Date: 12/15/2014

RADIOLOGY OUTPATIENT ASSESSMENT QUESTIONNAIRE

MEDICAL HISTORY:

1. Please indicate the reason you are having this exam (why did your doctor order this test?):

2. Please list any known diagnosis or describe any injury, pain or other symptoms related to this exam:

3a. Also, what specific part of your body is affected (location & side)?

3b. How long you have had symptoms (duration)?

3. If you have ever had cancer, please indicate type and year diagnosed:

4. Please list any previous surgery or treatment (including radiotherapy) related to the reason you are having this exam:

5. Have you had a nuclear medicine injection in the past 7 days, such as for bone scan or thyroid? No Yes

5a. If yes, what type of injection/scan, and what date did you receive it?

6. Before today, have you had any radiology study of the area being examined now? No Yes → When?

What type (X-ray, ultrasound, CT, MRI, etc.)?

Were prior exams at one of these *Mount Sinai Health System* sites?

<input type="checkbox"/> Mount Sinai Hospital	<input type="checkbox"/> Mount Sinai Beth Israel
<input type="checkbox"/> Mount Sinai St. Luke's	<input type="checkbox"/> Mount Sinai West (formerly Roosevelt)
<input type="checkbox"/> Mount Sinai Brooklyn (formerly Kings Highway/Beth Israel Brooklyn)	<input type="checkbox"/> New York Eye & Ear Infirmary at Mount Sinai
<input type="checkbox"/> Another Mount Sinai-affiliated imaging center:	

FOR FEMALE PATIENTS OF REPRODUCTIVE AGE (11-50 YEARS):

7. To the best of your knowledge, are you pregnant or do you think you could be? Yes No Possible/unsure

8. If you may be pregnant or are unsure, indicate the start of your last complete menstrual period: ___/___/___

FOR ALL PATIENTS, PLEASE SIGN BELOW:

9. Please print name, sign, date and time

JEFFREY EPSTEIN Patient Friend
 PRINTED NAME Relative Other:

[Signature] 12/15/2014
 SIGNATURE DATE TIME