Name: JEFFREY EPSTEIN

Date of Birth: JAN 20, 53 Height: 5'11" Weight: 175 Social Security #: [redacted]

Some of the following items may be hazardous to your safety or can interfere with you MRI/MRA examination.
Please check YES or NO for each of the following items.

YES	NO	
		Cardiac Pacemaker or Defibrillator
		Brain Aneurysm clip (s)
		Transdermal Patch: Nicotine / Nitroglycerine
		Shunts (e.g. Spinal / intraventricular/ VP shunt)
		Bone Growth /Fusion stimulator
		Neurostimulator
		Cochlear /Otologic / Ear Implant
		Implanted Drug Infusion Device / Insulin Pump
		Electrodes (on body, head or brain)
		Any Implant Held in Place by Magnet
		Carotid Artery Vascular Clamp
		Intravascular stents, filters, or coils
		Vascular Access Port and/or Catheter
		Swan-Ganz Catheter
		Internal Pacing Wires
		Any type of prosthesis: eye,penile, etc
		Metal or Wire Mesh Implants
		Harrington Rods (spine)
		Joint Replacement
		Bone/Joint pin, screw, nail, wire, plate
		Body piercing (s)
		Tattooed Makeup (eyeliner, lips, etc)
		Any Metal Fragments
		IUD or Diaphragm
		Hearing aid (remove before MRI/MRA)
		Dentures (remove before MRI/MRA)
		Asthma or other breathing disorder
		Anxiety
		Other:

1. What problems are you having that made the doctor order this study?

2. Have you ever been to the hospital for an invasive procedures or surgery? **Yes / No**

   Date — Reason

3. Have you ever had an accident that required metal fragments to be removed from your eye?

4. ~~Women: Could you be pregnant? Yes / No~~

5. Do you have a history of kidney disease? **Yes / No**

6. Do you have sickle cell anemia? **Yes / No**

7. Have you had an allergic reaction that required emergency treatment? **Yes / No**

8. Do you or have you:
   - High blood pressure? **Yes / No**
   - Diabetes? **Yes / No**
   - High cholesterol? **Yes / No**
   - Smoked tobacco? **Yes / No**

9. Do you have chest pain? **Yes / No**
   If yes:
   Is it substernal? **Yes / No**
   Is it brought on by exertion or emotional stress? **Yes / No**
   Is it relieved by rest or nitroglycerine? **Yes / No**

Patient Signature: _____ **Date:** JAN. 18 2018

MRI Screening Form: 10/22/12