ZILKHA RADIOLOGY PACS _____ ADS _____ EMR _____

369 East Main Street; Suite 18; East Islip, NY 11730-2800 Tele (631) 277-1600 Fax (631) 277-1638
1161 Montauk Highway; West Islip, NY 11795-4930 Tele (631) 669-1717 Fax (631) 669-0854

Patient Medical History/Current Medication List

Date _____

Patient Name: _____ **Date of Birth:** _____

Please list Current Prescription Medication, Over-the-Counter Medications, Multivitamins &/or Supplements Name, Dosage and Amount of Times per day you take the drug/supplement along with the route of administration:

Name	Dosage	Times Per Day	How is it Taken? (Mouth, Injection, etc.)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

I hereby state that the information listed above is accurate to the best of my knowledge.

Patient or Legal Guardian Signature _____**Date**_____