735 Cherry Rd
Rock Hill, SC 29732
803.818.3932
www. betteruc.com

New Patient History Form

PATIENT NAME:____

What brings you to see us (be brief)? ____

Do you have any medical problems? ____

____

Have you had any surgeries? ____

Do any medical problems run in the family?____

When was your last Tetanus vaccine? ______________**Weight**________ **Height** ________ **Sex**_____

Please list all of your current medications? (If long, you may give a list to the nurse)

Name:	Dose:	Name:	Dose:
____________________	____________	____________________	_____________________
____________________	____________	____________________	_____________________
____________________	____________	____________________	_____________________

Are you allergic to any medications? ____

Preferred Pharmacy Name: ______________________________ Street: ____________________________

Medical Record Release Consent

I voluntarily consent to the release of my medical record to the following entities:

Name:_____________________________________ Name:_____________________________________

Address: ___________________________________ Address: ___________________________________

Fax: ______________________________________ Fax: ______________________________________

Phone: ____________________________________ Phone: ____________________________________

Name:_____________________________________ ☐All medical records

Address: ___________________________________ ☐ Last office visit

Fax: ______________________________________ ☐Labs/Imaging

Phone: ____________________________________

Signature: ____