Quakertown Family Medical Center, P.C.
Cira Amenta, D.O.
Kathy Gotwals, Pa-C.

920 Lawn Ave Suite 4 Sellersville, PA 18960
1548 W. Broad St Quakertown, PA 18951
Phone (267) 347-4747
Fax (267) 347-1157

NEW PATIENT QUESTIONNAIRE

Please fill out this form as thoroughly as possible, printing all responses clearly. All information contained in these pages is completely confidential and will not be released unless you authorize us to do so.

PERSONAL INFORMATION						
Last Name	First	Middle	Prefix	Sex M F	Birth Date	Today's Date
Street Address	City	State	Zip	Social Security Number		
Home Phone	Mobile Phone	Email Address				

Medical History

Check ☑ conditions you have or had in the past.

	Alcoholism		Chemical dependence		Hepatitis		Psychiatric care
	Anemia		Depression		Herpes		Rheumatic Fever
	Anxiety		Diabetes		High blood pressure		Seasonal allergies
	Arthritis		Eating disorder		High cholesterol		Sexual difficulty
	Asthma		Emphysema/COPD		HIV/AIDS		Sexually transmitted infection
	Autoimmune disease		Epilepsy/Seizures		Kidney disease		Skin rash
	Bleeding/Clotting disorder		Erectile dysfunction		Liver disease		Sleep apnea
	Bone/Joint disorder		GERD (reflux)		Multiple sclerosis		Stroke
	Breast lump		Golter		Osteoporosis		Thyroid problem
	Cancer (see below)		Gout		Peripheral vascular disease		Tuberculosis
	Congestive heart failure		Headaches		PPD positive		Urinary Incontinence
	CAD/Heart disease		Heart attack		Prostate problem		Vaginal infection
	Other (please describe)						

If you have/had cancer, please name type(s) and describe treatment with corresponding dates in the space below.

Date of last physical exam:	Former primary care provider:

Reason for today's visit

Please describe any symptoms/complaints that you would like to discuss with your primary care provider at today's appointment.

WOMEN ONLY

Number of pregnancies: Number of living children: Number of abortions: Number of miscarriages:

DATE	TYPE OF DELIVERY	SEX	COMPLICATIONS

Patient Name _____ Date of Birth _____ Today's Date _____

MEDICATIONS	*List all medications, including over-the-counter medications and supplements. Write dosage and frequency for each medication.*

**Please attach additional sheets if necessary.*

ALLERGIES			
	No known allergies		Yes, I have the following medication and/or food allergies. Please describe your reaction to each medication/food listed.

SURGICAL HISTORY		
YEAR	LOCATION	TYPE (Please describe any complications)

I attest that the above information is correct to the best of my knowledge.

Signature of Patient / Legal Guardian / Legal Representative

Date

Name of Legal Guardian / Legal Representative (Please Print)

Relationship to Patient

Quakertown Family Medical Center P.C.

Internal Medicine
HIPPA Form

Cira Amenta D.O.
Kathy Gotwals PA-C

Authorization to Release Health Information

I, _____, hereby authorize any physician, nurse or
(Print Name)

health care professional that has attended to me at Quakertown Family Medical Center P.C. to release and/or discuss all Protected Health Information pertaining to my care to:

_____
(Print Name(s))

_____
(Print Name(s))

Therefore, Quakertown Family Medical Center P.C. will not be held liable for the release of this information to the above individual(s).

_____
Patient's Signature Today's Date