Diane J Sutter, MD

3800 Delaware Avenue Suite 102

Kenmore, NY 14217

716-650-5548 (o) 716-783-8557 (f)

Date: \_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_ Zip: \_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_The best time to contact me is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best number to contact me is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check Appropriate: Single In Relationship Married Widowed Separated Divorced

Race: \_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity: \_\_\_\_\_\_\_\_\_\_\_\_ Primary Language: \_\_\_\_\_\_\_\_\_\_\_\_

If Student, Name of School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State \_\_\_\_\_\_\_\_\_\_\_\_ full time or part time

Spouse or Parent's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name and Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please Read: I hereby authorize my insurance benefits to be paid directly to Diane J Sutter MD I understand I am responsible for all charges including my added costs incurred due any effort to collet for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Instructions: For new patients being seen for the first time, please complete entire form. For patients who have completed this form in the past, please add any new information since the last time you filled out the form.

Patient Name (First, Middle, Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Last Menstrual Period: | Age at Menopause: \_\_\_\_\_\_\_\_ N/A \_\_\_\_\_ |
| Age at first period: | Sexually Active: Yes\_\_\_\_\_ No \_\_\_\_\_  |
| Date of last mammogram: \_\_\_\_\_\_\_\_\_ N/A \_\_\_\_\_ | Partner : Male \_\_\_\_\_ Female \_\_\_\_\_ Other \_\_\_\_\_ |
| Date of last PAP:  | Abnormal Pap: Yes\_\_\_\_\_ No\_\_\_\_\_  |
| Date of last Bone Density: \_\_\_\_\_\_\_\_\_ N/A \_\_\_\_\_ | Type of Birth Control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ N/A \_\_\_\_ |
| Date of last Colonoscopy: \_\_\_\_\_\_\_\_\_ N/A \_\_\_\_\_ | Gardasil Vaccine: Yes \_\_\_\_\_ No\_\_\_\_\_\_  |
| Tubal Ligation Yes \_\_\_\_ No\_\_\_\_ N/A\_\_\_\_ |  |
| Vasectomy Yes \_\_\_\_ No\_\_\_\_ N/A\_\_\_\_ |  |
|  |  |

**Allergies** (medication, other): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Hospitalizations/Surgeries** (include year):

1. Hysterectomy Yes \_\_\_\_ No \_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Ovaries Removed Yes \_\_\_\_ No\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 8. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical and Family History:** Please circle ‘Self’ for any medical problems you have had and ‘Family’ for any medical problems family members have had (parents, grandparents, aunts, uncles, brothers, sisters):



FAMILY HISTORY:





**Personal History:**

Highest school grade level achieved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_





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**Current Medications and Supplements** (include vitamins, herbals, birth control, over the counter). Please list dose and frequency:

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