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 ____
2. Ovaries Removed Yes ____ No____
3. _____
4. _____
5. _____
6. _____
7. _____
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):

No Health Issues	Self___	Family___			
COPD	Self___	Family___	Anxiety	Self___	Family___
Endometriosis	Self___	Family___	Depression	Self___	Family___
Hepatitis C	Self___	Family___	Anemia	Self___	Family___
Thyroid Issues	Self___	Family___	Arthritis	Self___	Family___
Ovarian Cancer	Self___	Family___	Breast Cancer	Self___	Family___
Insomnia	Self___	Family___	Osteoporosis	Self___	Family___
Hypertension	Self___	Family___	Celiac Disease	Self___	Family___
High Cholesterol	Self___	Family___	Fibromyalgia	Self___	Family___
Diabetes	Self___	Family___	Gastric Reflux	Self___	Family___
Asthma	Self___	Family___	Hemorrhoids	Self___	Family___
Heart Disease	Self___	Family___	Lichen Sclerosis	Self___	Family___
PCOS	Self___	Family___	Menopause	Self___	Family___
Herpes	Self___	Family___	Migraines	Self___	Family___

FAMILY HISTORY:

	Alive	Deceased	Cause of Death	Medical Problems
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sisters (Number of ____)	_____	_____	_____	_____
Brothers (Number of ____	_____	_____	_____	_____

Cancer in the family:		
Breast	_____	relationship to you _____
Ovarian	_____	relationship to you _____
Colon	_____	relationship to you _____
Melanoma	_____	relationship to you _____
Prostate	_____	relationship to you _____
Other	_____	relationship to you _____

Personal History:

Highest school grade level achieved: _____

Occupation: _____

Number of Children: _____				
Pregnancies:	Total:	_____	Full Term:	_____
	Miscarriages	_____	Terminations:	_____

	Smoke					
	Cigarette	Yes ___	No ___	How many per day:		_____
	Vape	Yes ___	No ___	How many per day:		_____
	Cannabis	Yes ___	No ___	How many per day:		_____
Former Smoker		Yes ___	No ___	Quit Date:_____		

Drink Alcohol:		Never ___	Rarely ___	Often ___	Daily ___
Recreational Drugs:		Yes ___	No ___	Type _____	
Drug Allergies:		Yes ___	No ___	details _____	
Food Allergies:		Yes ___	No ___	details _____	
Primary Care Doctor		name:	_____		
		phone number:	_____		

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

1	_____
2	_____
3	_____
4	_____
5	_____
6	_____
7	_____
8	_____
9	_____
10	_____
11	_____
12	_____
13	_____
14	_____
15	_____
16	_____
17	_____
18	_____
19	_____
20	_____