Please complete, print and bring to your appointment. Please do not return email.

Health History Form

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

Who referred you? _____ Primary Care Physician: _____Dr.#_____

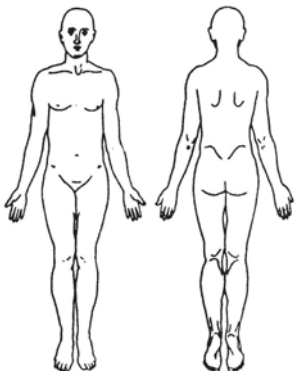
Occupation: _____ Marital Status_____ (married/single/partner/divorced/widowed)

Age: ____ Height: ____ Weight: ____ Sex: ____ Number of Children____

Reason for Office Visit: _____

_____

How Long have you had problem? _____ What started the problem? _____



Please print then indicate on diagram where you are experiencing pain.

What types of therapy have you tried for this problem/condition? (Please check)

Diet modification ☐ Vitamins/minerals ☐ Herbs ☐ Homeopathy ☐ Chiropractic ☐

Acupuncture ☐ Conventional medicines ☐ Physical therapy ☐

How would you rate your pain today? _____

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Severe Pain**

Please rate the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): _____

What are the major causes of your stress? (i.e.: changes in job, residence, finances, legal issues, etc.)

_____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last 3 months? _____

_____

Do you experience any of these symptoms EVERYDAY?
(Please check appropriate box(es)

- ☐ Debilitating fatigue
- ☐ Depression
- ☐ Disinterest in sex
- ☐ Disinterest in eating
- ☐ Shortness of breath
- ☐ Panic attacks
- ☐ Headaches
- ☐ Dizziness
- ☐ Insomnia
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Fecal incontinence
- ☐ Urinary incontinence
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Rectal bleeding
- ☐ Discharge
- ☐ Itching/rash
- ☐ Diarrhea

Family History (Please check if a parent or sibling has been diagnosed)

- ☐ Arthritis
- ☐ Alzheimer's disease
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Heart disease
- ☐ Mental illness
- ☐ Obesity
- ☐ Stroke
- ☐ Cancer

Other_____

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Center for Wellness Medicine
171 Defense Highway
Annapolis, MD 21401

Your Medical History (Please check appropriate box(es)

Medical History

- ○ Arthritis
- ○ Allergies/hay fever
- ○ Asthma
- ○ Alcoholism
- ○ Alzheimer's disease
- ○ Autoimmune disease
- ○ Blood pressure problems
- ○ Bronchitis
- ○ Cancer
- ○ Chronic fatigue syndrome
- ○ Carpal tunnel syndrome
- ○ Cholesterol, elevated
- ○ Circulatory problems
- ○ Colitis
- ○ Dental problems
- ○ Depression
- ○ Diabetes
- ○ Diverticular disease
- ○ Drug addiction
- ○ Eating Disorder
- ○ Epilepsy
- ○ Emphysema
- ○ Eyes, ears, nose, throat problems
- ○ Environmental sensitivities
- ○ Fibromyalgia
- ○ Food intolerance
- ○ Gastroesophageal reflux disease
- ○ Genetic disorder
- ○ Glaucoma
- ○ Gout
- ○ Heart disease
- ○ HIV/AIDS
- ○ Infection, chronic
- ○ Inflammatory bowel disease
- ○ Irritable bowel syndrome
- ○ Kidney or bladder disease
- ○ Learning disabilities
- ○ Liver or gallbladder disease (stones)
- ○ Mental illness
- ○ Mental retardation
- ○ Migraine headaches
- ○ Neurological problems (Parkinson's, paralysis)
- ○ Sinus problems
- ○ Stroke
- ○ Thyroid trouble
- ○ Obesity
- ○ Osteoporosis
- ○ Pneumonia
- ○ Sexually transmitted disease
- ○ Seasonal affective disorder
- ○ Skin problems
- ○ Tuberculosis
- ○ Ulcer
- ○ Urinary tract infection
- ○ Varicose Veins
- ○ Other (please list below)

Medical (Men)

- ○ Benign prostatic hyperplasia (BPH)
- ○ Prostate cancer
- ○ Decreases sex drive
- ○ Infertility
- ○ Other:

Medical (Women)

- ○ Menstrual irregularities
- ○ Endometriosis
- ○ Infertility
- ○ Fibrocystic breasts
- ○ Fibroids/ovarian cysts
- ○ Premenstrual syndrome (PMS)
- ○ Breast cancer
- ○ Pelvic inflammatory disease
- ○ Vaginal infections
- ○ Decreased sex drive
- ○ Other:

- ○ Form of birth control:

- ○ # of children: _____
- ○ # of pregnancies: ___
- ○ C-section
- ○ Surgical menopause
- ○ Menopause
- ○ Date of last menstrual cycle:

Any recent changes in normal menstrual flow? (e.g. heavier, large clots, scanty, etc.)

Health Habits

Tobacco:
Cigars or Cigarettes#/day:

Alcohol:
drinks/ week:

Caffeine:
Coffee: #6oz. cups/day: _____
Tea: #6 oz. cups/day: _____
Soda w/ caffeine: # cans/day:

Water: # glasses/day: _____

Exercise

- ○ 5-7 days per week
- ○ 3-4 days per week
- ○ 1-2 days per week
- ○ 45 minutes or more per workout
- ○ 30-45 minutes duration per workout
- ○ Less than 30 minutes

Nutrition and Diet

- ○ Vegetarian
- ○ Vegan
- ○ Salt restriction
- ○ Fat restriction
- ○ Starch/carbohydrate restriction
- ○ Total calorie restriction

Specific food restriction:

- ○ Dairy
- ○ Wheat
- ○ Eggs
- ○ Soy
- ○ Corn
- ○ All gluten
- ○ Other:

Eating Habits

- ○ Skip breakfast
- ○ Three meals/day
- ○ Two meals/day
- ○ One meal/day
- ○ Eat constantly whether hungry or not
- ○ Generally, eat on the run
- ○ Add salt to food

Current Supplements

- ○ Multivitamin/Mineral
- ○ Vitamin C
- ○ Vitamin E
- ○ EPA/DHA
- ○ Evening Primrose/GLA
- ○ Calcium, Source:

- ○ Vitamin D
- ○ Magnesium
- ○ Zinc
- ○ Other Minerals
- ○ Friendly flora (acidophilus)
- ○ Digestive enzymes
- ○ Amino Acids
- ○ CoQ10
- ○ Antioxidants
- ○ Chinese herbs
- ○ Ayurvedic herbs
- ○ Homeopathy
- ○ Protein Shakes
- ○ Superfoods (e.g. bee pollen, phytonutrients)
- ○ Liquid meals
- ○ Glucosamine Sulfate
- ○ Chondroitin Sulfate
- ○ SAMe
- ○ Turmeric (curcumin)

Office Notes:

Frederick T. Sutter, MD, LLC
Center for Wellness Medicine

Medication & Surgical History Form

Date: _____

Patient Name:_____ Date of Birth: _____

Allergies

Name of Substance (drug or food)	Type of Reaction
Click if none	

Do you react to latex or rubber (gloves, balloons, etc.) with a rash, wheezing, etc.? □ Yes □ No

Current Medications

Prescription Drugs (such as Atenolol, eye drops, ointments)	Strength (5 mg, etc)	Directions (such as 1 tablet twice a day) Check box if taken only as needed.		Name of the provider who prescribed the medication
Click if none				
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	

Over-the-Counter Medications (such as ibuprofen)	Strength	Directions (such as "take as needed for pain")

Herbs, Vitamins, Minerals, Etc. (such as Glucosamine)	Strength	Directions (such as one tablet per day)

Patient Name:_____ Date of Birth:_____

Type Of Surgery	Approximate Date	Surgeon / Hospital

Social History

Tobacco Use

Do you smoke or use any tobacco products?…… ☐ Yes ☐ No ☐ Quit

Number of cigarettes each day? _____

For how many years? _____

Year that you quit? _____

Other forms of tobacco used? _____

Alcohol Use

Do you drink alcohol?…… ☐ Yes ☐ No ☐ Quit

Type of Alcohol? ☐ Beer ☐ Wine ☐ Hard Liquor

How much? _____

How often? _____

Have you ever felt that you should cut down on your drinking?…….. ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking? …… ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking? …… ☐ Yes ☐ No

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ☐ Yes ☐ No

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PATIENT DEMOGRAPHICS

Today's Date: _____

Patient Name: _____ DOB: _____

Address: _____ Sex: FEMALE ◯ MALE ◯

_____ SSN#: _____

Home Tele #: _____ Cell #:_____

Work Tele#: _____ Employer Name: _____

Employer Address : _____

E-Mail: _____ Referred By: _____

I authorize Dr. Sutter's office to send promotional and informational emails to my email address.

What is your favorite past time? (security question)_____

Emergency Contact: _____ Tele#: _____ Relationship: _____

Emergency Contact Address: _____

Marital Status:

- ☐ Never Married
- ☐ Married
- ☐ Annulled
- ☐ Polygamous
- ☐ Domestic Partner
- ☐ Widowed
- ☐ Separated
- ☐ Divorced
- ☐ Interlocutory

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient Declined

Race:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native
- ☐ Hawaiian/other Pacific Islander
- ☐ White
- ☐ Patient Declined

PLEASE COMPLETE THE FOLLOWING INSURANCE INFORMATION:

Primary Care Physician: _____

Tele #: _____

Address: _____

PRIMARY INSURANCE: _____

POLICY #:_____ GROUP #:_____

INSURED NAME: _____

2ND INSURANCE: _____

POLICY #: _____ GROUP #: _____

INSURED NAME: _____

If visit is related to a Worker's Comp. or Motor Vehicle Accident injury, please complete the following information:

INSURANCE NAME: _____

DATE OF INJURY OR ACCIDENT: _____ CLAIM #: _____

ADJUSTER NAME: _____ TELE #: _____

ATTORNEY'S NAME:_____ TELE #: _____

Please read and sign back page

*******PLEASE READ AND SIGN THE FOLLOWING*******

AUTHORIZATION TO PAY BENEFITS: I authorize services to be submitted to the above health insurance carrier(s) and payment of insurance or government benefits to be paid directly to Frederick T. Sutter, MD, LLC.

AUTHORIZATION TO RELEASE INFORMATION: I authorize the release of any medical or other information necessary to determine benefits and process covered services provided by Frederick T. Sutter, MD, LLC.

FINANCIAL AGREEMENT: I understand that I am responsible for all charges related to any services or supplies not covered by my insurance. Patient copayment will be paid at time of service. Payment of insurance balances are expected within 30 days of receipt of patient billing statement. I understand that some services or products recommended by the office of Frederick T. Sutter, MD, LLC, are not covered by insurance. Payment is expected at the time of service for these supplies or services. I understand that Frederick T. Sutter MD, LLC reserves the right to report delinquent accounts to a collection agency.
A copy of this authorization will be deemed as valid as the original authorization.

_____

PATIENT OR AUTHORIZED PERSON'S SIGNATURE **DATE**

Frederick T. Sutter, MD, LLC

Center for Wellness Medicine

NOTICE TO PATIENTS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. The General Authorization for Release of Medical Records that you sign authorizes your medical care provider, Frederick T. Sutter, M.D., LLC ("Provider"), to disclose the information in your medical records to the extent needed for the following purposes:

1. For the purpose of providing treatment to you. This would include, for example, sharing information with employees and contractors of Provider, or with other health care providers who are treating you or consulting in your care.
2. For the purpose of arranging payment for your care. This would include, for example, your insurer or other third-party payor who is responsible for paying all or part of the cost of your care.
3. For the purpose of Provider's "health care operations." This would include such things as internal quality assessment activities, contacting other health care providers regarding treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service, resolutions of internal grievances and the provision of legal and auditing services.

B. A Specific Authorization for Release of Medical Records that you may sign authorizes Provider to make a specific disclosure that is not covered under section A, above. A Specific Authorization will name the party to whom you are authorizing disclosure, and will contain any limitations on the authority to disclose your records.

C. You may revoke any authorization provided to Provider by giving Provider a written notice of revocation. Provider may refuse to treat you if you revoke the General Authorization.

D. Provider may be required by law, in some cases, to make disclosures of your record that you have not authorized. Examples are subpoenas in criminal or civil litigation, or requests/surveys by licensure agencies or the U.S. Department of Health and Human Services.

E. Provider may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you

F. You have the following rights with respect to your medical records/information:

1. You have the right to request restrictions on the use and disclosure of your medical records/information; however Provider is not required to agree to restrictions not guaranteed by law. You will be informed if Provider will not agree to a requested restriction.
2. You have the right to receive confidential communications of your health information and to direct the place and manner of communication.
3. You have the right to inspect and copy your medical records. (Provider is entitled to charge you a reasonable fee related to the cost of copying your records).
4. You have the right to seek to amend your medical records, and if Provider does not agree with your request, to note your objection in the medical record.
5. You have a right to receive an accounting (list) of disclosures of your medical records/information made by Provider. (Except for those disclosures that fall within the scope of Provider's "health care operations" or disclosures made for payment or treatment purposes.)
6. You have the right to receive a paper copy of this notice.

G. Provider is required by law to maintain the privacy of protected health information, and to provide patients with this notice of its duties and practices, as well as changes to those practices.
Patients will be provided with revised notices, as appropriate.

H. If a patient believes that his or her privacy rights have been violated, the patient may complain to Provider, or to the Secretary of the U.S. Department of Health and Human Services. To complain to Provider, please write or call us with the details. Provider will not retaliate in any way against a patient for making a complaint.

I. If you as a patient or guardian believe that your privacy rights have been violated, and wish to notify our practice, please call our office and ask to speak with our designated **Privacy Complaints Contact Person**: Linda Showalter.

J. Provider reserves the right to change its privacy practices and to make its new policies effective for all protected health information that provider maintains. If such changes are made, Provider will issue an updated "Notice to Patients" to all of Provider's patients.

GENERAL AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, patient of Frederick T. Sutter, M.D., LLC ("Provider"), understand that my signature below gives Provider permission, to the extent necessary, to use my medical record, and to provide access to my medical record, while and after I am treated by Provider, for the reasons that follow:

1. For the purpose of providing treatment to me;
2. For the purpose of arranging for payment for my care; and
3. For the purpose of Provider's "health care operations." This last category includes such things as internal quality assessment activities, contacting other health care providers regarding

treatment alternatives, evaluating provider performance, training providers of care, legal and medical review of care provided, business planning and management, customer service, resolution of internal grievances and the provision of legal and auditing services.

I understand that my permission allows Provider to transmit permissible information through any means that is reasonably secure, including via e-mail, assuming that reasonable protective measures are taken to preserve the confidentiality of the information.

I understand that I may revoke this authorization at any time, but that Provider may refuse to give me further treatment if I do so.

I understand that I have the right to request that Provider restricts how my medical information is used. If you wish to request a restriction, request a separate form to fill out. Your request will be reviewed and a return form will be completed in response to your request.

I understand that I have a number of rights identified below (and listed more fully on the Patient Notice provided to me by Provider):

* The right to review, and copy, my medical record.
* The right to request the amendment (changing) of my medical record.
* The right to grant or deny access to my record to others.
* The right to decide how information from my record will be conveyed to others.
* The right to complain about how my records are handled, to the Secretary of the U.S. Department of Health and Human Services, and to Provider.
* The right to revoke, in writing, any consent that I provide for access to my record.
* The right to authorize Provider to give information about my care to relatives or close friends, to the extent of their involvement with my care or payment.
* The right to review a record of access to my medical record.
* The right to be notified following a breach of unsecured protected health information (PHI).
* The right to restrict certain disclosures of PHI to a health plan where I pay out of pocket **in full** for the health care item or service.
* The right for other uses and disclosures not otherwise described in the Notice of Privacy Practices (NPP) will be made only with authorization from me.
* The right that my authorization is required for the sale of PHI.
* The right that my authorization is required for marketing purposes, including subsidized treatment communications.

I understand that I have the right to either grant or deny access to my medical record, and that my specific written permission will be sought if access is requested for any reason not set forth above.

I understand that I may be contacted for fundraising purposes: however, I have the right to opt out of fundraising communications with each solicitation.

DISCLOSURE TO FAMILY/FRIENDS

____ I do not want Frederick T. Sutter, M.D., LLC ("Provider") to disclose any information concerning my care or treatment by Provider to individuals without my express written consent or legal authorization.

____ I authorize Provider to disclose information related to my care and treatment to the following named individual(s):

____ I authorize Dr. Sutter's office to phone my home to confirm any future appointments that I may have with his office.

____ I authorize Dr. Sutter's office to send promotional and informational emails to my email address: _____

_____ _____

_____ _____

_____ _____

The authorizations provided for above are subject to the following limitations or restrictions:

_____

_____

_____

_____

_____

The provider may decide to change some of the above-stated policies, and I understand that I will be given a revised Notice if this occurs.

Please acknowledge receipt and review of this notice by signing below. For further information, please call Linda Showalter at (410)-224-4446.

_____

Patient Name (Printed)

_____ _____

Signature of Patient (or legally responsible individual) Date

_____ _____

Witness Date

Frederick T. Sutter, MD, LLC
Center for Wellness Medicine

POLICY FOR MISSED APPOINTMENTS & CHANGES/CANCELLATIONS

If you need to change or cancel an appointment, we kindly ask that sufficient notice be considered so that another patient may take advantage of the time you are changing. The policy is as follows:

- **24-hours notice** (1 complete business day not including weekends or holidays) to reschedule an appointment for a follow-up visit.
- **48-hours notice** (2 complete business days not including weekends or holidays) to reschedule an appointment for a new patient visit.

Please note that cancellations or changes with less than the above-mentioned notice are considered "missed appointments". More than 2 appointments not cancelled at least 24 hours prior to the appointment time (48 hours for new patients) may be billed a $25 missed appointment fee. More than 3 missed appointments not cancelled at least 24 hours prior to the appointment time (48 hours for new patients) may result in dismissal from the practice.

We implement this policy because the health of our patients is our highest priority. It is with this in mind that we discourage missed appointments and appointment cancellations in all but the most exceptional situations.

INSURANCE & PAYMENT POLICY

Proof of Insurance: Please complete the patient information form before seeing Dr. Sutter. At that time, we will also ask for proof of insurance in the form of a copy of your current, valid photo I.D. and current, valid insurance card. If you are not insured or cannot provide proof of insurance then payment in full for each visit is required.

Insurance: If you are insured by a plan with which we are not a provider, payment in full for each visit is required. Please contact your insurance company to verify that Frederick T. Sutter M.D., LLC is a participating physician. Further, we ask that you pay for any non-covered services in full at the time of your visit and denied services will be billed to the address you have provided.

Co-Payments & Deductibles: If we are a participating provider with your insurance company, they require that we collect all co-pay and deductibles at the time of service.

Non-Payment: If your account is past due, you will receive a letter stating that payment is expected upon receipt. Partial payments will be accepted if arrangements have been made. If your account remains unpaid, we may refer your account to collection and/or you may be dismissed from this practice. If either collection or dismissal does occur, you will be notified by mail at the address you have provided.

FORM COMPLETION

There will be a $25 fee per form completed by Dr. Frederick Sutter and/or staff members.

AGREEMENT

I understand the office policies as stated above and I agree to fulfil my responsibilities as a patient as stated herein.

_____ _____

Patient Signature Date