ROBERT S CUTLER, D.O. Proctologist, Board Certified
SHERI S. GRISSO, ARNP Nurse Practitioner, Board Certified

Medical and Surgical Treatment of Colon and Rectal Disorders Colorectal Cancer Screening

COLORECTAL HISTORY QUESTIONAIRE

Please indicate with a check mark if any of the following pertain to you:

	NO	YES
Do you currently suffer from, or have you had any recurring symptoms of:		
1. Rectal discomfort or spasm?---	☐	☐
2. Rectal protrusion or bulging?---	☐	☐
3. Difficulty in holding bowel movements?--	☐	☐
4. Rectal seepage?---	☐	☐
5. Lower abdomominal aches, cramping or pain?--	☐	☐
6. Changes in your bowel habits (constipation, diarrhea, frequency)?-----------------	☐	☐
7. Growths around the anus?--	☐	☐
8. Discharge of pus or development of cysts (lumps) From the anus, surrounding tissues or tailbone?--	☐	☐
9. Rectal itching?---	☐	☐
Have you **EVER** had:		
1. Rectal bleeding or bright red or pink discharge on tissue after wiping?-------------	☐	☐
2. Polyps (growths) or cancer (bowel, rectal or lower-intestinal)?----------------------	☐	☐
3. A blood relative with a history of colon or rectal polyps?------------------------------	☐	☐
4. A blood relative with a history of colorectal cancer?-----------------------------------	☐	☐
5. Ulcerative colitis or Crohn's disease?--	☐	☐
Have you had any of the following examinations:		
1. Rectal (fingers) exam?--	☐	☐
2. Hemoccult stool exam?---	☐	☐
3. Sigmoidoscopy (a look into your lower colon)?---	☐	☐
4. If yes date of procedure____________________Findings_________________		
5. Colonoscopy (a look around your entire colon)?--	☐	☐
If yes date of procedure___________________Finding___________________		
6 Men Only: PSA (prostate specific antigen) a blood test?------------------------------	☐	☐
If yes date of test________________________Result___________________		

Although, many rectal disorders may be diagnosed in an office setting, I understand a colonoscopy is necessary for a definitive diagnosis of my symptoms. I understand this is a procedure which may possibly locate polyps which could potentially prevent colorectal cancer. I am aware that my provider is limited by my decision and that his or her inability to fully examine me could, in fact, lead to my death or disability since he is unable to fully diagnose my condition without it. I agree to either schedule this procedure today or sign a refusal to do so and accept the consequences of this decision.

Name ____________________ Signature ____________________________ DOB ______________ Date _____________

13005 Southern Boulevard, Medical Mall 1, Suite 121, Loxahatchee, FL 33470 (561)842-5050
538 Port St. Lucie Boulevard, Port St Lucie, Fl 34984 (561)871-6222
Fax:(561)793-9989

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Colorectal Cancer Screening

Current Medications (include over the counter and vitamins)

Medication Name / for what condition / how long you have been taking/ how many and how often / provider that refills

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SURGERIES (Include dates, hospital or city and name of surgeon)

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Previous or Current ILLNESS (not listed above) including ACCIDENTS (include dates and treatments)

____

____

SMOKER: Never________Quit(date)________Smokes/Smoked________packs per day for________yrs.

ALCOHOL: None______Rarely______Socially______Daily (check)___1___2___3___4 or more drinks a day.

Name: ___________ Allergies to Medications__________________DOB: Appt Date____________

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Robert S. Cutler, D.O., Proctologist, Board Certified
Sheri S. Grisso, ARNP, Nurse Practitioner, Board Certified

Check if you have currently or have had in the past. Check both if applicable. Leave blank if neither apply.

Have you EVER had?

GASTROINTESTINAL

	Currently	in the past
poor appetite	☐	☐
indigestion	☐	☐
heartburn	☐	☐
nausea	☐	☐
vomiting	☐	☐
vomiting blood	☐	☐
diarrhea	☐	☐
constipation	☐	☐
rectal bleeding	☐	☐
change in bowel habits	☐	☐
abdominal pain or cramps	☐	☐
swallowing problems	☐	☐

GENERAL

	Currently	in the past
fever	☐	☐
chills	☐	☐
dizziness	☐	☐
easily bruised	☐	☐
swollen glands	☐	☐
general weakness	☐	☐
chest pains	☐	☐
irregular heartbeat	☐	☐
loss of memory	☐	☐
neck pain	☐	☐
pains in back	☐	☐
persistent headaches	☐	☐
aches/pains	☐	☐
shortness of breath	☐	☐

GENITALIA

	Currently	in the past
possibly pregnant	☐	☐
change in menses or spotting	☐	☐
pain with intercourse	☐	☐

KIDNEY

	Currently	in the past
getting up at night to urinate	☐	☐
difficulty passing urine	☐	☐
pain or burning with urination	☐	☐
dribbling upon urinating	☐	☐
weak or slow stream	☐	☐
recurrent infections	☐	☐
blood in urine	☐	☐
bed wetting problem	☐	☐
unable to urinate	☐	☐
kidney stone	☐	☐
DifficultyControlling Urine/Lack Of Bladder Control	☐	☐
frequency of urination	☐	☐
discharge	☐	☐

FAMILY HISTORY Please think carefully **ABOUT YOUR RELATIVES (living or deceased)** include parents, siblings, aunts, uncles, grandparents & cousins. Indicate if maternal (M) or paternal (P) side.

Diabetes (please indicate if treated with medication by mouth, insulin (injected) or diet)

____

High Blood Pressure

____

Heart disease (Heart attack, Chest pain, Congestive Heart Failure-swollen legs & fluid overload)

____

Stroke

____

Thyroid disease (Hyperthyroid- skinny or Hypothyroid- fat)

____

Bleeding tendencies

____

Cancer

____

Other information you feel is important to your family history:

Name__________________________ Allergies to Medications________________________ DOB _____________ Date _____________

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10. **For Specific Government Functions/National Security:**
We may disclose to military authorities, veterans, federal officials, correctional institutions or law enforcement officials as required for lawful intelligence, counterintelligence, and other national security activities including protecting the President of the United States.
11. **Reminders of Health-Related Benefits or Services:**
We may use and/or disclose your PHI to provide reminders (including but not limited to voicemail messages, postcards, and/or letters) including, but not limited to appointments, treatment alternatives, and/or other health care services and benefits that we offer.
12. **Patient Directories:**
We may include your name in our patient directory for use by our sales and marketing staff, unless you object in whole or in part. We may disclose your PHI unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.
13. **For Worker's Compensation Purposes:**
We may provide PHI in order to comply with worker's compensation laws.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR CONSENT:

We may use and/or disclose your PHI without your consent or authorization for the following reasons:

1. **For Public Health Activities:**
As authorized by law to collect or receive information for births, deaths, preventing or controlling disease, injury or disability. Entities subject to FDA regulations. Employers for work related illness or injury to comply with OSHA. We will also provide coroners, medical examiners and funeral directors necessary information relating to an individuals death.
2. **For Health Oversight Activities:**
We will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

V. PATIENT RIGHTS YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

1. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we place additional restrictions on how we use or disclose your PHI. We will consider your request but are not legally required to accept your additional restrictions. If we accept your request, we will put any limits in writing and abide by them except in emergencies. You may not limit the uses and disclosures that we are legally required to make.
2. **The Right to Choose How We Send PHI to You:** You have the right to request that we communicate with you about your health information to an alternative location (for example, sending information to you to your work address rather than your home address). You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
3. **The Right to See and Get Copies of Your PHI with Limited Exceptions:** You may obtain a form to request access by using the contact information listed at the end of this Notice. With limited exceptions, in most cases, you have the right to look at or get copies of your PHI that we have, but you are required to make the request in writing to obtain access to your PHI. If we don't have your PHI but know who does, we will tell you how to obtain it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have your denial reviewed. If you request copies of your PHI, we will charge you **$01.75** for each page and **$10.00** per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your PHI as long as you agree to that and to the cost, however if you make more than one request in the same year, we will charge you $25.00 for each additional request. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI. You may request access by making your request in writing. Contact us for a full explanation of our fee structure.
4. **The Right to Get a List of the Disclosures We Have Made:** You have the right to request a list of instances in which this office disclosed your PHI annually. The list will not include disclosures that do not require your consent, uses or disclosures that you have already consented to, such as those made for treatment, payment or health care operations, and certain other activities, directly to you, to your family, or in our facility directory for the last 6 years but not before 4/1/03. We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last year. The list will include the date of the disclosure, to whom your PHI was disclosed, a description of the information disclosed and the reason for the disclosure. We will provide the list to you at no cost, however if you make more than one request, we will charge you $25.00 for each additional request.
5. **The Right to Correct or Update your PHI:** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we amend the existing PHI or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing, under certain circumstances, if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it and tell others that need to know about the change to your PHI.

VI. PERSON TO CONTACT FOR MORE INFORMATION ABOUT THIS NOTICE

If you have any questions, concerns or complaints about our privacy practices contact our Privacy Officer at our main office. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, or in response to a request you made to amend or restrict the use or disclosure of your PHI you may contact us using the information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate, intimidate or request patient to waive the right to complain in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: OFFICE MANAGER

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on October 1, 2002.
Updated July 15, 2006

Received By: ______________________________ Date: ________________

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