

# CONNECTICUT COLON & RECTAL SURGERY, LLC

Christina Czyrko, MD and Steven H. Brown, MD  
440 New Britain Avenue, Suite 1, Plainville, CT 06062  
Phone: (860) 826-3880 Fax: (860) 826-3883

## CONSULT-FREE COLONOSCOPY

Connecticut Colon and Rectal Surgery, LLC has developed a program which allows some patients to schedule a screening colonoscopy without the need for an office visit before the procedure.

***Please note: You MUST answer every question or we will not be able to schedule you for a Consult-Free Colonoscopy.***

### Instructions

1. Complete the entire Consult-Free Colonoscopy Questionnaire. If you have any questions, please call our office.  
*\*This questionnaire is double sided.*
2. Provide copies of **all insurance cards (both front & back)**. This would include your primary insurance, secondary, and tertiary insurance that you may have.
3. Provide a copy of your **photo ID**. This can be a copy of your driver's license, passport, or lawful permanent resident card (green card).
4. Return this form to our office via mail, fax, or in person
5. One of our clinicians will review your information. If you qualify for an Consult-Free Colonoscopy, we will contact you to schedule your procedure. If you do not qualify, we will schedule you for an office visit to discuss your needs with one of our highly-skilled providers.

**To return your completed form by mail:**

Connecticut Colon & Rectal Surgery, LLC  
Attn: Consult-Free Colonoscopy  
440 New Britain Avenue  
Suite 1  
Plainville, CT 06062

**To return your completed form by fax:**

(860) 826-3883

*\*Manual faxes only. We do not accept electronic faxes*

**To contact our office with any questions:**

(860) 826-3880

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**Consult-Free Colonoscopy Questionnaire**

**Patient Information**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Unit #: \_\_\_\_\_

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

Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Communication Preference:  Email  Text Message  Phone Call:  Home  Cell

Email address: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Gender/Sex:  Female  Male

Height (feet/inches): \_\_\_\_\_ Weight (lbs.) \_\_\_\_\_

Primary care doctor: \_\_\_\_\_ Telephone: \_\_\_\_\_

Cardiologist: \_\_\_\_\_ Telephone: \_\_\_\_\_

Obstetrician / Gynecologist (OB-GYN): \_\_\_\_\_

Pharmacy and address: \_\_\_\_\_

Primary insurance: \_\_\_\_\_ ID: \_\_\_\_\_

Secondary insurance: \_\_\_\_\_ ID: \_\_\_\_\_

Tertiary insurance: \_\_\_\_\_ ID: \_\_\_\_\_

Language spoken: \_\_\_\_\_ Interpreter Needed:  Yes  No

I would prefer instructions in:  English  Polish  Spanish

Last date I was seen by my primary care physician: \_\_\_\_\_

Last date I was seen by my cardiologist: \_\_\_\_\_

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1. Consult-Free Colonoscopy at our practice is approved for select patients at age 45 to 70.

a. How old are you now? \_\_\_\_\_

*Those who desire a colon cancer screening below the age of 45 or above the age of 70 are encouraged to schedule an office visit to determine if a screening is medically appropriate.*

2. Have you had a colonoscopy in the past?  Yes  No

a. If the answer is yes, please provide the name and phone number of the physician/facility who performed the procedure, as well as the date.

Name (physician and/or facility): \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Procedure: \_\_\_\_\_

*If the procedure was not with Dr. Christina Czyrko or Dr. Steven H. Brown, please sign the attached medical record release authorization.*

3. Do you have a personal history of colon cancer?  Yes  No  Unsure

4. Do you have a personal history of colon polyps?  Yes  No  Unsure

5. Do you have a family history of colon cancer?  Yes  No  Unsure

6. Do you have a family history of colon polyps?  Yes  No  Unsure

7. If the colonoscopy was recommended because of a family history of colon cancer or polyps, which relative had cancer or polyps and how old were they?

Relative who had cancer or polyps: \_\_\_\_\_ Age of relative at the time: \_\_\_\_\_

Relative who had cancer or polyps: \_\_\_\_\_ Age of relative at the time: \_\_\_\_\_

Relative who had cancer or polyps: \_\_\_\_\_ Age of relative at the time: \_\_\_\_\_

8. Have you had a positive Cologuard within the last year?  Yes  No  Unsure

9. Do you currently have any gastrointestinal symptoms?  Yes  No

*Such as abdominal pain, bleeding, weight loss, constipation, diarrhea*

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**Tobacco Status: Smoking**

- Never       Former       Current (some days)       Current (every day)  
 Cigarettes       Cigar       Pipe

If yes, how many packs per day do you smoke? \_\_\_\_\_ How many years? \_\_\_\_\_

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**Tobacco Status: Smokeless**

- Never       Former       Current (some days)       Current (every day)  
 Chew       Snuff
- 

**E-Cigarettes**

- Never       Former       Current (some days)       Current (every day)  
 Nicotine       THC       CBD       Flavoring       Other: \_\_\_\_\_  
 Disposable       Pre-filled or Refillable Cartridge       Refillable Tank  
 Pre-filled Pod       Other: \_\_\_\_\_
- 

**Alcohol History**

- Never       Daily       Weekly       Occasional/Social

Average number of drinks per week? \_\_\_\_\_

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**Drug History**

- Yes       No       Not currently       Never       Medical       Recreational  
 Daily       Weekly       Occasional/Social

**Types:**  "Crack" Cocaine       Amphetamines       Amyl nitrate       Anabolic Steroids  
 Benzodiazepines       Cocaine       Codeine       Fentanyl       Flunitrazepam       GHB       Hashish  
 Heroin       Hydrocodone       Hydromorphone       IV       Ketamine       LSD       Marijuana  
 MDMA (ecstasy)       Mescaline       Methamphetamines       Methaqualone       Morphine       Nitrous oxide  
 Opium       Oxycodone       Psilocybin       Solvent Inhalants       Other: \_\_\_\_\_

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## Medical History

### Symptoms:

- None  Abdominal pain  Acid reflux  Black stool  Stool incontinence  Gas/Bloating  
 Change in bowel habits  Chills  Colitis  Constipation  Fever  Nausea  Indigestion  
 Hemorrhoids  Loss of appetite  Rectal bleeding  Vomiting  Weight loss  
 Other, please explain:
- 
- 
- 

### Medical conditions:

- None  Alzheimer's Disease  Anemia  Anxiety disorder  Arthritis  Sleep apnea  
 Asthma  Atrial fibrillation  Bipolar disorder  Bleeding disorder  Lung clots  
 Congestive heart failure  Depression  Diabetes  Fibromyalgia  Heart arrhythmia  
 Elevated cholesterol  Emphysema/COPD  GERD/Acid reflux  Hepatitis  Hiatal hernia  
 Heart attack/MI  Heart valve murmur  Hemodialysis  High blood pressure  HIV/AIDS  
 Kidney problems  Liver cirrhosis  Stroke/TIA  Pacemaker/defibrillator  Pancreatitis  
 Parkinson's disease  Schizophrenia  Seizure disorder  Stomach/duodenal ulcer  
 Thyroid disease  Tuberculosis  Other (describe below)
- 
- 
- 

### PAST SURGERIES:

- NONE  COLON SURGERY  CORONARY BYPASS  LUNG SURGERY  HIATAL HERNIA REPAIR  
 DEFIBRILLATOR (AICD) PLACEMENT  GASTRIC BYPASS SURGERY  PACEMAKER PLACEMENT  
 OTHER (DESCRIBE BELOW)
- 
- 
- 

### FAMILY HISTORY:

- NONE  BLEEDING PROBLEMS  BREAST CANCER  CELIAC DISEASE  COLON CANCER  
 COLON POLYPS  CROHN'S DISEASE  HEPATITIS  PROSTATE CANCER  RECTAL CANCER  
 STOMACH CANCER  UTERINE / OVARIAN CANCER  OTHER (DESCRIBE BELOW)
- 
- 
- 

HAVE YOU HAD ANY PROBLEMS WITH ANESTHESIA?  YES  NO

PROVIDE ANY ADDITIONAL COMMENTS OR INFORMATION BELOW:

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**MISCELLANEOUS**

1. Do you have or have you been treated for any of the following?
- a. Ulcerative Colitis or Crohn’s disease     Yes     No
  - b. Renal failure or dialysis             Yes     No
  - c. Defibrillator, pacemaker, or artificial heart valve     Yes     No  
*If yes, please attach a copy of the card provided with the make and model.*
  - d. Bleeding disorder     Yes     No
  - e. Organ transplant     Yes     No
  - f. Sleep Apnea     Yes     No  
Do you use a CPAP machine?     Yes     No
  - g. Cancer     Yes     No  
If yes, have you had radiation or chemotherapy?     Yes     No
2. Are you able to walk without help for 2 blocks or more?     Yes     No
3. Do you have any type of disability?     Yes     No  
If yes, please list: \_\_\_\_\_
4. Do you take any blood thinners other than Aspirin?     YES     NO

**ALLERGIES:**

PLEASE LIST ALL ALLERGIES (ENVIRONMENTAL, MEDICATION, FOOD)	THE REACTION YOU HAVE.



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*Patient statement for consult-free colonoscopy:*

I have reviewed the consult-free colonoscopy questionnaire and have answered all the questions truthfully to the best of my knowledge.

I hereby authorize Connecticut Colon & Rectal Surgery, LLC to obtain my medical records from my primary care physician and/or cardiologist through direct communication, electronic health record system and/or electronic medical record system.

Since we do not use a paper system for documenting the care of patients, we can only use our EMR. We hope that you will find the EMR system facilitates your care. If you don't want your medical information stored in our EMR, we unfortunately cannot care for you in this practice. If you have any questions, please do not hesitate to ask us about our EMR.

Patient Signature: \_\_\_\_\_

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