



## **RHEUMATOLOGY & INFUSION CENTER**

Dr. Timothy Lonesky DO

Dr. Scott Lewis DO

Melissa Cheng CRNP

Megan Fackler CRNP

**26 OXFORD WAY, SUITE A  
SOMERSET, KY 42503**

**Phone 606-802-2300    Fax: 606-802-2400    email: [info@lcrheumatology.com](mailto:info@lcrheumatology.com)**

**Website: [www.insidelcr.com](http://www.insidelcr.com)**

Our goal is to be a premiere rheumatology practice where we offer compassionate and efficient care.

You can mail, fax, or email the packet before your visit or simply bring your completed packet in during your visit.

If you are unable to print the NEW PATIENT packet, please call or email us requesting one to be sent to you. Our office directions are included in the NEW PATIENT packet.

In Addition: Bring any recent labs and tests that are relevant.  
Bring a copy of your license and insurance card to every visit.

Thank You,  
LC Rheumatology Staff

**\*WE DO NOT ACCEPT ANY FORM OF MEDICAID\***  
**As of January 1,2020 we will no longer accept any New Patients with Medicaid as  
a Secondary Insurance!**

**DIRECTIONS:**

\*Please use 75 Hail Knob Road in GPS as our address is not always accurate ( we are the building next to that address ) We are located off of Hail Knob Road, behind Lake Cumberland Regional Hospital.



## RHEUMATOLOGY & INFUSION CENTER

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

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

Phone # \_\_\_\_\_ Phone # \_\_\_\_\_

Soc Sec # ( needed for prescriptions: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M\_\_ F\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_

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

Please list insurance companies you have coverage through below in order of coverage:

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

Subscriber of Insurance: Self / Spouse \_\_\_\_\_

Date of Birth of Subscriber ( if different than yourself ): \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Care Physician: \_\_\_\_\_

In Case of an Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency contact Phone # \_\_\_\_\_

**\*HOW DID YOU HEAR ABOUT LC RHEUMATOLOGY? \***

Family member/ Friend \_\_\_\_ Physician's office \_\_\_\_ Advertisement \_\_\_\_ Other

\_\_\_\_\_



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## RHEUMATOLOGY & INFUSION CENTER

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Below is a request for medical records in case we need to obtain any medical history from you in the future. **Please fill in your name, date of birth, and signature only!**

### Request for Release of Medical Records

**My name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Signature:** \_\_\_\_\_

**To:** \_\_\_\_\_

I hereby authorize you to release my medical records to:

LC Rheumatology and Infusion Center

26 Oxford Way, STE A Somerset,

KY 42503

Phone: 606-802-2300

Fax: 606-802-2400



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## RHEUMATOLOGY & INFUSION CENTER

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I, \_\_\_\_\_, authorize the staff of LC Rheumatology, to speak with the person(s) listed below, concerning any of my medical records, prescriptions and appointment information.

1. \_\_\_\_\_ relationship: \_\_\_\_\_

2. \_\_\_\_\_ relationship: \_\_\_\_\_

3. \_\_\_\_\_ relationship: \_\_\_\_\_

4. \_\_\_\_\_ relationship: \_\_\_\_\_

Signature of patient \_\_\_\_\_ Date: \_\_\_\_\_

**\*If at any time the information above should change, please contact LC Rheumatology immediately so we can update the information in your chart \***

**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_

**What brings you to the rheumatologist:**

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If needed, please write on the backside of this paper to further describe your condition.

Body region of symptoms: \_\_\_\_\_

Mark Quality of symptoms: \_\_\_ achy \_\_\_ stiff \_\_\_ throbbing \_\_\_ burning \_\_\_ tingling \_\_\_ sharp \_\_\_ dull

When did your symptoms start: \_\_\_\_\_

What diagnosis have you been given, if any? \_\_\_\_\_

Which Providers have you seen for this condition? \_\_\_\_\_

What has helped your symptoms? \_\_\_\_\_

What has not helped your symptoms? \_\_\_\_\_

**MEDICAL HISTORY** At any time have you or a blood relative had any of the following?

	<u><i>Yourself</i></u>	<u><i>Relative</i></u>	<u><i>Relationship</i></u>
Rheumatoid Arthritis	___	___	_____
Psoriasis/ Psoriatic Arthritis	___	___	_____
Lupus or “SLE”	___	___	_____
Fibromyalgia	___	___	_____
Ankylosing Spondylitis	___	___	_____
Sjogren’s Syndrome	___	___	_____
Osteoporosis	___	___	_____
Osteoarthritis	___	___	_____
Gout	___	___	_____

**PAST MEDICAL HISTORY**

__Diabetes	__Pulmonary Embolism	__Tuberculosis
__High Blood Pressure	__ COPD	__ Colitis
__Crohn’s/ Ulcerative Colitis	__Celiac Disease	__Kidney Stones
__High Cholesterol	__Stroke	__Anemia
__Hypothyroidism	__Epilepsy (seizures)	__Hepatitis
__Cancer (type)	__kidney disease	__Stomach Ulcer

Other Significant illnesses (please list): \_\_\_\_\_

**Previous Operations**

Type	Year	Reason
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

## Social History

What is your highest level of education? ☐ High School ☐ Some College ☐ College Graduate

What is your Occupation? \_\_\_\_\_

Are you Currently Working? \_\_\_\_\_

If not working, are you: ☐ Retired ☐ Disabled ☐ Sick Leave

Do you receive disability or SSI? ☐ Yes ☐ NO If yes, for what disability? \_\_\_\_\_

Number of days you exercise weekly? \_\_\_\_\_ What kind of exercise? \_\_\_\_\_

Do you smoke? ☐ Yes ☐ No If yes, how much? \_\_\_\_\_

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? \_\_\_\_\_

\_\_\_\_\_ I would like for my rheumatologist to pray for me after the work day

**Please Check if you have experienced any of the following over the past month**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> fever                 | <input type="checkbox"/> dry mouth                 | <input type="checkbox"/> muscle pain, aches, cramps      |
| <input type="checkbox"/> weight gain           | <input type="checkbox"/> problems with smell/taste | <input type="checkbox"/> muscle weakness                 |
| <input type="checkbox"/> weight loss           | <input type="checkbox"/> lump in throat            | <input type="checkbox"/> paralysis of arms/ legs         |
| <input type="checkbox"/> feeling sickly        | <input type="checkbox"/> cough                     | <input type="checkbox"/> numbness/tingling arms or legs  |
| <input type="checkbox"/> headaches             | <input type="checkbox"/> shortness of breath       | <input type="checkbox"/> fainting spells                 |
| <input type="checkbox"/> unusual fatigue       | <input type="checkbox"/> wheezing                  | <input type="checkbox"/> swelling of hands               |
| <input type="checkbox"/> swollen glands        | <input type="checkbox"/> pain in chest             | <input type="checkbox"/> swelling of ankles              |
| <input type="checkbox"/> loss of appetite      | <input type="checkbox"/> heart pounding            | <input type="checkbox"/> swelling in other joints        |
| <input type="checkbox"/> skin rash             | <input type="checkbox"/> trouble swallowing        | <input type="checkbox"/> joint pain                      |
| <input type="checkbox"/> hives                 | <input type="checkbox"/> heartburn                 | <input type="checkbox"/> back pain                       |
| <input type="checkbox"/> easy bleeding         | <input type="checkbox"/> stomach pain/ cramps      | <input type="checkbox"/> neck pain                       |
| <input type="checkbox"/> easy bruising         | <input type="checkbox"/> nausea                    | <input type="checkbox"/> use of drugs not sold in stores |
| <input type="checkbox"/> other skin problems   | <input type="checkbox"/> vomiting                  | <input type="checkbox"/> smoking cigarettes              |
| <input type="checkbox"/> loss of hair          | <input type="checkbox"/> constipation              | <input type="checkbox"/> > 2 alcoholic drinks per day    |
| <input type="checkbox"/> dry eyes              | <input type="checkbox"/> diarrhea                  | <input type="checkbox"/> depression                      |
| <input type="checkbox"/> other eye problems    | <input type="checkbox"/> dark or bloody stools     | <input type="checkbox"/> anxiety                         |
| <input type="checkbox"/> problems with hearing | <input type="checkbox"/> problems with urination   | <input type="checkbox"/> problems with thinking          |
| <input type="checkbox"/> ringing in the ears   | <input type="checkbox"/> gynecologic problems      | <input type="checkbox"/> problems with memory            |
| <input type="checkbox"/> stuffy nose           | <input type="checkbox"/> dizziness                 | <input type="checkbox"/> problems with sleeping          |
| <input type="checkbox"/> sores in the mouth    | <input type="checkbox"/> losing your balance       | <input type="checkbox"/> sexual problems                 |
|  |  | <input type="checkbox"/> burning in sex organs           |
|  |  | <input type="checkbox"/> problems with social activities |



**Over the Last Week, Were you Able to:**

	Without <b>ANY</b> Difficulty	With <b>Some</b> Difficulty	With <b>Much</b> Difficulty	<b>Unable</b> To DO
Dress Yourself?	__0	__1	__2	__3
Get in and out of bed?	__0	__1	__2	__3
Lift a full cup or glass to your mouth?	__0	__1	__2	__3
Walk outdoors on flat ground?	__0	__1	__2	__3
Wash and dry your entire body?	__0	__1	__2	__3
Bend down to pick up clothing off floor?	__0	__1	__2	__3
Turn regular faucets on and off?	__0	__1	__2	__3
Get in and out of a vehicle?	__0	__1	__2	__3
Walk 2 miles, if you wish?	__0	__1	__2	__3
Participate in recreational activities?	__0	__1	__2	__3
Get a good nights sleep?	__0	__1	__2	__3
Deal with feelings of anxiety/nervousness	__0	__1	__2	__3
Deal with feelings of depression/sadness	__0	__1	__2	__3

**AMOUNT OF PAIN YOU HAVE HAD OVER THE PAST WEEK? ( 0= NO PAIN, 10= WORST POSSIBLE )**

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

**HOW ARE YOU DOING WITH YOUR HEALTH CONDITION AT THIS TIME? ( 0= BAD, 10= GREAT )**

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

Pharmacy (include city ): \_\_\_\_\_

Mailing Pharmacy: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Drug Allergies: \_\_\_ No \_\_\_ Yes ( please list ) \_\_\_\_\_

\_\_\_\_\_

Medications ( including dose/ frequency ): If you have a written list, please give a copy to the receptionist to make a copy.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

8. \_\_\_\_\_

9. \_\_\_\_\_

10. \_\_\_\_\_

**PLEASE BE SURE TO LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING!**

