RHEUMATOLOGY & INFUSION CENTER

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26 OXFORD WAY, SUITE A
SOMERSET, KY 42503

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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

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.

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 _____

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

PRIMARY CARE PHYSICIAN:_____

What brings you to the rheumatologist:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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 your or a blood relative had any of the following?

	Yourself	***Relative***	***Relationship***
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

__fever
__weight gain
__weight loss
__feeling sickly
__headaches
__unusual fatigue
__swollen glands
__loss of appetite
__skin rash
__hives
__easy bleeding
__easy bruising
__other skin problems
__loss of hair
__dry eyes
__other eye problems
__problems with hearing
__ringing in the ears
__stuffy nose
__sores in the mouth

__dry mouth
__problems with smell/taste
__ lump in throat
__cough
__shortness of breath
__wheezing
__pain in chest
__heart pounding
__trouble swallowing
__heartburn
__stomach pain/ cramps
__nausea
__vomiting
__constipation
__diarrhea
__dark or bloody stools
__problems with urination
__gynecologic problems
__dizziness
__losing your balance

__ muscle pain, aches, cramps
__ muscle weakness
__ paralysis of arms/ legs
__ numbness/tingling arms or legs
__fainting spells
__swelling of hands
__swelling of ankles
__swelling in other joints
__ joint pain
__back pain
__neck pain
__use of drugs not sold in stores
__smoking cigarettes
__ > 2 alcoholic drinks per day
__depression
__ anxiety
__problems with thinking
__problems with memory
__problems with sleeping
__sexual problems
__burning in sex organs
__problems with social activities

Over the Last Week, Were you Able to:

	Without **ANY** Difficulty	With **Some** Difficulty	With **Much** Difficulty	**Unable** 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 <u>ALL</u> MEDICATIONS THAT YOU ARE CURRENTLY TAKING!