



Dr. Timothy Lonesky DO Dr. Scott Lewis DO
Tamra Thompson CRNP

**150 War Admiral, Suite 2
Danville, KY 40422**

Phone: 859-654-0160 Fax: 859-712-9273 email: insideLCR@gmail.com

Website: 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

DIRECTIONS:

We are located beside the Bluegrass Pharmacy off North 127



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 _____



RHEUMATOLOGY & INFUSION CENTER

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

150 War Admiral, Suite 2

Danville, KY 40422

Phone: 859-654-0160

Fax: 859-712-9273

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 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

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

