Kenneth R. Smith, MD
9700 Park Plaza Ave
Bldg # 1, Suite 103
Louisville, KY 40241
(502) 429-3937

Primary Care Physician: ______________________________

Are you allergic to any one of the following: (please circle)

Adhesive tape	Yes	No	Iodine	Yes	No
Anesthesia	Yes	No	Latex	Yes	No
Cephalosporins	Yes	No	Penicillin	Yes	No
Codeine	Yes	No	Sulfa Drugs	Yes	No
Demerol	Yes	No			

Other Allergies; (please list) ______________________________

____

Please list all medications you are currently taking: (including eye drops)

1) ____________________ 3) ____________________
2) ____________________ 4) ____________________
5) ____________________ 6) ____________________

Past History & Review Systems:
Have you had or still have the following?

Allergic Symptoms	Yes	No	if yes, type ____________
Blood Clotting Problems	Yes	No	
Bowel Problems	Yes	No	
Cancer	Yes	No	if yes, type ____________
Cardiac Disease	Yes	No	
Chest Pain	Yes	No	
Diabetes	Yes	No	
Eye Conditions	Yes	No	if yes, type ____________
Hepatitis or jaundice	Yes	No	
High Blood Pressure	Yes	No	
Migraine Headaches	Yes	No	
Immunologic Disorders	Yes	No	if yes, type ____________
Neurological Diseases	Yes	No	if yes, type ____________
Respiratory Problems	Yes	No	
Rheumatoid Arthritis	Yes	No	
Skin-related Problems	Yes	No	if yes, type ____________
Stroke	Yes	No	if yes, when ____________
Thyroid Problems	Yes	No	

Other: ______________________________

Past Surgical History

Please list all surgeries:

1)____Year__________
2)____Year__________
3)____Year__________
4)____Year__________
5)____Year__________
6)____Year__________
7)____Year__________
8)____Year__________

Has anyone in your family had any of the following?

Condition	
Cancer	Who? ____________________
Heart Problems	Who? ____________________
Cataracts	Who? ____________________
Diabetes	Who? ____________________
Glaucoma	Who? ____________________
Macular Degeneration	Who? ____________________
Retinal Detachment	Who? ____________________
Other	____________________

Social History

Do you Smoke?	Yes	No	If yes, how often and how much?________
Do you Drink Alcohol?	Yes	No	If yes, how often and how much?________
Do you use Illicit Drugs?	Yes	N0	If yes, how often and how much?________

Marital Status: (circle one)

Single	Married
Divorced	Separated

Today's Date: ______________________________

OFFICE USE ONLY

Patient name______________________________

Apt. Time & Reason ______________________________

Insurance Carriers	1) ____________________			
	2) ____________________			
Copays	$ ________	Cash	Check	Credit Card____________
Vision Coverage	Yes	No		