Westchester Health Associates Ophthalmology Division
185 Kisco Avenue Mt. Kisco, NY 10549 Phone 914-666-4939 Fax 914-242-7209

Dear New Patient:

Welcome to the Ophthalmology Division of Westchester Health Associates. Thank you for selecting us to provide your family medical eye care. Here are a few reminders:

Insurance Card/Referrals:
Please bring your most up to date insurance card with you. Some insurance policies require a referral from your primary care doctor before you can be examined by a specialist. If your plan requires a referral, please call your primary care physician at least a few days before your exam to obtain a referral. If a referral is required but has not arrived in our office, we may be unable to see you.

Please remember to bring:
For all patients: Please bring any eyeglasses you are currently using with you. Also fill out the attached medical history form completely (both pages) ahead of time and bring it with you to the appointment.

For contact lens wearers: Please wear your contact lenses when you come in for your exam and bring your eyeglasses with you. However, if you are having a problem with your contact lenses, please wear your glasses, but bring your contact lenses with you. Also, please bring either the boxes/packages the contacts came in or your current contact lens prescription.

Services our Practice Offers to Our Patients: Medical insurance companies require a medical diagnosis in order to cover an ophthalmic examination. Each insurance carrier has different criteria for what they consider medically necessary. Please contact your plan if you have any questions about your coverage.

Services NOT covered by medical insurance: These services are not covered by most medical insurance plans because they are considered vision related and not medical. Examples of these services are:

1. Refraction: This is how we determine the type of spectacle correction needed to improve your vision. This involves measuring for near sightedness, farsightedness, and astigmatism. This procedure is called REFRACTION and is not covered by most medical insurance plans.

2. Routine Eye Exam: This is a comprehensive eye exam where there is no specific eye complaint and there is no medical eye diagnosis or problem.

3. Contact Lens Fitting: Determining the correct power, shape, curvature, oxygen transmissibility, adaptation and wearing schedule best suited for the particular eye. This involves patient training and follow up exams to ensure corneal health and correct contact lens wear.

4. Annual Contact Lens Evaluation ($30): This is the examination of the contact lenses to determine their health impact on the cornea (swelling, blood vessel growth, etc.), need for power changes, need for change in fitting or lens type based on shape changes of the eye, wear schedule changes, and other factors affecting the eye.

Optical Shop: We have a full service optical shop, City Specs. Please feel free to come early and browse through our optical shop before your appointment. Also you may view the ophthalmology page of our website for links to the brands our optical shop carries. Please click here to view our optical shop.

Medical History and Review of Systems Form

Name:_____ Date of Birth:_____

Do you have VSP Vision Insurance? YES or NO Today's Date:_____

Past Medical History:

Are you allergic to any medications? YES or NO If yes, please list here:

_____

_____

Please list all medications you are taking, including prescription, over-the-counter medications, vitamins, supplements, and eye drops:

_____

_____

_____

Do you have or have you ever had any of the following? Please circle either yes or no for each one:

Condition	**Please Circle Either YES OR NO:**	**Condition**	**Please Circle Either YES OR NO:**
Cancer	YES NO	Abdominal Pain	YES NO
High Blood Pressure	YES NO	Diarrhea	YES NO
High Cholesterol	YES NO	Constipation	YES NO
Heart Disease	YES NO	Nausea/vomiting	YES NO
Chest Pain	YES NO	Frequent Urination	YES NO
Heart Murmur	YES NO	Painful Urination	YES NO
Irregular Heartbeat	YES NO	Arthritis	YES NO
Stroke	YES NO	Back Pain	YES NO
Diabetes	YES NO	Headaches/migraines	YES NO
Thyroid Problems	YES NO	Epilepsy/seizures	YES NO
Asthma	YES NO	Numbness	YES NO
Wheezing	YES NO	Dizziness/vertigo	YES NO
Chronic Frequent Cough	YES NO	Anxiety	YES NO
Nasal Congestion	YES NO	Depression	YES NO
Difficulty Hearing	YES NO	Seasonal Allergies	YES NO
Cataracts	YES NO	Glaucoma	YES NO

Please list all surgeries you have had along with the date/year it was done:

_____

_____

_____

_____

Do you currently have any problems in the following areas? Please answer each question by circling either YES OR NO:

Symptom	Please Circle Either YES OR NO:	Symptom	Please Circle Either YES OR NO:
Loss of Vision	YES NO	Seeing Halos	YES NO
Blurred Vision	YES NO	Dryness	YES NO
Fluctuating Vision	YES NO	Tearing/Watering	YES NO
Distorted Vision	YES NO	Discharge/Crusting	YES NO
Glare/Light Sensitivity	YES NO	Redness	YES NO
Loss of Side Vision	YES NO	Sandy/Gritty Feeling	YES NO
Double Vision	YES NO	Itching	YES NO
Flashing Lights/Floaters	YES NO	Burning	YES NO
Foreign Body Sensation	YES NO	Pain or Soreness	YES NO
Trouble w/Night Vision	YES NO	Infection of Eye or Lid	YES NO
Drooping Eyelid	YES NO	Tired Eyes	

Family History: Does anyone in your family have any of the following?

Condition	Please Circle YES OR NO:	List Family Relationship Below:
Blindness or Macular Degeneration	YES NO	
Glaucoma	YES NO	
Arthritis	YES NO	
Cancer	YES NO	
Diabetes	YES NO	
Heart Disease/High Blood Pressure	YES NO	
Kidney Disease	YES NO	
Lupus	YES NO	
Stroke	YES NO	
Thyroid Disease	YES NO	
Migraine Headaches/Other	YES NO	

Social History:

Occupation (If retired, please list former occupation) _____ Race _____

Marital status_____ Do you live ___ alone, _____ or with other adult(s)

Do you drive? YES OR NO Do you wear contact lenses? YES OR NO

Do you spend a lot of time outdoors? YES OR NO If "yes," do you wear sunglasses? YES OR NO

Do you have a history of drug abuse? YES OR NO

Do you drink alcohol? YES OR NO If "yes," please circle one: occasionally, 1/day, 2-3/day, 4+/day

Do you currently smoke? YES OR NO If "yes," please circle one: 1/2pack/day, 1pack/day, 1+pack/day

Have you smoked in the past? YES OR NO

Patient's Signature: _____ Date:_____