WellTrac

**2510 Wigwam Parkway, Suite 109, | Henderson, NV 89074 |**
**Office: (702) 266-8180|**

**Patient Name:** _____

**Appointment Date:** _____ **Appointment Time:** _____

Thank you for scheduling your annual physical exam at WellTrac. In all likelihood, this will be the most thorough, comfortable and efficient health assessment you've ever had. You can expect a pleasant experience, in a comfortable atmosphere, with plenty of time at the end of your appointment to talk over your test results with a WellTrac physician.

**Please read and complete all paperwork before you arrive for your appointment**. If you have your paperwork completed, please arrive 10-15 minutes prior to your appointment.

If you don't have your paperwork completed, please plan to arrive 30 minutes early. This will give you time to complete the required forms and, of course, the WellTrac staff will be happy to provide any assistance as needed.

Please plan on being with us for approximately **1.5 to 2.0** hours.

**If you find yourself running behind and anticipate arriving more than fifteen minutes late for your scheduled appointment, please call the WellTrac office to advise the staff. If the schedule is completely booked for the day, you may be asked to reschedule and thereby avoid the WellTrac $50 cancellation fee**.

**Please do not bring children with you**. You will be moving from room to room for each test and children are not allowed in the examination rooms or lobby areas.

**Remember:**

- **Take all prescription medications as prescribed**
- **DO NOT EAT ANYTHING at least 5-8 hours prior to your exam –** accurate blood work requires a 5-8 hour fasting period
- **Drink** plenty of water
- **Bring** your completed paperwork to your appointment or advise the front office if you have completed your paperwork online
- **Bring** a list of all prescribed medications and the dosages
- **Bring** exercise clothes and athletic shoes if you are having a treadmill stress test. Do not have any caffeine or smoke at least 5 hours prior to your stress test
- **Bring** your identification

**Need to cancel or reschedule?**
If you have to miss your scheduled appointment, please let us know at least 48 hours in advance. For shorter notices, you may be billed a $50 cancellation fee. **To cancel or reschedule, please call (702) 266-8180.**

Thank you for choosing WellTrac. We look forward to seeing you!

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# Scheduled Tests & Payment Information

In addition to your complete history and physical examination by the physician, you may be eligible for the physical tests described below.

- **The Core battery of tests including:**
- **Screening Ultrasound –** included as an extension of the physical examination; may show abnormalities of the carotid arteries and internal organs, such as the thyroid gland, liver or kidneys, which are not detectable by routine examination
- **Complete Laboratory Blood and Urine Analysis –** extensive evaluation of blood counts, blood chemistries and urine composition
- **Body Composition Analysis –** general indicator of the percentage of your body that is composed of fat, which is related to your risk of many health problems
- **Chest X-Ray Series –** radiographic image of the chest structures including the heart and lungs; screens for conditions such as lung cancer, emphysema and heart enlargement
- **Electrocardiogram (EKG/heart tracing) –** screens for heart disease
- **Spirometry (lung function) -** screens for conditions such as asthma, emphysema and weight-related decrease in lung capacity
- **Audiometry –** hearing test performed in a sound-proof booth

**Treadmill Stress Test –** screens for coronary artery disease by evaluation your heart's response to the increased work of exercise. We recommend a Treadmill Stress Test if you are:

- Age 40 or older with plans to start a vigorous (more than walking) exercise program
- Age 50 or older with no regular exercise
- Age 30 or older with two or more cardiac risk factors including: family history of heart disease, tobacco use, last of exercise, high cholesterol, diabetes, hypertension
- Having chest pain, chest discomfort or shortness of breath with the mild exertion that has not been evaluated or diagnosed

**Dexa (Bone Density) scan – screens for osteoporosis. We recommend a Dexa (Bone Density) Scan if you meet one or more of the following criteria:**

- Female over age 50 or male over age 60
- Female over age 40 with a history of early or natural or surgical menopause
- Female over age 40 with a history of osteoporosis
- Having a history of long-term steroid use (for asthma, rheumatoid arthritis, sarcoidosis, Crohn's Disease, etc.)
- Over age 40 with a history of regular smoking

**Digital Mammogram – For the foreseeable future digital mammography will be referred to a contracted radiology facility.**

**Female Exam –** Pap smear using Thin-Prep Pap (IG), breast exam and pelvic exam

**PSA Blood Test –** Prostate cancer screen for males over the age of 40

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# Treadmill Stress Test Prep Instructions

**Treadmill Stress Test** is a screening test that can diagnose coronary artery disease (CAD), commonly found in men and women 40 or older.

**PLEASE BRING YOUR TENNIS SHOES AND WEAR LOOSE COMFORTABLE CLOTHING. IN ADDITON, WE ASK THAT FEMALE PERSONNEL HAVING A STRESS TEST TO WEAR A SPORTS BRA.**

**DO NOT SMOKE 5 HOURS PRIOR.**

**DO NOT TAKE ANY BETA BLOCKERS 24 HOURS PRIOR.**

**BELOW IS A LIST OF COMMONLY USED BETA BLOCKERS THAT SHOULD BE AVOIDED:**

| | | |
|---|---|---|
| Abebutolol | Inderal | Sotalol |
| Atenolol | Inderide | Teneretic |
| Atenolol HCTZ | Kerlon | Tenormin |
| Betapace | Labetalol | Timolide |
| Bextaxolol | Levatol | Timolol |
| Bisorolol | Lopressor | Timolol HCTZ |
| Bisoprolol | Metoprolol | Toprol |
| Blocadren | Normodyne | Trandate |
| Calan | Penbutolol | Verapamil |
| Carteolol | Pindolol | Visken |
| Cartrol | Propranalol | Zebeta |
| Carvedilol | Propranolol HCTZ | Ziac |
| Coreg | Sectral | |

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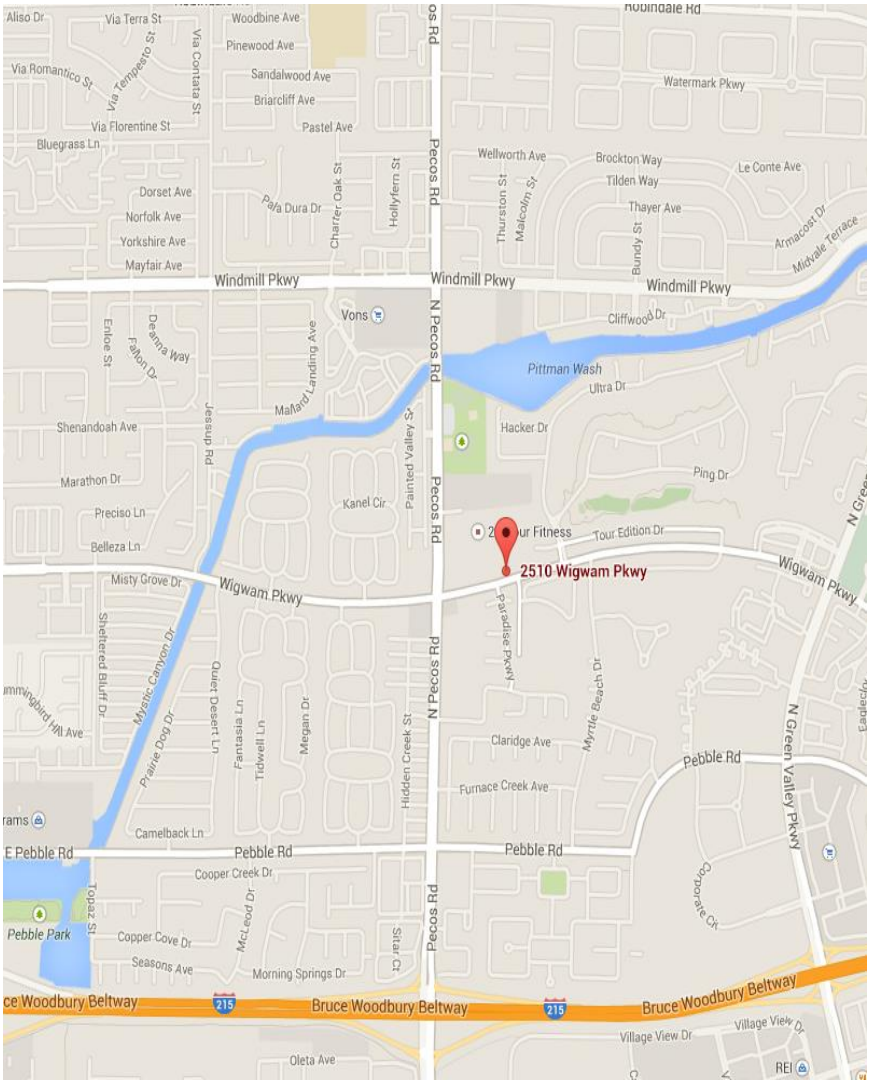
# Map & Directions for Henderson Clinic

WellTrac is conveniently located on Wigwam Parkway, one block east of the intersection with Pecos. We are in the Sansone Business Offices, Building 2510, located in the front of the building on the first floor, Suite 109.

**2510 Wigwam Parkway**
**Suite 109**
**Henderson, Nevada 89074**
**Phone: (702) 266-8180**




**From Henderson using I-215:**
Take Interstate 215 West and exit onto Pecos Road/St. Rose Parkway. Turn right onto Pecos Road. Travel two blocks. Turn right on Wigwam, drive past the 24HR Fitness complex (on the left). At the end of the shopping center, turn left into the Sansone office complex.

**From Las Vegas using I-215:**
Take Interstate 215 East and exit onto Pecos Road/St. Rose Parkway. Turn left onto Pecos Road. Travel two blocks. Turn right on Wigwam, drive past the 24HR Fitness complex (on the left). At at the end of the shopping center, turn left into the Sansone office complex.

**From Boulder City:**
Take Interstate 93 North to Interstate 215 West. Take Interstate 215 West and exit onto Pecos Road/St. Rose Parkway. Turn right onto Pecos Road. Travel two blocks. Turn right on Wigwam, drive past the 24HR Fitness complex (on the left). At the end of the shopping center, turn left into the Sansone office complex.

**From Las Vegas using Interstate 93/95**:
Take Interstate 93/95 South (towards Henderson) to Interstate 215 West. Take Interstate 215 West and exit onto Pecos Road/St. Rose Parkway. Turn right onto Pecos Road. Travel two blocks. Turn right on Wigwam, drive past the 24HR Fitness complex (on the left). At the end of the shopping center, turn left into the Sansone office complex.

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# Patient Information Sheet

How did you hear about WELLTRAC? Please check all that apply:

| | | | |
|---|---|---|---|
| ❑ Employer | ❑ Spouse's Employer | ❑ Internet search | ❑ Yellow Pages |
| ❑ Print Ad | ❑ TV Commercial | ❑ Direct Mail | ❑ Friend/Family |
| ❑ Physician: _____ | | | |

| | | |
|---|---|---|
| Name: (Last) (First) (MI) | | |
| Address: | | |
| City: | State: | ZIP: |
| Home # | Cell # | Work # |
| Date of Birth: | Social Security Number: | |
| Personal Email Address: | | |
| Employer/Property: | | |
| Department: | Title: | |
| Primary Insurance: | | |
| Insured Name: | Date of Birth: | |
| Social Security Number: | Insurance ID: | |
| Insurance Claims Mailing Address: | | |
| Secondary Insurance: | | |
| Insured Name: | Date of Birth: | |
| Social Security Number: | Insurance ID: | |
| Insurance Claims Mailing Address: | | |

I understand WELLTRAC will submit charges for services to my insurance. As the undersigned, I understand that I am responsible for all charges for services provided. I hereby authorize payment of insurance claims to WELLTRAC. I authorize the release of any medical information necessary to process the claim.

_____ _____

Signature

WellTrac

# NOTICE OF PRIVACY PRACTICES SUMMARY

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY. PLEASE SEE THE FRONT DESK TO RECEIVE A FULL, MORE DETAILED COPY OF OUR NOTICE OF PRIVACY PRACTICES.**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically , on paper, or orally, to be kept confidential. This law gives patient significant new rights to understand and control how your health information is used. HIPAA provides penalties for the misuse of personal health information. In compliance with Federal Law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health information for the purpose of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care or health related services with one or more subsequent healthcare providers to assist in your treatment.
- Payment means providing information to obtain reimbursement for healthcare services you receive. For example, we may disclose information when billing your insurance company to make reimbursement on your behalf.
- Operations means your information may be used to assess the care and outcomes in your case to improve the quality and effectiveness of the healthcare and service we provide including professional review and performance evaluation.

We may use or disclose identifiable information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, and auditing purposes. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. We may use your protected health information for public health oversight, in response to a subpoena or court order, to military authorities, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials; to report suspected abuse, neglect or domestic violence. Unless you request otherwise, we may use or disclose health information to a family member, friend or personal representative, to the extent necessary to help with your healthcare or with payment for your healthcare. Unless you request otherwise, we may use your confidential information to remind you of appointments by leaving messages at home and/or work. In any other situation, we will ask you for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses or disclosures.

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your medical information about you for treatment, payment and healthcare operations. We must agree to your request if: (1) except as otherwise required by law, the disclosure is to a health plan for purpose of carrying out payment of healthcare operations (and is not for purposes of carrying out treatment); and (2) the medical information pertains solely to a healthcare item or service for which the healthcare provider involved has been paid out-of-pocket in full.
- Obtain a paper copy of the notice of privacy practices upon request.
- Access, inspect and obtain a copy of your health record, with limited exceptions. A reasonable fee may be assessed.
- Request to amend your health record. We may deny your request in certain situations.
- Obtain an accounting of disclosures of your health information made outside of treatment, payment, or health care operations…or based on your previous authorization.
- Request communications of your health information by alternative means at alternate locations or different methods.
- Revoke your authorizations to use or disclose health information except to the extent that action has already taken.

We are required to abide by the terms of the Notice of Privacy practices currently in effect. We reserve the right to change our policies at any time. Before we make a significant change in our policies, we will change our policies; we will change our notice and post the new notice in the waiting area. You can also request a copy of our notices at any time.

If you are concerned that we have violated your privacy rights, or you disagree with the decision we made about access to your records, you may contact the person listed below. You also may send a written compliant to the U.S. department of Health and Human services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:
Sarah Waghorn, Privacy Officer
WellTrac, LLC
2510 Wigwam Parkway, Ste. 109
Las Vegas, NV 89074
(702) 266-8180

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(877) 696-6775 (Toll Free)

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# Acknowledgement & Consent

Please review this form carefully. If you understand and agree with each statement, check the check mark box of each paragraph and sign where indicated at the bottom of the form.

☐ **ACKNOWLEDGEMENT OF RECEIPT:** I have received a copy of WellTrac's Notice of Patient Information Practices.

☐ **CONSENT FOR CARE AND TREATMENT:** I consent to any examinations, laboratory procedures, radiology, other diagnostic tests, special therapies, and other medical interventions as deemed necessary under the direction of my physician.

☐ **DISCLOSURE OF FEE DIVISION:** WellTrac, L.L.C provides management and other administrative services to Terrance Ballard, MD, PC. I acknowledge that any fees paid to Terrance Ballard, MD, PC, may be utilized to pay such services.

☐ **CONSENT FOR COMMUNICATIONS:** I authorize WellTrac to send emails and/or newsletters related to health and wellness issues. I understand WellTrac will not sell, give or otherwise distribute my contact information without my consent.

Please list first and last names of family members, friends, or other people to whom we may release your medical information (i.e., spouse, parent, etc.):

1) _____ 2) _____

3) _____ 4) _____

Do you have an answering machine or voice mail? _____ yes _____ no
If yes, may we leave messages on your answering machine or voice mail? _____ yes _____ no

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____
(Please Print)

Signature of Patient Date

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## Medical History Questionnaire (Page 01)

Name: _____ Date: _____ Age: _____

**Current Medications**

Please provide a detailed and accurate list of all medications.

| Prescription Name | Dosage | Frequency | Reason |
|---|---|---|---|
| | | | |
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**Vitamins/Supplements**

Please provide a detailed and accurate list of Vitamins/Supplements.

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Current Primary Care Physician:**

Name: _____

Address: _____

Fax #: _____ Telephone #: _____

**Current Pharmacy:**

Name: _____

Address: _____

Fax #: _____ Telephone #: _____

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## Medical History Questionnaire (Page 02)

**Name:** _____ **Date:** _____ **Age:** _____

**PLEASE MARK EACH APPLICABLE BOX WITH AN "X" OR FILL IN THE APPROPRIATE INFORMATION**

### ETHNIC GROUP

❒ African American ❒ Asian ❒ Caucasian
❒ Hispanic ❒ Native American ❒ Other _____

### CHILDHOOD HISTORY

❒ Rheumatic Fever ❒ Seizures ❒ Radiation to the Head or Neck
❒ Other: _____

### PAST MEDICAL HISTORY

❒ Allergies (seasonal) ❒ Colon Polyps ❒ GERD ❒ Migraine Headaches
❒ Anemia ❒ COPD ❒ Heart Attack ❒ Mitral Valve Prolapse
❒ Anxiety ❒ Coronary Artery Disease ❒ Hepatitis C ❒ Osteoarthritis
❒ Arthritis ❒ Crohn's Disease ❒ Hiatal Hernia ❒ Osteopenia
❒ Asthma ❒ Depression ❒ High Blood Pressure ❒ Osteoporosis
❒ Atrial Fibrillation ❒ Diabetes ❒ High Cholesterol ❒ Renal Disease
❒ Benign Prostate Enlargement ❒ Irritable Bowel ❒ Seizure Disorder
❒ Blood Clots ❒ Gallbladder Disease ❒ Kidney Stones ❒ Thyroid Disorder
❒ Cancer ❒ Gastric Reflux ❒ Liver Disease ❒ Ulcer
Type: _____
❒ Other_____

### SURGICAL HISTORY

❒ Operations (dates): _____
_____
❒ Transfusions (dates): _____

### FOR WOMEN ONLY

Your age at first menstrual period: _____ Are you currently pregnant? ❒ Yes ❒ No
First day of last menstrual period: _____
How many live births have you had? _____ Age at first birth: _____
Have you passed through menopause (either surgically or naturally)? ❒ Yes ❒ No
Your age at time of menopause: _____
Have you ever used any form of Hormone Replacement Therapy (after menopause only)? ❒ Yes ❒ No
Are you currently using any form of Hormone Replacement Therapy (after menopause only)? ❒ Yes ❒ No

| HAVE YOU EVER HAD A…. | Date | Results |
|---|---|---|
| ❒ Colonoscopy | _____ | _____ |
| ❒ Treadmill Stress Test | _____ | _____ |
| ❒ Cardiac Catheterization | _____ | _____ |
| ❒ Mammogram | _____ | _____ |
| ❒ Pap Smear | _____ | _____ |
| ❒ Dexa (Bone Density) Scan | _____ | _____ |

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## Medical History Questionnaire (Page 03)

### ALLERGIES

_____
_____
_____
_____

### PRIOR IMMUNIZATIONS

❒ Tetanus (date) _____ ❒ Hepatitis A (date) _____ ❒ Hepatitis B (date) _____
❒ Pneumovax (date) _____ ❒ Shingles (date) _____

### PERSONAL HISTORY

**Highest education level:** ❒ High school ❒ Some College ❒ Bachelors ❒ Masters ❒ Doctorate

**Current employment status:**

❒ Employed ❒ Unemployed ❒ Retired ❒ Homemaker
Current occupation: _____
Hours per week worked: ❒ <30 ❒ 30-50 ❒ 50-70 ❒ >70
Are you happy there? ❒ Yes ❒ No ❒ Somewhat

**Marital Status:**

❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Domestic Partner

**Children:**

Sons _____ Daughters _____

**Do you smoke or use tobacco?** ❒ Yes ❒ No ❒ Former

If yes: Type: ❒ Cigarettes ❒ Cigar ❒ Pipe ❒ Smokeless
Number per day: _____
Number of Years: _____

**Ever Tried to Quit?** ❒ Yes ❒ No
**Date you finally quit:** _____

**Second-hand smoke:**

Have you been exposed to cigarette smoke in your home or at your place of employment? ❒ Yes ❒ No

**Do you drink alcohol?** ❒ Yes ❒ No ❒ Former
If yes, how frequently? ❒ Daily ❒ Several days per week ❒ Occasional
If yes, how many servings per day? 12 oz beer_____
5 oz wine_____
1 oz liquor_____

**How many times/week (on avg.) do you engage in physical activity for at least 20 minutes?**

❒ Never ❒ Occasional ❒ 1- 2 ❒ 3 or more

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## Medical History Questionnaire (Page 04)

### FAMILY HISTORY

Are you adopted?

❒ Yes. If known, complete the following information about your blood relatives (include children). Exclude adoptive parents, siblings and adopted children.

❒ No. Complete the following information about your blood relatives. Exclude adoptive siblings and adopted children.

Mother

❒ Alive Age _____

❒ Deceased Age _____

Cause of death: _____

Father

❒ Alive Age _____

❒ Deceased Age _____

Cause of death: _____

| | Number Alive | Ages | Number Deceased | Ages at Death | Causes of Death |
|---|---|---|---|---|---|
| Brothers | _____ | _____ | _____ | _____ | _____ |
| Sisters | _____ | _____ | _____ | _____ | _____ |
| Sons | _____ | _____ | _____ | _____ | _____ |
| Daughters | _____ | _____ | _____ | _____ | _____ |

Mark the appropriate boxes to identify all illnesses/conditions which you know have occurred in your blood relatives. Use the following abbreviations for relatives:

| | | |
|---|---|---|
| M – Mother | K – Son | GS – Grandson |
| F – Father | D – Daughter | GD – Granddaughter |
| S – Sister | PGM – Paternal Grandmother | NP – Nephew |
| B – Brother | MGM – Maternal Grandmother | NC – Niece |
| U – Uncle | PGF – Paternal Grandfather | C – Cousin |
| A – Aunt | MGF – Maternal Grandfather | |

| Relative | |
|---|---|
| ❒ Diabetes | _____ |
| ❒ Coronary Heart Disease | _____ |
| ❒ Stroke/TIA | _____ |
| ❒ Colon Cancer | _____ |
| ❒ Lung Cancer | _____ |
| ❒ Prostate Cancer | _____ |
| ❒ Breast Cancer | _____ |
| ❒ Ovarian Cancer | _____ |
| ❒ Thyroid Cancer | _____ |
| ❒ Other Cancer (type)_____ | _____ |
| ❒ High Blood Pressure | _____ |
| ❒ High Cholesterol | _____ |
| ❒ Liver Disorder | _____ |
| ❒ Alcohol/Drug Abuse | _____ |
| ❒ Depression | _____ |
| ❒ Tuberculosis | _____ |
| ❒ Anesthesia Complications | _____ |
| ❒ Osteoporosis | _____ |
| ❒ Hemochromatosis (iron overload) | _____ |

Additional information you would like us to know: _____

_____

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## Medical History Questionnaire (Page 05)

### CURRENT OR RECENT COMPLAINTS

**Constitutional**

- ❒ Anxiety
- ❒ Decreased Appetite
- ❒ Decreased Energy
- ❒ Depression
- ❒ Fatigue
- ❒ Fever
- ❒ Insomnia
- ❒ Irritability
- ❒ Night Sweats
- ❒ Stress
- ❒ Weight Gain
- ❒ Weight Loss

**Gastrointestinal**

- ❒ Abdominal Pain
- ❒ Blood in Stool
- ❒ Change in Bowel Pattern
- ❒ Difficulty swallowing
- ❒ Heartburn
- ❒ Hemorrhoids

**Dermatologic**

- ❒ Pruritus (Itch)
- ❒ Rash
- ❒ Change in Mole

**Head, Eyes, Ears, Nose and Throat**

- ❒ Headache
- ❒ Dry Eyes
- ❒ Change in Vision
- ❒ Hearing Loss
- ❒ Tinnitus (Ringing in Ears)
- ❒ Hoarseness
- ❒ Snoring

**Genito-Urinary**

- ❒ Decreased Stream
- ❒ Painful Urination
- ❒ Frequency
- ❒ Urgency
- ❒ Hematuria (Blood in urine)
- ❒ Nocturia (Increased urination @ night)
- ❒ Incontinence
- ❒ Problems with Sexual Function

**Musculoskeletal**

- ❒ Back pain
- ❒ Joint pain
- ❒ Muscle Weakness

**Respiratory**

- ❒ Cough
- ❒ Dyspnea (Shortness of breath)
- ❒ Hemoptysis (Coughing blood)
- ❒ Snoring
- ❒ Pleurisy
- ❒ Wheezing

**Reproductive/GYN (For Women Only)**

- ❒ Irregular periods
- ❒ Previous abnormal Pap smear
- ❒ Unusually heavy bleeding
- ❒ Severe cramps
- ❒ Problems with bladder control
- ❒ Vaginal Discharge
- ❒ Breast Discharge
- ❒ Breast Lump

**Hematologic**

- ❒ Unusual Bruising
- ❒ Unusual Bleeding
- ❒ Swollen Lymph Node

**Cardiac**

- ❒ Chest Pain
- ❒ Shortness of Breath
- ❒ Edema
- ❒ Palpitations

**Metabolic/Endocrine**

- ❒ Cold Intolerance
- ❒ Heat Intolerance
- ❒ Hair Loss
- ❒ Polydipsia (Excess Thirst)
- ❒ Polyphagia (Excess Hunger)
- ❒ Polyuria (Excess Urine)
- ❒ Tremor
- ❒ Voice Change

**Immunologic**

- ❒ Skin Welts (Hives)
- ❒ Asthma

**Vascular**

- ❒ Claudication
- ❒ Varicose Veins
- ❒ Thrombophlebitis

**Neurologic**

- ❒ Dizziness
- ❒ Dysarthria (Abnormal Speech)
- ❒ Focal Weakness
- ❒ Headache
- ❒ Loss of Consciousness
- ❒ Memory Impairment
- ❒ Seizure
- ❒ Vertigo
- ❒ Difficulty Concentrating
- ❒ Depression

Additional information you would like us to know: _____

_____