Patient Name: ______________________________

Appointment Date: ______________________________ 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 time at the end of your appointment to talk over your test results with a WellTrac physician.

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**Please read and complete all paperwork before you arrive for your appointment and then arrive 15 minutes before your scheduled appointment. If you cannot complete your paperwork prior to arrival, please allow 30 minutes to complete it in our office.**

**PLEASE NOTE:** Paperwork packet must be completed before we conduct the exam. Your appointment visit consists of a blood draw, chest x-ray, screening ultrasound, EKG and urinalysis and various other tests as part of your premier annual wellness exam. **Please plan on being with us for approximately 1½ 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 $100 cancellation fee.**

For this **visit** please remember to:

- **Bring your completed paperwork** to your appointment
- **Take all prescription medications as prescribed (except as indicated for a stress treadmill)**
- **DO NOT EAT ANYTHING at least 5-8 hours prior to your exam –** accurate blood work requires 5-8 hour fasting
- **Drink** plenty of water
- **Bring** your identification
- **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 exam rooms or lobby areas.
- **Bring** exercise clothes and athletic shoes if you're having the treadmill stress test. Do not have any caffeine or smoke/vape at least 5 hours prior to your stress test

**Need to cancel or reschedule?** If you have to miss your scheduled appointment, please let us know at least 48 hours in advance. **To cancel or reschedule, please call 702-266-8180**. (Less than 48 hour notice may incur a $100 fee.)

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

## Scheduled Tests

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

**The tests include:**

- **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. This includes a Vitamin D and a PSA blood test for men.
- **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 abnormalities, cancer, emphysema and heart enlargement.
- **Electrocardiogram (EKG/heart tracing) –** screens for heart disease.
- **Treadmill Stress Test –** screens for coronary artery disease.
- **Spirometry (lung function) -** screens for conditions such as asthma, emphysema, and weight-related decrease in lung capacity.
- **Audiometry –** hearing test performed in an OSHA rated audio booth.

**PLEASE BRING YOUR TENNIS SHOES AND WEAR LOOSE COMFORTABLE CLOTHING. IN ADDITON, WE ASK THAT FEMALE PATIENTS HAVING A STRESS TEST TO WEAR A SPORTS BRA.**
**DO NOT SMOKE/VAPE 5 HOURS PRIOR.**
**DO NOT TAKE ANY BETA BLOCKERS 24 HOURS PRIOR TO YOUR EXAM.**
**BELOW IS A LIST OF COMMONLY USED BETA BLOCKERS THAT SHOULD BE AVOIDED:**

| | | |
|---|---|---|
| Acebutolol | 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 | |

## Map & Directions

WellTrac is conveniently located on West Sahara Ave. just west of the exit from I-15 at W. Sahara and located across the street from the Palace Station in the 2-story white office building behind the restaurants. We are on the first floor, Suite 100.

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**2500 W. Sahara Ave., Suite 100 Las Vegas, Nevada 89102**
Phone: (702) 266-8180

**From Henderson using I-215:**
Take Interstate 215 West and merge onto I-15 north. Once past the hotel/entertainment area of Las Vegas, exit on the Sahara Avenue exit. Turn left on W. Sahara, drive under the interstate. Travel approximately two blocks. Turn right into the parking lot shared by the bank building, restaurants and in the back of the lot to the two-story white office building with the 2500 located prominently on the building.

**From Boulder City:**
Take Interstate 93 North to Interstate 215 West. Take Interstate 215 West and merge onto I-15 north. Once past the hotel/entertainment area of Las Vegas, exit on the Sahara Avenue exit. Turn left on W. Sahara, drive under the interstate. Travel approximately two blocks. Turn right into the parking lot shared by the bank building, restaurants and in the back of the lot to the two-story white office building with the 2500 located prominently on the building.

**From Las Vegas using Interstate 93/95**:
Take Interstate 93/95 South 15 and exit onto Sahara Avenue. Turn right onto Sahara Avenue. Travel approximately two blocks. Turn right into the parking lot shared by the bank building, restaurants and in the back of the lot to the two-story white office building with the 2500 located prominently on the building.

# Patient Information Sheet

| Name: | | |
|---|---|---|
| Address: | | |
| City: | State: | Zip: |
| Home #: | Cell #: | Work #: |
| Date of Birth: | | |
| Personal E-Mail Address: | | |

I understand WellTrac will ***NOT*** submit charges for services for this preventative physical to my insurance. As the undersigned, I understand that I am responsible for all charges for services provided.

Signature Date

# Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

**WELLTRAC'S LEGAL DUTY**

WellTrac is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

WellTrac uses your personal health information for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. For example, WellTrac may also use your personal information to contact you to provide appointment reminders, or provide information about treatment alternatives or other health related benefits that could be of interest to you.

WellTrac may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes and for emergencies. We also provide information when required by law.

In any other situation, WellTrac's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

WellTrac may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic or on our website. You may also request an updated copy of our Notice of Information Practices at any time.

**PATIENT'S INDIVIDUAL RIGHTS**

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. WellTrac will consider all such requests on a case-by-case basis, but is not legally required to comply with them.

**CONCERNS AND COMPLAINTS**

If you are concerned that WellTrac may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Office at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on WellTrac's health information practices, or if you have a complaint, please contact the following office:

**HIPAA Compliance Office**
**WellTrac, L.L.C.**
**2500 W. Sahara Ave., Suite 100**
**Las Vegas, NV 89102**
**EVERY PATIENT MUST RECEIVE A COPY OF THIS FORM**

## HIPAA Compliance Patient Consent Form

Our Notice of Patient Information Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed:

_______________________________________________________________________________

_______________________________________________________________________________

This consent was signed by: _______________________________________
(Print Name Please)

Signature: _______________________________________________ Date: ____________________

**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.

| | | | |
| --- | --- | --- | --- |
| | | | |
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**Current Primary Care Physician:**

Name: ____________________________________________________________________

Address:__________________________________________________________________

Fax #:______________________________ Telephone #:_________________________________

**Current Pharmacy:**

Name:____________________________________________________________________

Address:_________________________________________________________________

Fax #:_____________________________ Telephone #:________________________________

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

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

## 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

**If Yes, 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 ❒ Occasionally

If yes, how many servings per day? ❒ less than 12 oz beer ❒ more than 12 ozs beer

❒ less than 5 oz wine ❒ more than 5 oz wine

❒ less than 1 oz liquor ❒ more than 1 oz liquor

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

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

# 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 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 /concerns you would like us to know:

______________________________________________________________________________

______________________________________________________________________________