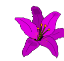
Morningstar Healing Arts 

Welcome to your annual wellness visit!

We look forward to seeing you again.

Please print out and complete **the Interim Health History Questionnaire** below.

Your annual visit includes review of your history, preventative topics and screenings, and a focused physical exam. Most insurance plans cover a wellness visit every year free from deductible and copay charges. We encourage you to contact your insurance provider to ensure that you understand what services are covered. Depending on your coverage, you may also be billed separately for lab tests and other procedures such as Paps, biopsies and vaccinations. If time permits, we may address other medical concerns. In this case, a separate evaluation and management code will be billed that may be subject to your deductible and co-pay. Insurance providers generally require us to distinguish between preventative and problem focused visits and treatment.
A few insurance plans, such as Providence and Pacific Source do not allow us to combine preventative and problem focused visits.

Please let us know if you have any special concerns, or if we are not meeting your expectations in any way.

Please give us 24 hours notice if you need to cancel your appointment, so that we may see others who may need our attention. We are available by phone Mondays through Fridays from 9 am to 12 noon and from 2 to 4:30pm at (541) 482-2032.

If you have any questions, please feel free to discuss this with our office manager, Janite Lee.

With blessings of good health,

Howard Morningstar, MD   Sue Morningstar, WHCNP   Aja Morningstar, MD

Interim Health History Questionnaire (v8: 7/22)

Please fill out ***both sides of*** *this confidential questionnaire as fully as you can. If you're uncomfortable with a question, it's okay to leave it blank. You're welcome to add whatever you feel will be helpful. By helping us know you as a whole person, you help us provide you with the best possible personalized health care.*

PREFERRED NAME: ____ Date of Birth:_______________

LEGAL NAME:____ Today's Date: ___________________

Pronouns______________________________ Gender assigned at birth_________________________

What is the main reason for your visit today? ____

List any concerns regarding your health, appearance or habits you wish to change:

____

Please list all medicines you take, including prescription drugs, over-the-counter remedies, herbs, supplements and vitamins (use a separate sheet if needed)

Name Dose & Frequency Why are you taking it?

____

____

____

____

____

List any medication allergies: ____

List any health care providers you have seen recently, what they were seen for, and treatments used: ____

Any new family medical history: ____

List dates for any of the following: Complete physical: ________ Eye exam: _________ PAP smear: _________
Eye exam: _________ Bone Density (DEXA): ________ Tetanus shot: ________ Mammogram: ________
Colonoscopy: ________ Cologuard: _________ Dental exam: ________ Menstrual period: _________
Prostate exam: _________ PSA (prostate) test: _______ COVID vaccine: __________ Cholesterol test: _________

Relationship status: _________________ How many sexual partners in the last year? ______

What genders were they __________________ Do you always practice "safe sex"? ________ Do you desire pregnancy in the next year? _______ Do you use any contraception? ___________________

Any family or sexual concerns: ____

Have you experienced any major stresses or life changes in the last year? ___________________

____

Do you feel safe at home now? ____

If you ever feel unsafe in your relationship, this is a SAFE space to talk about it.

How do you manage stress? ____

How do you relax or have fun? ____

What kind of work are you doing?____

Please describe your exercise routine: ____

Please describe a typical day's diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Favorite snacks: ____________________________ How much water do you drink daily ____________

How many alcoholic drinks do you have daily? _______ weekly? _______

Do you use tobacco? What kind?________ Regularly in the past? __________ When quit? ________

Do you use any other drugs socially? ____

Have you ever felt alcohol or other drugs were a problem for you? ____________________________

Do you always wear a seat belt? ________ Do you ever drive impaired? __________________

Are there any unlocked guns at home? ________ Do you always use a bike helmet? ____________

Do you have a POLST, living will or advanced directive? _______________

Would you like to discuss your wishes regarding end of life care? _____________________________

SYMPTOM REVIEW CHECKLIST

Please ***circle*** *any of the following that you've experienced recently:*

Poor appetite	Trouble swallowing	Chronic cough	Blood transfusion
Lack of energy	Food intolerance	Neck swelling	Balance problems
Trouble sleeping	Nausea or Vomiting	Short of breath	Trouble walking
Often sad	Black/bloody stools	Sleep in a chair	Falling down
Alone in the world	Diarrhea	Snoring	Joint pains
Often anxious	Constipation	Wheezing	Swollen joints
Panic attacks	Abdominal pain	Painful breathing	Backaches
Frequently angry	Hemorrhoids	Chest pain	Sore muscles
Violent behavior	Often dizzy	Ankle swelling	Foot pains
Self-destructive	Fainting spells	Racing heart	Breast lump
Physical abuse	Frequent headache	Palpitations	Nipple discharge
Emotional abuse	Weakness	Poor circulation	Painful testicles
Sexual abuse	Numbness	Often feel cold	Testicle lump
Hopeless	Tingling	Wake up to urinate (on most nights)	Penile discharge
Considered suicide	Poor coordination		Enlarged prostate
Weight loss	Tremor	How many times:	Slow urine stream
Chronic pain	Seizures	_______________	Irregular periods
Chronic skin sores	Vision loss	Often thirsty	Painful menses
Hair loss	Itchy or painful eyes	Urine problems	Vaginal discharge
Rashes	Hearing loss	Sexual difficulty	Yeast infections
Changed mole	Ringing in ears	S T D (?what type)	Pelvic pain
Lumps or swelling	Ear infection / pain	_______________	Unexpected vaginal bleeding
Itching or hives	Hay fever	Reduced sex drive	
Heartburn	Sinus problems	Night sweats	Hot flashes
Bloating	Hoarseness	Easy bruising	
Gas or belching	Nosebleeds	Slow healing	

Anything else we should know? __________________________________ _____________________________

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________________ DATE:______________

Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	______
Somewhat difficult	______
Very difficult	______
Extremely difficult	______

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