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

Morningstar Healing Arts

Interim Health History Questionnaire

Please fill out this confidential questionnaire as fully as you can. If you're uncomfortable with any question, it's okay to leave it blank, or we can talk about it without writing it down. By helping us know you as a whole person, you help us provide you with the best possible personalized health care.

NAME: ______________________________ Date of Birth: ______________ Today's date: _____________

What's the main reason for your visit today? ____

Please list any other health concerns: ____

List any concerns regarding your 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: ____

What other therapies are you using to improve your health or treat a medical condition?

____

____

List any health care providers that you consult: ____

____

List any new family medical history: ____

When was last: Eye exam _______ Colonoscopy_______ Cologard _______ Covid19 vax: _________

Tetanus vaccine _________ *For men:* when was your last PSA (prostate cancer test)? :__________

For women:: last menstrual period _______ Mammo/breast exam ___________

PAP screening_____ bone density DEXA?_______

Are you? (circle) Single Married Living with partner Separated Divorced Widowed

How many sexual partners have you had in the last year? ______ Were they (circle) Male Female

Do you practice "safe sex"? ________any sexually transmitted infections? ____________________

Any sexual concerns? (libido, pain, bleeding, erection difficulties):____________________________

____

Please list any major life stresses in the last year (birth, major illness/accident/injury, death of family member, moved, new work, financial, relationships or?) ________________________________

____

How do you manage stress? ____

How do you relax or have fun? ____

What kind of work are you doing?____

Please describe your exercise routine: ____

____

How much water do you drink daily? _______ (# of glasses) Please describe a typical day's diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Favorite snacks: ____

How many caffeine products do you use daily? __________________ What kinds? _____________

How many alcohol drinks do you have daily? ______ weekly? _______ What kinds? _____________

Do you use tobacco now? (circle): cigarettes cigars e-cig pipe snuff chew

Please list any other drugs you use recreationally: ____

SYMPTOM REVIEW CHECKLIST

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

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

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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