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: Aja *Page 1 of 2 (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
Lack of energy
Trouble sleeping
Often sad
Alone in the world
Often anxious
Panic attacks
Frequently angry
Violent behavior
Self-destructive
Physical abuse
Emotional abuse
Sexual abuse
Hopeless
Considered suicide
Weight loss
Chronic pain
Chronic skin sores
Hair loss
Rashes
Changed mole
Lumps or swelling
Itching or hives
Heartburn
Bloating
Gas or belching

Trouble swallowing
Food intolerance
Nausea or Vomiting
Black/bloody stools
Diarrhea
Constipation
Abdominal pain
Hemorrhoids
Often dizzy
Fainting spells
Frequent headache
Weakness
Numbness
Tingling
Poor coordination
Tremor
Seizures
Vision loss
Itchy or painful eyes
Hearing loss
Ringing in ears
Ear infection / pain
Hay fever
Sinus problems
Hoarseness
Nosebleeds

Chronic cough
Neck swelling
Short of breath
Sleep in a chair
Snoring
Wheezing
Painful breathing
Chest pain
Ankle swelling
Racing heart
Palpitations
Poor circulation
Often feel cold
Wake up to urinate (on most nights)
How many times:
_____
Often thirsty
Urine problems
Sexual difficulty
S T D (?what type)
_____
Reduced sex drive
Night sweats
Easy bruising
Slow healing

Blood transfusion
Balance problems
Trouble walking
Falling down
Joint pains
Swollen joints
Backaches
Sore muscles
Foot pains
Breast lump
Nipple discharge
Painful testicles
Testicle lump
Penile discharge
Enlarged prostate
Slow urine stream
Irregular periods
Painful menses
Vaginal discharge
Yeast infections
Pelvic pain
Unexpected vaginal bleeding
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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