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: Howard *Page 1 of 2 (v10: 10.24)*

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
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 urgency
Night sweats
Easy bruising
Slow healing
Blood transfusion

Balance problems
Trouble walking
Falling down
Joint pains
Swollen joints
Backaches
Sore muscles
Foot pains

Men:

Painful testicles
Erectile difficulties
Penile discharge
Enlarged prostate
Slow urine stream

Women:

Breast lump
Nipple discharge
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 _____

A2663B 10-04-2005