

 **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? _____

Interim Health History Questionnaire: Howard Page 2 of 2

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 | <i>Men:</i> |
| 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 | <i>Women:</i> |
| 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? _____

