

 **Morningstar Healing Arts** 

Welcome to your Annual Wellness Visit!

We look forward to seeing you again.

Please print out and complete the following Interim Health History Questionnaire.

Your annual visit includes review of your history, preventative topic 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.

Insurance providers generally require us to distinguish between preventative and problem focused visits and treatment. 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 copay.

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 9am to 12pm and from 2pm to 4pm 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 W. Morningstar, MD Sue M. Morningstar, WHCNP Aja Morningstar, MD

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 fidgety 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: _____

<p>10. If you checked off <i>any problems</i>, 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?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
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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: _____

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: _____

Interim Health History Questionnaire: Aja Page 2 of 2

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 | How many times:
_____ | Enlarged prostate |
| Weight loss | Tremor | _____ | Slow urine stream |
| Chronic pain | Seizures | Often thirsty | Irregular periods |
| Chronic skin sores | Vision loss | Urine problems | Painful menses |
| Hair loss | Itchy or painful eyes | Sexual difficulty | Vaginal discharge |
| Rashes | Hearing loss | S T D (?what type) | Yeast infections |
| Changed mole | Ringing in ears | _____ | Pelvic pain |
| Lumps or swelling | Ear infection / pain | Reduced sex drive | Unexpected vaginal
bleeding |
| Itching or hives | Hay fever | Night sweats | Hot flashes |
| Heartburn | Sinus problems | Easy bruising | |
| Bloating | Hoarseness | Slow healing | |
| Gas or belching | Nosebleeds | | |

Anything else we should know? _____