

 **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

Interim Health History Questionnaire: Howard Page 2 of 2

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 many caffeine products do you use daily? _____ What kinds? _____

How many alcohol drinks do you drink:: 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 | 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 | <i>Men:</i> |
| Sexual abuse | Numbness | Often feel cold | Painful testicles |
| Hopeless | Tingling | Wake up to urinate
(on most nights) | Testicle lump |
| Considered suicide | Poor coordination | How many times:
_____ | Penile discharge |
| Weight loss | Tremor | _____ | Erection difficulty |
| Chronic pain | Seizures | Often thirsty | Slow urine stream |
| Chronic skin sores | Vision loss | Urine problems | <i>Women:</i> |
| Hair loss | Itchy or painful eyes | Sexual difficulty | Irregular periods |
| Rashes | Hearing loss | S T D (?what type) | Painful menses |
| Changed mole | ringing in ears | _____ | Vaginal discharge |
| Lumps or swelling | Ear infection / pain | Reduced sex drive | Yeast infections |
| Itching or hives | Hay fever | Night sweats | Pelvic pain |
| Heartburn | Sinus problems | Easy bruising | Unexpected vaginal
bleeding |
| Bloating | Hoarseness | Slow healing | Hot flashes |
| Gas or belching | Nosebleeds | | |
| Anything else we should know? _____ | | | |