In order to better address your medical needs, we are asking you to complete the enclosed packet prior to your Medicare Wellness visit.

Contents:

1. Information about your Medicare Wellness visit
2. A questionnaire about your overall health and daily activities
3. A form for you to list the names of your current physicians and health care providers
4. Advance directive information and optional forms to complete

**Another essential component to your visit is to ensure your medication list is up-to-date.

Please bring all of your current medication bottles with you to your visit for review.

Advance Directive

An advance directive is an important collection of legal documents for all adults to have. It serves as a guide for your family and healthcare team to follow if a life-threatening event were to happen. Developing a guide keeps you in charge when it comes to decisions about medical treatment—even when you're no longer capable of making those decisions. This kind of planning also shows compassion for family and friends. When loved ones are left guessing, too often the result is guilt, uncertainty, and arguments. By making your wishes known, you can help your loved ones feel more comfortable with your chosen course of care.

Each of the documents you need for your guide serves a different purpose. A living will, health-care power of attorney, and a do not resuscitate/do not intubate order (optional) are legal instructions known as advance directives.

- A living will tells medical professionals and your family which medical treatments you want to receive or refuse—and under what conditions. It only goes into effect if you meet specific medical criteria and are unable to make decisions.
- A health-care power of attorney allows you to appoint someone to make health-care decisions for you any time you're unable to do so. Most people choose trusted family members or friends who are comfortable talking to doctors. The healthcare power of attorney can also be referred to as a health-care proxy or a durable power of attorney for health care. It is different than a regular power of attorney, which only covers financial matters.[2]
- A do not resuscitate/do not intubate order is an optional component of your advance directive if you do not want your heart restarted if it stops or you do not want a breathing tube put in if you stop breathing.[1]

If you have an advance directive or have assigned a healthcare proxy, our office would like to have a copy of that information in your health record.

If you do not have an advance directive, we have enclosed blank copies of an advance directive and declaration of a healthcare proxy. Please consider completing these forms to help those you care about know your wishes.

*These forms do not require notarization but do require 2 witnesses to become legal documents.

1.Patient Information: Advance Directives (The Basics). (2014, January 1). Retrieved December 2, 2014.
2.Why Advance Directives Are Important. (2010, January 1). Retrieved December 2, 2014.

Name_____**Birthdate**_____

LIST OF CURRENT HEALTHCARE PROVIDERS

Specialty**	**Name of Doctor**	**Address of Doctor**	**Phone number**

****cardiology, acupuncture, chiropractor, dentistry, allergist, dermatology, endocrinology, gastroenterology, hematology/oncology, infectious disease, neurology, gynecology, ophthalmology/optometrist/eye doctor, orthopedic surgeon, podiatry, psychiatry, urology, surgery, pain management, ear/nose/throat (ENT), pulmonary, rheumatology, nephrology, and any other doctor you see

Name_____**Birthdate**_____

Do you have an advanced directive or living will? *(If yes, please bring a copy so it can be scanned into your medical chart.)*	Y	N
Do you have a health care proxy or surrogate decision maker?	Y	N
Are you able to dress on your own?	Y	N
Are you able to feed yourself?	Y	N
Are you able to bathe yourself?	Y	N
Do you prepare your own meals?	Y	N
Do you do your own housekeeping?	Y	N
Does anyone help you with your finances?	Y	N
Have you fallen in the past 12 months?	Y	N
If yes, did the fall result in an injury?	Y	N
Do you have difficulty with your hearing?	Y	N

Are you able to…			
Climb the stairs	Yes	With Help	No
Get in & out of the car?	Yes	With Help	No
Go down the stairs?	Yes	With Help	No
Put on socks?	Yes	With Help	No

Do you currently smoke?	Y	N	If no, have you ever smoked?	Y	N
Do you drink alcohol?	Y	N			
If yes, how often?	Most days		Less than 3 times per week		Rarely

What would you consider your usual activity level to be?	Sedentary	Moderately active	Vigorous
Are you able to walk?	A short distance	5-10 blocks	Unlimited distance
What types of physical activity do you participate in? (Gardening, walking, etc.)	*(write here)*		
What type of diet do you eat? (Circle all that apply)	Diabetic Well balanced Vegetarian Frequently eat out	Packaged foods High fat Low fat High sugar	Low sugar High salt Low salt Other

Name_____ **Birthdate**_____

Do you have smoke detectors in your home	Y	N
Do you have firearms in your home	Y	N
Do you use seat belts?	Y	N
Do you have carbon monoxide detectors in your home?	Y	N
Do you have Radon in your home? *Unknown*	Y	N
If yes, has it been treated?	Y	N
What type of home heating do you have? *(circle answers)*	electric gas oil wood	

Please list who lives with you:

Have you experienced in the past year….
(Please mark Yes or No in white boxes)

Constitutional	Yes	No	**Eyes**	Yes	No
Night sweats			Vision change in past 6 months		
Unintentional weight change			Wear glasses/contact lenses		
Fatigue >6 months			**Ears/Nose/Throat**		
Respiratory			Voice change		
Chronic/frequent cough			Frequent nose bleeds		
Shortness of breath			**Gastrointestinal**		
Cardiovascular			Blood in stools		
Chest pain			Nausea/vomiting		
Palpitations/irregular heart beat			Change in bowel habits		
Cannot climb 2 flights of stairs			**Genitourinary**		
Musculoskeletal			Blood in urine		
Painful/swollen joints			Difficulty holding urine		
Difficulty walking			**Psychiatric**		
Neurological			Currently sexually active		
Chronic/frequent headaches			Concerns about sexual function		
Memory problems			Feeling depressed/sad lately		
Endocrine			Nervous/anxious		
Any loss in height			Suicide attempt or thoughts		
Excessive thirst/urination			**Skin**		
For Women Only			Hair loss/excess hair growth		
Abnormal vaginal discharge/bleeding			Rashes/itching		
Discharge/lump in breast			**For Men Only**		
			Discharge from penis		

Name_____ **Birthdate**_____

Please circle the response that best describes how you feel:

Over the **last two weeks,** how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

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? **Please circle your response.**

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Adapted from PHQ-9, by Spitzer, Williams, Kroenke, and colleagues.

(For office use: Total score _____)

Name_____**Birthdate**_____

HUNTERDON HEALTHCARE SYSTEM
2100 Wescott Drive
Flemington, NJ 08822

INSTRUCTION DIRECTIVE – (LIVING WILL)

To My Family, Doctors, and All Those Concerned with My Care:

I, _____, being of sound mind, make this statement as a directive to be followed if for any reason I become unable to participate in decisions regarding my medical care. (*Initial* any that apply.)

A. _____ 1. I direct that life-sustaining procedures be *withheld* or *withdrawn:* a) if I become permanently unconscious; b) if I have a terminal illness; c) if I experience extreme mental deterioration; or d) if I have another type of irreversible illness. The above conditions shall have no reasonable expectation of recovery or chance of regaining a meaningful quality of life. These medical conditions shall be determined by my attending physician and at least one additional physician. I understand that I will be kept comfortable.

OR

_____ 2. I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition.

B. This section asks you to think about the values that are important to you regarding treatment in case of severe mental or physical illness.

_____ 1. I do not wish my life to be prolonged by medical treatment(s) if my quality of life is unacceptable to me. The following are conditions that are **un**acceptable to me. (Initial only those that describe a way of living that you could not tolerate):

_____ a) Permanently unconscious with a ventilator breathing for me.
_____ b) Permanently unconscious with a feeding tube and/or intravenous (IV) hydration.
_____ c) On a ventilator when there is little or no chance of recovery.
_____ d) Being conscious (awake), but unable to communicate (for example, with a stroke), and being fed with a feeding tube and/or hydrated with IV's to keep me alive.
_____ e) Living with a dementia like Alzheimer's disease so severe that I am unable to recognize those who love me.

OR

_____ 2. I want to live as long as possible, regardless of the quality of life that I experience.

C. If you chose A. 1., above, the life-sustaining procedures that would be withheld or withdrawn include, but are not limited to: CPR, mechanical ventilation, surgery, chemotherapy, radiation, dialysis, transfusion, and antibiotics. Initial the following if it applies to you.

_____ In the circumstances described in A. 1., above, I also direct that artificially provided nutrition and fluids be withheld and withdrawn and that I be allowed to die.

D. _____ Upon my death, I am willing to donate any parts of my body that may be beneficial to others.

Additional Comments or Exceptions:

_____

These directions express my legal right to request or refuse treatment. Therefore, I expect my family, doctor, and all those concerned with my care to regard themselves as legally and morally bound to act in accord with my wishes.

Signed _____

Witnesses (cannot be health care representative or alternative representative if any are named on the other side of this page). I declare that the person who signed this document, or asked another to sign this document on his/her behalf, did so in my presence and that he/she appears to be of sound mind and free of duress or undue influence.

Witness _____ **Date** _____

Witness _____ **Date** _____

Reminder: Give a copy of this document to your doctor, health care representative, and other concerned individuals.

Written and approved by the Medical Society of New Jersey 7/95.