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**HEALTH CARE VALUES HISTORY FORM**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

If someone assisted you in completing this form, please fill in his or her name, address, and relationship to you.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

The purpose of this form is to assist you in thinking about and writing down what is important to you about your health and medical care. If you should at some time become unable to make health care decisions for yourself, your thoughts as expressed on this form may help others make a decision for you in accordance with what you would have chosen.

The first section of this form asks whether you have already expressed your wishes concerning medical treatment through either written or oral communications and if not, whether you would like to do so now. The second section of this form provides an opportunity for you to discuss your values, wishes, and preferences in a number of different areas, such as your personal relationships, your overall attitude toward life, and your thoughts about illness.

This form is not a legal document, although it may be used as evidence of your health care values in a legal proceeding.

## WHY A HEALTH CARE VALUES HISTORY FORM?

The Health Care Values History Form recognizes that health care decisions we make for ourselves are based on those beliefs, preferences and values that matter most to us: How do we feel about independence and control? About pain, illness, dying and death? What in life gives us pleasure? Sorrow? A discussion of these and other values can provide important information for those who might, in the future, have to make medical decisions for us when we are no longer able to do so.

Further, a discussion of the questions asked on the Health Care Values History Form can provide a solid basis for families, friends, physicians and others when making such health care decisions on your behalf should you become unable to do so yourself. By talking about such issues ahead of time, family disagreements may be minimized. And when such decisions do need to be made, the burden of responsibility may be lessened because others feel confident of your wishes.

## HOW DO I FILL OUT THE HEALTH CARE VALUES HISTORY FORM?

Section 1 allows you to record both written and oral instructions you might already have prepared. Simply answer the questions. If you have not yet written or talked about these issues, you might wait to complete this section at a later date, perhaps after you have completed Section 2.

Section 2 asks a number of questions about issues such as: Your attitude toward your health; Your feelings about your health care providers; Your thoughts about independence and control; Personal Relationships; Your overall attitude toward life and preferences for life activities; Your attitude toward illness/dying/death; Your religious background and beliefs; Your living environment and daily routine; Your attitude toward finances.

There are a number of ways in which you might begin to answer these questions. Perhaps you would like to write out some of you own thoughts before you talk with anyone else. Or you might ask family and friends to come together and talk about your, and their, responses to the questions.

Often simply making copies of the Health Care Values History Form available to others is enough to get people talking about a subject that, for many of us, is difficult and painful to consider. The most important thing to remember is that **it is easier to talk about these issues BEFORE a health care crisis occurs**. Feel free to add questions and comments of your own to those already provided.

## **WHAT SHOULD I DO WITH MY COMPLETED HEALTH CARE VALUES HISTORY FORM?**

Make certain that all those who might be involved in future medical decisions made on your behalf are aware of your wishes: family, friends, physicians and other health care providers, your lawyer, your Pastor. If appropriate, provide written copies to these people. But remember that each of us continues to grow and change, and so the Health Care Values History Form should be discussed and updated fairly regularly, as preferences and values evolve. Consider attaching a copy of it to your Patient Advocate Designation or Durable Power of Attorney or filing the Health Care Values History Form with your important medical papers.

## **WHO SHOULD CONSIDER PREPARING A HEALTH CARE VALUES HISTORY FORM?**

*Everyone.* While it has been customary to focus on older people, it is just as important that younger people discuss these issues and make their wishes known. Often some of the most difficult medical decisions must be made on behalf of these younger patients. If they had talked with families and friends, these decision makers could feel reassured they were following the patient's wishes.

**People with disabilities can also address their values as to medical care and treatment. Family members, advocates, or others can assist the person in filling out a Health Care Values History Form.**

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We hope this Health Care Values History Form is of help to you, your families and friends. Many people have commented that it is important to reflect not so much on "How I want to die," but rather on "**How I want to LIVE until I die.**"

Sincerely,

Hafeli Staran Hallahan Christ & Dudek, P.C.

**SECTION 1**

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**A. WISHES CONCERNING SPECIFIC MEDICAL PROCEDURES**

If you have already expressed your wishes, either written or orally, concerning any of the following medical procedures, please complete this information. If you have not, please indicated your preferences regarding these procedures. *(Note: You may also wish to consider completing a Patient Advocate Designation, which is a legal document that allows someone you name to make decisions on your behalf in accordance with your preferences if you are unable to. Please ask us for more information!)*

**Organ Donation**

To whom expressed: \_\_\_\_\_  
If oral, when? \_\_\_\_\_  
If written, when? \_\_\_\_\_  
Documentation location: \_\_\_\_\_  
Comments/Preferences: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Kidney Dialysis**

To whom expressed: \_\_\_\_\_  
If oral, when? \_\_\_\_\_  
If written, when? \_\_\_\_\_  
Document location: \_\_\_\_\_  
Comments/Preferences: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Cardiopulmonary Resuscitation (CPR)**

To whom expressed: \_\_\_\_\_  
If oral, when? \_\_\_\_\_  
If written, when? \_\_\_\_\_  
Document location: \_\_\_\_\_  
Comments/Preferences: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Respirators**

To whom expressed: \_\_\_\_\_

If oral, when? \_\_\_\_\_

If written, when? \_\_\_\_\_

Document location: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Artificial Nutrition**

To whom expressed: \_\_\_\_\_

If oral, when? \_\_\_\_\_

If written, when? \_\_\_\_\_

Document location: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Artificial Hydration**

To whom expressed: \_\_\_\_\_

If oral, when? \_\_\_\_\_

If written, when? \_\_\_\_\_

Document location: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**B. GENERAL COMMENTS**

Do you wish to make any general comments about the information you provided in this section?

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\_\_\_\_\_

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\_\_\_\_\_

**SECTION 2**

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**A. YOUR OVERALL ATTITUDE TOWARD YOUR HEALTH**

1. How would you describe your current health status? If you currently have any medical problems, how would you describe them? \_\_\_\_\_

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2. If you have current medical problems, in what ways, if any, do they affect your ability to function? \_\_\_\_\_

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3. How do you feel about your current health status? \_\_\_\_\_

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4. How well are you able to meet the basic necessities of life—eating, food preparation, sleeping, personal hygiene, etc.? \_\_\_\_\_

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5. Do you wish to make any general comments about your overall health? \_\_\_\_\_

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**B. YOUR PERCEPTION OF THE ROLE OF YOUR DOCTOR AND OTHER HEALTH CAREGIVERS**

1. Do you like your doctors? \_\_\_\_\_

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2. Do you trust your doctors? \_\_\_\_\_

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3. What characteristics are important to you regarding your doctors or other health care providers? What characteristics or values makes you want to change doctors or other health care providers?

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4. Do you think your doctors should make the final decision concerning any treatment you might need? \_\_\_\_\_

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5. How do you relate to your caregivers, including nurses, therapists, chaplains, social workers, etc.?

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6. Do you wish to make any general comments about your doctor and other health caregivers, and preferences regarding medical treatment (e.g., use of minimal medications)?

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**C. YOUR THOUGHTS ABOUT INDEPENDENCE AND CONTROL**

1. How important is independence and self-sufficiency in your life? Are there certain areas in your life that are more important than others regarding independence and self-sufficiency (e.g., finances, employment, independent living)? \_\_\_\_\_

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2. If you were to experience decreased physical and mental abilities, how would that affect your attitude toward independence and self-sufficiency? \_\_\_\_\_

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3. Do you wish to make any general comments about the value of independence and control in your life? \_\_\_\_\_

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#### **D. YOUR PERSONAL RELATIONSHIPS**

1. Do you expect that your friends, family and/or others will support your decisions regarding medical treatment you may need now or in the future? \_\_\_\_\_

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2. Have you made any arrangements for your family or friends to make medical treatment decisions on your behalf? If so, who has agreed to make decisions for you and in what circumstances? \_\_\_\_\_

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3. What, if any, unfinished business from the past are you concerned about (e.g., personal and family relationships, business and legal matters)? \_\_\_\_\_

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4. What role do your friends and family play in your life? \_\_\_\_\_

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5. Do you wish to make any general comments about the personal relationships in your life? \_

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**E. YOUR OVERALL ATTITUDE TOWARD LIFE AND LIFE ACTIVITIES**

1. Are you happy to be alive? \_\_\_\_\_

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2. Do you feel that life is worth living? \_\_\_\_\_

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3. What activities do you enjoy (e.g., hobbies, watching television)? Describe the activities in detail (e.g. type of television shows)\_\_\_\_\_

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4. What type of music do you enjoy? It is an important part of your life? \_\_\_\_\_

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5. What accomplishments in your life are you most proud of?

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6. How important is your current or past career path(s) to you? What do/did you do regarding employment? \_\_\_\_\_

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7. How satisfied are you with what you have achieved in your life? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. What makes you laugh/cry? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. What do you fear most? What frightens or upsets you? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. What goals do you have for the future?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. Do you wish to make any general comments about your attitude toward life and/or your life activities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**F. YOUR ATTITUDE TOWARD ILLNESS, DYING AND DEATH**

1. What will be important to you when you are dying (e.g., physical comfort, no pain, family members present, etc.)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Where would you prefer to die? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. What is your attitude toward death? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. How do you feel about the use of life-sustaining measures in the face of :  
Terminal illness? \_\_\_\_\_  
\_\_\_\_\_  
Permanent coma? \_\_\_\_\_  
\_\_\_\_\_  
Irreversible chronic illness (e.g., Alzheimer's disease)? \_\_\_\_\_  
\_\_\_\_\_

5. Do you wish to make any general comments about your attitude toward illness, dying, and death? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**G. YOUR RELIGIOUS BACKGROUND AND BELIEFS**

1. What is your religious background? What is the level of your involvement in religious activities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. How do your religious beliefs affect your attitude toward serious or terminal illness? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Does your attitude toward death find support in your religion? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. How does your faith community, church, or synagogue view the role of prayer or religious sacraments in an illness? \_\_\_\_\_

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5. Do you wish to make any general comments about your religious background and beliefs? \_\_\_\_\_

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## **H. YOUR LIVING ENVIRONMENT AND DAILY ROUTINE**

1. What has been your living situation over the last 10 years (e.g., lived alone, lived with others, etc.)? What type of living situation do you prefer? \_\_\_\_\_

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2. How difficult is it for you to maintain the kind of environment for yourself that you find comfortable? Does any illness or medical problem you have now mean that it will be harder in the future? \_\_\_\_\_

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3. Do you wish to make any general comments about your current living environment? \_\_\_\_\_

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## **SUGGESTIONS FOR USE**

After you have completed this form, you may wish to provide copies to your doctors and other health caregivers, your family, your friends, and your attorney. If you have a Patient Advocate Designation, you may wish to attach a copy of this form to those documents.

*This document was drafted by Patricia E. Kefalas Dudek, Esq.*