GIRARD Medical Center

1. How do you rate your overall heath?
   a. Excellent
   b. Very Good
   c. Good
   d. Fair
   e. Poor

2. During the past four weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?
   a. Not at all
   b. Slightly
   c. Moderately
   d. Quite a bit
   e. Extremely

3. During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?
   a. Not at all
   b. Slightly
   c. Moderately
   d. Quite a Bit
   e. Extremely

4. During the past four weeks, how much body pain have you generally had?
   a. No pain
   b. Very mild pain
   c. Mild pain
   d. Moderate pain
   e. Severe pain

5. During the past four weeks, was someone available to help you if you needed and wanted help?
   a. Yes, as much as I wanted
   b. Yes, quite a bit
   c. Yes, some
   d. Yes a little
   e. No, not at all

6. During the past four weeks, what was the hardest physical activity you could do for at least two minutes?
   a. Very heavy
   b. Heavy
   c. Moderate
   d. Light
   e. Very light

7. Can you get to places out of walking distance without help?
   a. Yes
   b. No

8. Can you go shopping for groceries or clothes without someone's help?
   a. Yes
   b. No

9. Can you prepare your own meals?
   a. Yes
   b. No

10. Can you do your housework without help?
    a. Yes
    b. No

11. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?
    a. Yes
    b. No

12. Can you handle your own money without help?
    a. Yes
    b. No

13. During the past four weeks, how would you rate your health in general?
    a. Excellent
    b. Very good
    c. Good
    d. Fair
    e. Poor

15. How have things been going for you during the past four weeks?
    a. Very well; could hardly be better
    b. Pretty well
    c. Good and bad parts about equal
    d. Pretty bad
    e. Very bad; could hardly be worse

16. Are you having difficulties driving your car?
    a. Yes, often
    b. Sometimes
    c. No
    d. Not applicable, I do not use a car

17. Do you always fasten your seat belt when you are in a car?
    a. Yes, usually
    b. Yes, sometimes
    c. No

18. How often during the past four weeks have you been bothered by any of the following problems? **(Options are as follows: Never, Seldom, Sometimes, Often or Always)**
    a. Falling or dizzy when standing up?
        i. _____
    b. Sexual Problems?
        i. _____
    c. Trouble eating well?
        i. _____
    d. Teeth or denture problems?
        i. _____
    e. Problems using the telephone?
        i. _____
    f. Tiredness or fatigue?
        i. _____

19. Have you fallen two or more times in the past year?
    a. Yes
    b. No

20. Are you afraid of falling?
    a. Yes
    b. No

21. Are you a smoker?
    a. No
    b. Yes, I might quit
    c. Yes, but I'm not ready to quit

22. During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?
    a. 10 or more drinks per week
    b. 6-9 drinks per week
    c. 2-5 drinks per week
    d. One drink or less per week
    e. No alcohol at all

23. Have you ever felt bad or guilty about your drinking or drug use?
    a. Yes
    b. No
    c. Not applicable

24. Do you exercise for about 20 minutes three or more days a week?
    a. Yes, most of the time
    b. Yes, some of the time
    c. No, I usually do not exercise this much

25. Have you been given any information to help you with the following:
    a. Hazards in your house that might hurt you?
        i. Yes
        ii. No
    b. Keeping track of your medications?
        i. Yes
        ii. No

26. How often do you have trouble taking medicines the way you have been told to take them?
    a. I do not have to take medicine
    b. I always take them as prescribed
    c. Sometimes I take them as prescribed
    d. I seldom take them as prescribed

27. How confident are you that you can control and manage most of your health problems?
    a. Very confident
    b. Somewhat confident
    c. Not very confident
    d. I do not have any health problems
28. Do you have a Living will or Advanced Medical Directive?
    a. Yes
    b. No
    c. I would like information regarding the above.

Please list current other physicians and suppliers (i.e.: home care, Medical equip.)

_____
_____
_____
_____
_____
_____

PHQ-2 Answer the following 2 questions with this scale (0=Not at all; 1= Several days; 2=More than half the days; 3= Nearly every day)

1. Little interest or pleasure in doing things.
2. Feeling down, depressed, or hopeless

Thank you very much for completing your Medicare Wellness Questionnaire. Please return to your doctor or nurse.

Providers complete the following in the computer:

1. Clinic Note
2. Female Wellness Checklist or Men's Wellness Checklist

DNR
DO-NOT-RESUSCITATE DIRECTIVE

K.S.A. 65-4941, ET. SEQ.

DECISION TO LIMIT EMERGENCY MEDICAL CARE

I, (Your name) _____, request that effective today, emergency care for me will be limited as described below.

If my heart stops beating or if I stop breathing, no medical procedures to restart breathing or heart functioning will be instituted. No resuscitation will be attempted.

- I understand that the procedure I am refusing, known as cardiopulmonary resuscitation, (CPR), includes chest compressions, assisted ventilations, intubation, defibrillation, administration of cardiotonic medications and other related medical procedures.
- I do not intend for this decision to prevent me from obtaining other medical care, especially comfort measures and pain medication.
- I understand I may revoke this directive at any time.
- I give permission for this information to be given to emergency care providers, doctors, nurses or other health care personnel.
- This DNR directive shall remain in effect while I am admitted at a medical care facility or care home as well as during transport to or from a home or facility.

X _____ _____
(Signature) (Date)

X _____ _____
(Witness Signature) (Date)

Attending Physician Order: I have discussed the use of cardiopulmonary resuscitation with this patient and recognize the patient's decision to refuse CPR.

- In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitation shall be attempted. **DNR**

X _____ _____
(Attending Physician's Signature) (Date)

_____ _____
(Address) (Facility, Clinic or Hospital Name)

Revocation: I hereby withdraw the above DNR directive.

X _____ _____
(Signature) (Date)

We thank Kansas Health Ethics, Inc. (now closed) for their efforts in the development of this and other documents. For more information about obtaining copies of this document contact Wichita Medical Research & Education Foundation, 316-686-7172 or lcarter@wichitamedicalresearch.org.