The Extended Values History

A form to assist you in making health care choices in accordance with your values

It is important that your medical treatment be **your choice.** The purpose of this form is to assist you in thinking about and writing down what is important to you about your health. If you should at some time become unable to make health care decisions, this form may help others make a decision for you in accordance with your values.

The main 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 towards life, and your thoughts about illness. Towards the end of the form is a space for indicating whether you have completed an Advance Directive (Living Will) and where such documents may be found.

The Extended Values History Form is **not copyrighted.** You are encouraged to make additional copies for friends and relatives to use.

Attach further pages if you need to write more.

NAME: ..... Signature: .....

D.O.B.:..... Today's Date: .....

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

Name: .....

Address: .....

Relationship: .....

OVERALL ATTITUDE TOWARDS LIFE AND HEALTH
What would you like to say to someone reading this document about your overall attitude towards life?

What goals do you have for the future?

How satisfied are you with what you have achieved in your life?

What, for you, makes life worth living?

What do you fear most? What frightens or upsets you?

What activities do you enjoy (eg hobbies, watching TV)?

How would you describe your current state of health?

If you currently have any health problems or disabilities, how do they affect: You? Your family? Your work? Your ability to function?

If you have any health problems or disabilities, how do you feel about them?

What would you like others (family, friends, doctors) to know about this?

Do you have difficulty in getting through the day with activities such as: eating? preparing food? sleeping? dressing and bathing? etc.

What would you like to say to someone reading this document about your general health?

PERSONAL RELATIONSHIPS
What role do family and friends play in your life?

How do you expect friends, family and others to support your decisions regarding medical treatment you may need now or in the future?

Have you made any arrangements for family or friends to assist in making medical treatment decisions on your behalf? If so, who has agreed to assist in making decisions for you and in what circumstances?

What general comments would you like to make about the personal relationships in your life?

THOUGHTS ABOUT INDEPENDENCE AND SELF-SUFFICIENCY
How does independence or dependence affect your life?

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

If your current physical or mental health gets worse, how would you feel?

LIVING ENVIRONMENT
Have you lived alone or with others over the last 10 years?

How comfortable have you been in your surroundings?

How might illness, disability or age affect this?

What general comments would you like to make about your surroundings?

RELIGIOUS BACKGROUND AND BELIEFS
What is your spiritual/religious background?

How do your beliefs affect your feelings towards serious, chronic or terminal illness?

How does your faith community, church or synagogue support you?

What general comments would you like to make about your beliefs?

RELATIONSHIPS WITH DOCTORS AND OTHER HEALTH CAREGIVERS
How do you relate to your doctors? Please comment on: trust; decision making; time for satisfactory communication; respectful treatment.

How do you feel about other caregivers, including nurses, therapists, chaplains, social workers etc?

What else would you like to say about doctors and other caregivers?

THOUGHTS ABOUT ILLNESS, DYING AND DEATH
What general comments would you like to make about illness, dying and death?

What will be important to you when you are dying (eg, physical comfort, no pain, family members present etc)?

Where would you prefer to die?

How do you feel about the use of life-sustaining measures if you were: suffering from irreversible chronic illness (eg Alzheimer's disease)? terminally ill? in a permanent coma?

What general comments would you like to make about medical treatment?

FINANCES
What general comments would you like to make about your finances and any costs connected with your health care?

What are your feelings about having enough money to provide for your care?

FUNERAL PLANS
What general comments would you like to make about your funeral and burial or cremation?

Have you made your funeral arrangements? If so, with whom?

OPTIONAL QUESTIONS
How would you like your obituary (announcement of your death) to read?

Write yourself a brief eulogy (a statement about yourself to be read at your funeral).

What would you like to say to someone reading this Extended Values History Form?

HEALTH CARE DECISION DOCUMENTS
Have you signed a Living Will?

Yes No

Where can it be found?

Name:

Address:

Phone: