Name: _____ Last 4: _____

IMPROVE: Quality Improvement Project

1. Of your current medications, which one are you most eager to stop taking?

_____

2. Of your current medications, which one is the most important to you?

_____

3. Are you satisfied with your current medications list? [ ] yes [ ] no

4. How many times a week do you miss taking all your medications? _____

5. Have your symptoms increased in the past 3 months? [ ] yes [ ] no

6. How would you rate your overall health?

[ ] excellent [ ] very good [ ] good [ ] fair [ ] poor

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7. How would you rate your overall quality of life?

[ ] excellent [ ] very good [ ] good [ ] fair [ ] poor

8. How many times have you fallen in the past 3 months?

[ ] 2 or more times [ ] 1 time [ ] not at all

9. How many times have you been hospitalized in the past 3 months?

[ ] 2 or more times [ ] 1 time [ ] not at all

10. Have you been eating less in the past 3 months? [ ] yes [ ] no

11. Have you lost weight without trying over the past 3 months? [ ] yes [ ] no

12. In the past 3 months, have you often been bothered by feeling down, depressed, or hopeless? [ ] yes [ ] no

13. In the past 3 months, have you often been bothered by little interest or pleasure in doing things? [ ] yes [ ] no

14. Do you need help from another person with any of the following (check all that apply)?

[ ] Bathing
[ ] Dressing
[ ] Toileting
[ ] Getting up from a chair
[ ] Grooming yourself
[ ] Feeding yourself
[ ] Preparing meals
[ ] Shopping
[ ] Cleaning the house
[ ] Using a telephone
[ ] Driving
[ ] Taking medications as prescribed
[ ] Paying bills