Welcome to the Loving Kindness Hospice Care Center

Name: _____ Date of Birth: ____/____/____

Home Address: _____ City: _____ Zip: _____

Residence in Homeland: _____ and U.S. Permanent Address: (if applicable) _____

Medical History

Has anyone in your family ever had any of these illnesses?

Illness	Yes	No
Heart Disease	☐	☐
Lung/Breathing	☐	☐
Cancer	☐	☐
High Blood Pressure	☐	☐
Arthritis	☐	☐
Diabetes	☐	☐

Have you ever had any surgeries? If so, please list them below.

_____ Date: ___/___/___

_____ Date: ___/___/___

_____ Date: ___/___/___

Are you allergic to any medications? If so, please list them below.

_____

_____

_____

_____