



NANNY SERVICES  
OF NEVADA

316 California Avenue  
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Reno, NV 89509  
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MEDICAL INFORMATION SHEET

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Date of birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Have you ever had any of the following?

- |   |                          |                          |   |   |
|---|--------------------------|--------------------------|---|---|
| 1. Severe Headaches                       | Yes                      | No                       |   |   |
| 2. Head Injury                            | <input type="checkbox"/> | <input type="checkbox"/> |   |   |
| 3. Hearing loss or ear trouble            | <input type="checkbox"/> | <input type="checkbox"/> | 31. Yellow Jaundice   | Yes No  |
| 4. Hay Fever                              | <input type="checkbox"/> | <input type="checkbox"/> | 32. Anemia  | <input type="checkbox"/> <input type="checkbox"/> |
| 5. Allergies                              | <input type="checkbox"/> | <input type="checkbox"/> | 33. Irregular heartbeat   | <input type="checkbox"/> <input type="checkbox"/> |
| 6. Chronic Cough                          | <input type="checkbox"/> | <input type="checkbox"/> | 34. Alcohol Excess (Drinking Problem)   | <input type="checkbox"/> <input type="checkbox"/> |
| 7. Shortness of breath                    | <input type="checkbox"/> | <input type="checkbox"/> | 35. Have you ever had a work related injury or illness?   | <input type="checkbox"/> <input type="checkbox"/> |
| 8. Asthma                                 | <input type="checkbox"/> | <input type="checkbox"/> | 36. Have you ever received compensation for an industrial injury?   | <input type="checkbox"/> <input type="checkbox"/> |
| 9. Heart Trouble                          | <input type="checkbox"/> | <input type="checkbox"/> | 37. Are you at present under a doctor's care for any condition?   | <input type="checkbox"/> <input type="checkbox"/> |
| 10. High Blood Pressure                   | <input type="checkbox"/> | <input type="checkbox"/> | 38. Are you taking medication at this time?   | <input type="checkbox"/> <input type="checkbox"/> |
| 11. Rheumatic Fever                       | <input type="checkbox"/> | <input type="checkbox"/> | 39. Have you ever, or do you now take any legal or illegal drugs or narcotics?  | <input type="checkbox"/> <input type="checkbox"/> |
| 12. Stomach or Duodenal Ulcer             | <input type="checkbox"/> | <input type="checkbox"/> | 40. Have you ever had any operations?   | <input type="checkbox"/> <input type="checkbox"/> |
| 13. Gallbladder Trouble                   | <input type="checkbox"/> | <input type="checkbox"/> | 41. Do you smoke?   |   |
| 14. Rupture (Hernia)                      | <input type="checkbox"/> | <input type="checkbox"/> | 42. Military service with medical discharge?  | <input type="checkbox"/> <input type="checkbox"/> |
| 15. Kidney Trouble                        | <input type="checkbox"/> | <input type="checkbox"/> | 43. Do you have any mental or physical impairment that would prevent you from performing the duties of the position you were hired for? | <input type="checkbox"/> <input type="checkbox"/> |
| 16. Dislocation of Joints                 | <input type="checkbox"/> | <input type="checkbox"/> | IF YES, list below what accommodations you have made or would need to perform this job  |   |
| 17. Broken Bones                          | <input type="checkbox"/> | <input type="checkbox"/> |   |   |
| 18. Bone or Joint Problems                | <input type="checkbox"/> | <input type="checkbox"/> |   |   |
| 19. Rheumatism or Arthritis               | <input type="checkbox"/> | <input type="checkbox"/> |   |   |
| 20. Back Pain or Injury                   | <input type="checkbox"/> | <input type="checkbox"/> |   |   |
| 21. Knee Injury                           | <input type="checkbox"/> | <input type="checkbox"/> |   |   |
| 22. Skin Problems or Chronic Rash         | <input type="checkbox"/> | <input type="checkbox"/> |   |   |
| 23. Nervous Disorders                     |                          |                          |   |   |
| 24. Fainting Spells                       | <input type="checkbox"/> | <input type="checkbox"/> |   |   |
| 25. Epilepsy                              | <input type="checkbox"/> | <input type="checkbox"/> |   |   |
| 26. Complications from Childhood Diseases | <input type="checkbox"/> | <input type="checkbox"/> |   |   |
| 27. Diabetes                              |                          |                          |   |   |
| 28. Tuberculosis                          | <input type="checkbox"/> | <input type="checkbox"/> |   |   |
| 29. Cancer                                | <input type="checkbox"/> | <input type="checkbox"/> |   |   |
| 30. Tumor                                 | <input type="checkbox"/> | <input type="checkbox"/> |   |   |

Details of all questions answered with "Yes": \_\_\_\_\_

I certify that the answers given herein are true and complete to the best of my knowledge. I understand that misrepresentation or omission of facts called for is cause for dismissal. I authorize you to make such investigations and inquiries of my employment, medical history, and other related matters as may be necessary.

Signature \_\_\_\_\_ Date \_\_\_\_\_