URGENT NURSING RESOURCE, INC.
14752 BEACH BLVD. Suite 101 LA MIRADA, CA 90638 Phone (7141 523-4178 fax (714) 523-4255 info@urgentnursing.com

Health Questionnaire

Name: (Last, First)	SSN:	Date:

This section to be completed by applicant

Do you have or ever been told you have:	Yes	No	If yes, explain:
Allergies, Asthma, Wheezing			
Chronic cough, Colds			
Rheumatic Fever			
Heart Trouble			
High Blood Pressure			
Frequent Headaches			
Fainting or Dizziness			
Epilepsy or Convulsions			
Nervous Breakdown			
Difficulty Hearing			
Need Hearing Aid			
Use Hearing Aid			
Difficulty Seeing			
Need Corrective Lenses			
Use Corrective Lenses			
Hernia			
Diabetes			
Varicose Veins			
Do you have any physical limitations?			
Do you take any prescription medications?			
Have you ever been treated for a drug or alcohol habit?			
Have you ever been treated for any back disorder?			
Are you in good health to the best of your			
Are you under a physician care?			

Name of Physician _____ Phone No. _____

Address _____

I hereby authorize the above information to be released to Urgent Nursing Resource, Inc.

Signature _____ Date _____