SOUTH CAROLINA STATE GUARD MEDICAL SERVICE INQUIRY

Name:____ SSN (Last 4) ____ ____ ____ ____

Address:____ Civilian Occupation:_______________________

Phone: ____-____-_______ Cell: ____-____-_______ Work: ____-____-_______

DOB: _____ / _____ / ________ Height (inches): ___________ Weight: ___________
use drop down menu for DOB

Medical History

Allergies:______________________________ Glasses: ☐ Yes ☐ No

______________________________________ Contacts: ☐ Yes ☐ No

______________________________________ Hearing Aids: ☐ Yes ☐ No

Other:_________________________________

____

______________________________________ Blood Type:_____________

Do you have a history of:

☐ Headaches	☐ Pneumonia	☐ Diabetes	☐ Rheumatic Fever
☐ Shortness of Breath	☐ Ulcer(s)	☐ Hepatitis	☐ Glaucoma
☐ Heart Palpitations	☐ GI Disorder(s)	☐ Anemia	☐ Epilepsy
☐ Heart Murmur	☐ Lactose Intolerance	☐ Osteoarthritis	☐ Bleeding Disorder
☐ Heart Attack	☐ Gallbladder Disease	☐ Hypertension (High B/P)	☐ Kidney Disease
☐ Chest Pain	☐ Prostate Disease	☐ Depression	☐ Thyroid Disorder
☐ Dizziness/Fainting	☐ GYN Disease/Disorder	☐ Gout	☐ Mental Health Issues
☐ Peripheral Vascular Disease	☐ Bowel Irregularities	☐ Stroke	☐ TB
☐ Allergies/Hay Fever	☐ Hearing Loss	☐ Chronic infectious disease	☐ Cancer
☐ Bronchitis	☐ Tinnitus (ringing in ears)	☐ HIV	☐ Shoulder Problems
☐ Knee or Hip Problems	☐ Back Problems		

☐ Other : ____

Tobacco use: ☐ Yes ☐ No ☐ Smoke ☐ Smokeless ☐Vapor

Alcohol use: How many drinks do you have in a week? ____

Do you have sleep problems? ☐ Yes ☐ No Trouble going to sleep or staying asleep? ☐ Yes ☐ No

Excessive sleepiness during the day? ☐ Yes ☐ No Sleep Apnea? ☐ Yes ☐ No Do you use a CPAP? ☐ Yes ☐ No

Exercise Routine:

☐ No exercise plan

☐ Less than 3 x per week

☐ 3 x per week for more than 30 minutes

☐ More than above

Nutrition:

Do you have appetite problems? ☐ Yes ☐ No

Special Diet: ________________________________

Do you feel you are "fit": ☐ Yes ☐ No Do you need help starting a fitness plan: ☐ Yes ☐ No

Do you have contact /exposure to blood / body fluids at your civilian jobsite: ☐ Yes ☐ No

Living Will: ☐ Yes ☐ No Immunizations: ☐Flu ☐Hep B ☐Pneumonia ☐Tetanus ☐Shingles

Family physician Name/Phone: __________________________________ ( )_____-_____-_________

Next of Kin (NOK) Name/Phone: __________________________________( )_____-_____-_________

Other Phone Numbers:____

Activity Restrictions:____

____

Hospitalizations/Surgeries in past 24 months: ☐ No ☐ Yes- Explain:

____

____

Fractures in past 24 months: ☐ No ☐ Yes- Explain:____

Medications (prescribed and over-the-counter):____

____

Remarks:

____

____

____

____

SIGNATURE: ____ PRINT LAST NAME: ___________________DATE: ___________

Office use only ☐ Category A ☐ Category B ☐ Category C

FULLY DEPLOYABLE DEPLOY W/ RESTRICTIONS NON-DEPLOYABLE

MEDICAL INQUIRY FORM SUBMISSION INSTRUCTIONS:

Thank you for your interest in the South Carolina State Guard. Following completion of the South Carolina State Guard Medical Inquiry you should select the SUBMIT button below which will open your selected mail system for submission. This form will be submitted directly to COL Carl Kinard with the SCSG Medical Detachment for evaluation. If the email prompt does not open, please submit this form to MED_Officer@sg.sc.gov. Do NOT submit this form to your assigned recruiter. Following submission, please contact your assigned recruiter via email informing them that the form has been completed and submitted and carbon copy (cc) the recruiting command general mail box at recruiting@sg.sc.gov

1. Submit form via the SUBMIT button or email to MED_Officer@sg.sc.gov
2. Inform your assigned recruiter and carbon copy (cc) recruiting@sg.sc.gov
3. Please maintain a copy of this form for your personal records