SOUTH CAROLINA STATE GUARD MEDICAL SERVICE INQUIRY

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

Address:_____ Civilian Occupation:_____

Phone: ____-____-_____ Cell: ____-____-_____ Work: ____-____-_____

DOB: _____ / _____ / _____ Height (inches): _____ Weight: _____

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: _____

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