

SOUTH CAROLINA STATE GUARD POST ENLISTMENT MEDICAL INQUIRY

Completion of this report is requested by the South Carolina Military Department to meet data requirements.

Name _____ Unit: _____ ID# (Initial and last four of SSN) _____

Address: _____

**A. To the best of your knowledge, have you had, or do you have any of the following medical problems?
Please answer YES or NO**

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| <p>_____ 1. Epilepsy</p> <p>_____ 2. Diabetes</p> <p>_____ 3. Cardiac Disease</p> <p>_____ 4. Arthritis</p> <p>_____ 5. Amputated foot, leg, hand or arm</p> <p>_____ 6. Loss of sight of one or both eyes or partial loss of uncorrected vision of more than 75% bilaterally</p> <p>_____ 7. Residual disability from Polio</p> <p>_____ 8. Cerebral Palsy - weakness or stiffness of arms, legs or other body parts that resulted from birth injury or diseases? Any spasticity?</p> <p>_____ 9. Multiple Sclerosis</p> <p>_____ 10. Parkinson's Disease</p> <p>_____ 11. Cerebral vascular accident - stroke or ruptured blood vessel in the head</p> <p>_____ 12. Tuberculosis</p> <p>_____ 13. Silicosis -chronic cough, emphysema, or other lung problems due to inhalation of dust of any kind</p> <p>_____ 14. Mental Retardation</p> <p>_____ 15. Psychoneurotic Disability that involved treatment in a recognized medical or mental institution or facility</p> <p>_____ 16. Hemophilia - Do you bleed easily and have a hard time stopping the bleeding?</p> <p>_____ 17. Chronic Osteomyelitis - long-term infection of bones or skin sores that do not heal</p> | <p>_____ 18. Ankylosis of Joints - joints that are stiff and will not fully move or frozen joints.</p> <p>_____ 19. Hyperinsulism - excessive insulin in the blood with low blood sugar and periods of weakness or fainting due to low blood sugar</p> <p>_____ 20. Muscular Dystrophy</p> <p>_____ 21. Arteriosclerosis - poor circulation, cold extremities, pain in legs while walking</p> <p>_____ 22. Thrombophlebitis - infection or inflammation of veins in legs, swelling or tenderness in leg calves</p> <p>_____ 23. Varicose Veins</p> <p>_____ 24. Heavy Metal Poisoning</p> <p>_____ 25. Ionizing Radiation Injury - exposed to radiation and developed sores that did not heal, vomited or bled freely?</p> <p>_____ 26. Compressed Air Sequelas - experienced the bends? Problems produced by flying at high altitude or problems resulting from exposure to high atmospheric pressure as in scuba diving?</p> <p>_____ 27. Ruptured Disc</p> <p>_____ 28. Hodgkin's Disease</p> <p>_____ 29. Brain Damage</p> <p>_____ 30. Deafness</p> <p>_____ 31. Sickle-cell Anemia</p> <p>_____ 32. Cancer</p> <p>_____ 33. Pulmonary Disease</p> <p>_____ 34. Degenerative Disc Disease</p> <p>_____ 35. Other pre-existing disease/conditions</p> <p>_____ 36. Serious Allergies</p> <p>_____ 37. Agent Orange Exposure</p> <p>_____ 38. Precautions</p> <p>_____ 39. Medications</p> <p>_____ 40. Post Surgeries</p> <p>_____ 41. HIV...Neg _____ Pos _____</p> |
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For "yes" responses above, indicate the nature of injury or illness and name of physician in remarks.

NOK and Phone Number: _____

Family Physician and Phone Number: _____

Remarks: _____

PLEASE INITIAL YOUR REPOSE AND EXPLAIN "YES" RESPONSES.

B. Has any doctor ever restricted your activities? _____NO _____YES

C. Have you ever been assessed any percentage of permanent disability to any part of your body for any reason whatsoever? _____NO _____YES

D. Are you presently under any medical treatment by a doctor, chiropractor, psychiatrist, psychologist, or other health care provider? _____NO _____YES

If so, please list the medical condition(s) being treated, name of doctors(s), field of specialty, address & phone

E. Are you presently taking any medication? _____NO _____YES

If so, please list the name of the medication, medical condition being treated, and the name, address, and phone of the doctor who prescribed the medication.

F. Have you ever had surgery to any part of your body? _____NO _____YES

If so, please list the part of your body operated on, the type of operation performed, name of hospital (if any), and name, address, and phone of all doctors performing the surgery.

G. Have you ever received treatment for your back, neck, knees, or lower extremities from a doctor, chiropractor, therapist, or other health care provider? _____NO _____YES

If so, please list the name, address, and phone number of all doctors, chiropractors, therapists, or other health care provider who provided such treatment, the dates of treatment, and the diagnosis of the provider.

H. Have you ever had an injury that required you to miss time from work? _____NO _____YES

If so, please list the type of injury, the amount of time missed from work, whether the condition was fully resolved or if it left you with any impairment, and whether you returned to work.

I. Are you aware of any condition or injury that might limit your ability to perform duties or assignments in the South Carolina State Guard? _____NO _____YES

If "YES" above, please return a statement from your physician of your ability to perform field duties.

Condition or Injury:

I HAVE READ AND FULLY UNDERSTAND THE ABOVE, AND CERTIFY BY MY SIGNATURE THAT ALL INFORMATION IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ DATE _____.

RECEIVED BY _____ DATE _____.