Standard Form 88
Revised April 1968
General Services Administration
Interagency Comm. on Medical Records
FPMR 101-11.809-3

REPORT OF MEDICAL EXAMINATION

Exception approved by GSA & ICMR, May 69
88-116-03

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
McPherson, Marvin O	CW3	[redacted]
4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
[redacted]	Annual CL II	28 May 85

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
		MILITARY	CIVILIAN		
M	W	15		OA	ACO 3rd Bn

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
6/19/50	Boaz AL	Donna McPherson / wife Same as 4

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
Physical Examination Section U.S. Lyster Army Hospital Fort Rucker, Alabama 36360	155 5587

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS
100 EC	0	0

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column; enter "NE" if not evaluated.)	ABNORMAL
	18. HEAD, FACE, NECK, AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS—GENERAL (Ext. & ext. canals) (Auditory acuity under items 70 and 71)	
	23. DRUMS (Perforation)	
	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
	25. OPHTHALMOSCOPIC	
	26. PUPILS (Equality and reaction)	
	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
	28. LUNGS AND CHEST (Include breasts)	
	29. HEART (Thrust, size, rhythm, sounds)	
	30. VASCULAR SYSTEM (Varicosities, etc.)	
	31. ABDOMEN AND VISCERA (Include hernia)	
	32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate, if indicated)	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES (Strength, range of motion)	
	36. FEET	
	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC (Equilibrium tests under item 72)	
	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

Q Thr

IO. Hx for L,

23. Valsalva — NL ABNL Omitted
32. Digital Rectal — NL ABNL Omitted
Stool for Blood — NEG POS

Duke - unk no spinal [illegible] no bone pain

DEPT OF THE ARMY
ARMY AEROMEDICAL CENTER

OCT 17 1985

HI Instruct

CLASS 2 FLYING DUTY
MEDICALLY QUALIFIED

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

Restorable teeth (0) · Non-restorable teeth (/) · Missing teeth (X) · Replaced by dentures (I I I / X X X) · Fixed Partial dentures (I) (I I I / (X))

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

Fillings upper lower

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY	1.002	46. CHEST X-RAY (Place, date, film number and result)
B. ALBUMIN	Neg	
C. SUGAR	Neg	
D. MICROSCOPIC	(23) unc	

47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS
RPR NR	unc		HCT 46.3

Sickledex 22 June 83
FORT — Neg

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD	56. TEMPERATURE
72	168	Br	Br	☐ SLENDER ☒ MEDIUM ☐ HEAVY ☐ OBESE	

57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)				
A. SITTING	SYS. 118 / DIAS. 76	B. RECUMBENT	SYS. / DIAS.	C. STANDING (3 min.)	SYS. / DIAS.	A. SITTING 64	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.

59. DISTANT VISION		60. REFRACTION			61. NEAR VISION		
RIGHT 20/ 20	CORR. TO 20/	BY	S.	CX	20/30	CORR. TO	BY
LEFT 20/ 25 20 PH S	CORR. TO 20/	BY	S.	CX	20/30	CORR. TO	BY

62. HETEROPHORIA (Specify Distance)

ES° 0 EX° 0 R. H. 0 L. H. 0 PRISM DIV. PRISM CONV. CT Okflo N PC 35 mm PD

63. ACCOMMODATION		64. COLOR VISION (Test used and result)	65. DEPTH PERCEPTION (Test used and score)	
RIGHT 4.6	LEFT 5.0	PIP 0/14 pass	PTA 0/9	UNCORRECTED pass / CORRECTED

66. FIELD OF VISION	67. NIGHT VISION (Test used and score)	68. RED LENS TEST	69. INTRAOCULAR TENSION
NAD	NIBH	passed	

70. HEARING			71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)
			Date 3/81	250 500	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
RIGHT WV	/15 SV	/15	RIGHT	X	5	0	0	0	0	15	X	Adequate
LEFT WV	/15 SV	/15	LEFT	X	0	0	5	15	20	30	X	

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

"I understand I must be cleared by a flight surgeon after hospitalization or sick in quarters (AR600-107); must inform him after treatment or activities which may require restriction (AR40-8); I have read AR 40-8; I have informed the examining physician of any changes in health since last examination."

Marion D. McKinsey

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnosis with item numbers)

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

76. A. PHYSICAL PROFILE					
P	U	L	H	E	S
1	1	1	1	1	1

77. EXAMINEE (Check)

A. ☒ IS QUALIFIED FOR Class II

B. ☐ IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

A	B	C	E
78			

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
JEFFREY A. STONE, D.O. CPT, MC/ES, USA [redacted]	
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)	SIGNATURE
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

549—16—82998-1 GPO

STANDARD FORM 93
REV. OCTOBER 1974
GSA FPMR 101-41.8

APPROVED
OFFICE OF MANAGEMENT AND BUDGET No. 29-R0191

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. SOCIAL SECURITY OR IDENTIFICATION NO.
McPherson, Marvin David	[redacted]
3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE)	**4. POSITION** (title, grade, component)
[redacted]	CW3

5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION	7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code)
Annual GL II	28 May 85	U. S. Lyster Army Hospital Aviation Medicine Service Physical Examination Section Fort Rucker, Alabama 36362

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint exists)

I am in good Health
No Medications
NKDA

9. HAVE YOU EVER (Please check each item)

YES	NO	(Check each item)
	X	Lived with anyone who had tuberculosis
	X	Coughed up blood
	X	Bled excessively after injury or tooth extraction
	X	Attempted suicide
	X	Been a sleepwalker

10. DO YOU (Please check each item)

YES	NO	(Check each item)
	X	Wear glasses or contact lenses
X		Have vision in both eyes
	X	Wear a hearing aid
	X	Stutter or stammer habitually
	X	Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	X		Scarlet fever, erysipelas		X		Cramps in your legs		X		"Trick" or locked knee
	X		Rheumatic fever		X		Frequent indigestion		X		Foot trouble
	X		Swollen or painful joints		X		Stomach, liver, or intestinal trouble		X		Neuritis
	X		Frequent or severe headache		X		Gall bladder trouble or gallstones		X		Paralysis (include infantile)
	X		Dizziness or fainting spells		X		Jaundice or hepatitis		X		Epilepsy or fits
	X		Eye trouble				Adverse reaction to serum, drug,		X		Car, train, sea or air sickness
	X		Ear, nose, or throat trouble		X		or medicine		X		Frequent trouble sleeping
	X		Hearing loss	X	X		Broken bones		X		Depression or excessive worry
	X		Chronic or frequent colds		X		Tumor, growth, cyst, cancer		X		Loss of memory or amnesia
	X		Severe tooth or gum trouble		X		Rupture/hernia		X		Nervous trouble of any sort
	X		Sinusitis		X		Piles or rectal disease		X		Periods of unconsciousness
	X		Hay Fever		X		Frequent or painful urination	X			alcohol
	X		Head injury		X		Bed wetting since age 12		X		smoking
	X		Skin diseases		X		Kidney stone or blood in urine	X			seatbelts
	X		Thyroid trouble		X		Sugar or albumin in urine		X		medication
	X		Tuberculosis		X		VD—Syphilis, gonorrhea, etc.				
	X		Asthma		X		Recent gain or loss of weight				
	X		Shortness of breath		X		Arthritis, Rheumatism, or Bursitis				
	X		Pain or pressure in chest		X		Bone, joint or other deformity				
	X		Chronic cough		X		Lameness				
	X		Palpitation or pounding heart		X		Loss of finger or toe	**12. FEMALES ONLY: HAVE YOU EVER**			
	X		Heart trouble		X		Painful or "trick" shoulder or elbow				Been treated for a female disorder
	X		High or low blood pressure		X		Recurrent back pain				Had a change in menstrual pattern

13. WHAT IS YOUR USUAL OCCUPATION?

Pilot

14. ARE YOU (Check one)

☐ Right handed ☒ Left handed

93-102

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	X	15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.
		B. Inability to perform certain motions.
		C. Inability to assume certain positions.
		D. Other medical reasons (*If yes, give reasons.*)
	X	16. Have you ever been treated for a mental condition? (*If yes, specify when, where, and give details.*)
	X	17. Have you ever been denied life insurance? (*If yes, state reason and give details.*)
	X	18. Have you had, or have you been advised to have, any operations? (*If yes, describe and give age at which occurred.*)
	X	19. Have you ever been a patient in any type of hospitals? (*If yes, specify when, where, why, and name of doctor and complete address of hospital.*)
	X	20. Have you ever had any illness or injury other than those already noted? (*If yes, specify when, where, and give details.*)
	X	21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (*If yes, give complete address of doctor, hospital, clinic, and details.*)
	X	22. Have you ever been rejected for military service because of physical, mental, or other reasons? (*If yes, give date and reason for rejection.*)
	X	23. Have you ever been discharged from military service because of physical, mental, or other reasons? (*If yes, give date, reason, and type of discharge whether honorable, other than honorable for unfitness or unsuitability.*)
	X	24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (*If yes, specify what kind, granted by whom, and what amount, when, why.*)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.
I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE
Marvin D McPherson	Marvin D McPherson

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

25. Physician's summary and elaboration of all pertinent data (*Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.*)

Fx L1 2° to tree fall - march 85

well healed FX OF L1 - Clear by ortho +
Dr mandel

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
	8/16/85		

REVERSE OF STANDARD FORM 93

U.S.G.P.O:1979-311-153(FINAL)

CLINICAL RECORD	ELECTROCARDIOGRAPHIC RECORD	PREVIOUS ECG ☐ YES ☐ NO

CLINICAL IMPRESSION: CII FIT.

MEDICATION:

☐ EMERGENCY ☑ ROUTINE ☐ BEDSIDE ☑ AMBULANT

AGE	SEX	RACE	HEIGHT	WEIGHT	B.P.	SIGNATURE OF WARD PHYSICIAN	DATE
35	M	W				Mandel 2	28 May 65

RHYTHM:

AXIS DEVIATION (QRS):

RATES: AURIC. VENT.

INTERVALS: PR QRS QT

P WAVES:

QRS COMPLEXES:

RS-T SEGMENT:

T WAVES:

UNIPOLAR EXTREMITY LEADS *(Specify)*

PRECORDIAL LEADS *(Specify)*

SUMMARY, SERIAL CHANGES, AND IMPLICATIONS: EKG - wnl

(Continue on reverse)

NO.	SIGNATURE OF PHYSICIAN	PATIENT'S IDENTIFICATION NO.	DATE
		REGISTER NO	WARD NO.

NAME: McPherson, Marlow B

PATIENT'S IDENTIFICATION *(For typewritten or written entries, give name, first, middle, grade, date, hospital or medical facility)*

SN: [redacted]

RANK: W3 UNIT: ACo 7th ATB

ELECTROCARDIOGRAPHIC RECORD

(Attach Tracings to SF-507)

Standard Form 520

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FPMR 101-11.806-8
OCTOBER 1975 520-106-02

Exception to SF 520 Approved by NARS (MAY 79)

Info removed by VNCA