

REPORT OF MEDICAL HISTORY

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

1. LAST NAME—FIRST NAME—MIDDLE NAME WHITE, Roscoe Anthony			2. GRADE AND COMPONENT OR POSITION Applicant		3. IDENTIFICATION NO. 1655106	
4. HOME ADDRESS (Number, street or RFD, city or town, zone and State)			5. PURPOSE OF EXAMINATION Enlistment		6. DATE OF EXAMINATION	
7. SEX Male	8. RACE Cauc	9. TOTAL YRS. GOVT. SERVICE MILITARY CIVILIAN	10. DEPARTMENT, AGENCY, OR SERVICE		11. ORGANIZATION UNIT	
12. DATE OF BIRTH 18 Nov 1935		13. PLACE OF BIRTH Glenwood, Arkansas		14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN Mrs. Geneva Ruth WHITE(W)		
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS AFES Dallas, Texas			16. OTHER INFORMATION RELIGION: BAPTIST			
17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS. (Follow by description of past history, if complaint exists)						

I am in good health.

18. FAMILY HISTORY					19. HAS ANY BLOOD RELATION (Parent, brother, sister, other) OR HUSBAND OR WIFE:		
RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH	YES	NO	RELATION(S)
FATHER	41	Good				<input checked="" type="checkbox"/>	HAD TUBERCULOSIS
MOTHER	39	"				<input checked="" type="checkbox"/>	HAD SYPHILIS
SPOUSE	18	"				<input checked="" type="checkbox"/>	HAD DIABETES
BROTHERS AND SISTERS	4	"				<input checked="" type="checkbox"/>	HAD CANCER
	3	"				<input checked="" type="checkbox"/>	HAD KIDNEY TROUBLE
						<input checked="" type="checkbox"/>	HAD HEART TROUBLE
CHILDREN						<input checked="" type="checkbox"/>	HAD STOMACH TROUBLE
						<input checked="" type="checkbox"/>	HAD RHEUMATISM (Arthritis)
						<input checked="" type="checkbox"/>	HAD ASTHMA, HAY FEVER, HIVES
						<input checked="" type="checkbox"/>	HAD EPILEPSY (Fits)
						<input checked="" type="checkbox"/>	COMMITTED SUICIDE
						<input checked="" type="checkbox"/>	BEEN INSANE

20. HAVE YOU EVER HAD OR HAVE YOU NOW (Place check at left of each item)								
YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)
<input checked="" type="checkbox"/>		SCARLET FEVER, ERYSIPELAS	<input checked="" type="checkbox"/>		GOITER	<input checked="" type="checkbox"/>		TUMOR, GROWTH, CYST, CANCER
<input checked="" type="checkbox"/>		DIPHTHERIA	<input checked="" type="checkbox"/>		TUBERCULOSIS	<input checked="" type="checkbox"/>		RUPTURE
<input checked="" type="checkbox"/>		RHEUMATIC FEVER	<input checked="" type="checkbox"/>		SOAKING SWEATS (Night sweats)	<input checked="" type="checkbox"/>		APPENDICITIS
<input checked="" type="checkbox"/>		SWOLLEN OR PAINFUL JOINTS	<input checked="" type="checkbox"/>		ASTHMA	<input checked="" type="checkbox"/>		PILES OR RECTAL DISEASE
<input checked="" type="checkbox"/>		MUMPS	<input checked="" type="checkbox"/>		SHORTNESS OF BREATH	<input checked="" type="checkbox"/>		FREQUENT OR PAINFUL URINATION
<input checked="" type="checkbox"/>		WHOOPING COUGH	<input checked="" type="checkbox"/>		PAIN OR PRESSURE IN CHEST	<input checked="" type="checkbox"/>		KIDNEY STONE OR BLOOD IN URINE
<input checked="" type="checkbox"/>		FREQUENT OR SEVERE HEADACHE	<input checked="" type="checkbox"/>		CHRONIC COUGH	<input checked="" type="checkbox"/>		SUGAR OR ALBUMIN IN URINE
<input checked="" type="checkbox"/>		DIZZINESS OR FAINTING SPELLS	<input checked="" type="checkbox"/>		PALPITATION OR POUNDING HEART	<input checked="" type="checkbox"/>		BOILS
<input checked="" type="checkbox"/>		EYE TROUBLE	<input checked="" type="checkbox"/>		HIGH OR LOW BLOOD PRESSURE	<input checked="" type="checkbox"/>		VENEREAL DISEASE
<input checked="" type="checkbox"/>		EAR, NOSE OR THROAT TROUBLE	<input checked="" type="checkbox"/>		CRAMPS IN YOUR LEGS	<input checked="" type="checkbox"/>		RECENT GAIN OR LOSS OF WEIGHT
<input checked="" type="checkbox"/>		RUNNING EARS	<input checked="" type="checkbox"/>		FREQUENT INDIGESTION	<input checked="" type="checkbox"/>		ARTHRITIS OR RHEUMATISM
<input checked="" type="checkbox"/>		CHRONIC OR FREQUENT COLDS	<input checked="" type="checkbox"/>		STOMACH, LIVER OR INTESTINAL TROUBLE	<input checked="" type="checkbox"/>		BONE, JOINT, OR OTHER DEFORMITY
<input checked="" type="checkbox"/>		SEVERE TOOTH OR GUM TROUBLE	<input checked="" type="checkbox"/>		GALL BLADDER TROUBLE OR GALL STONES	<input checked="" type="checkbox"/>		LAMENESS
<input checked="" type="checkbox"/>		SINUSITIS	<input checked="" type="checkbox"/>		JAUNDICE	<input checked="" type="checkbox"/>		LOSS OF ARM, LEG, FINGER, OR TOE
<input checked="" type="checkbox"/>		HAY FEVER	<input checked="" type="checkbox"/>		ANY REACTION TO SERUM, DRUG OR MEDICINE	<input checked="" type="checkbox"/>		PAINFUL OR "TRICK" SHOULDER OR ELBOW
								"TRICK" OR LOCKED KNEE
								FOOT TROUBLE
								NEURITIS
								PARALYSIS (Inc. infantile)
								EPILEPSY OR FITS
								CAR, TRAIN, SEA, OR AIR SICKNESS
								FREQUENT TROUBLE SLEEPING
								FREQUENT OR TERRIFYING NIGHTMARES
								DEPRESSION OR EXCESSIVE WORRY
								LOSS OF MEMORY OR AMNESIA
								BED WETTING
								NERVOUS TROUBLE OF ANY SORT
								ANY DRUG OR NARCOTIC HABIT
								EXCESSIVE DRINKING HABIT
								HOMOSEXUAL TENDENCIES

21. HAVE YOU EVER (Check each item)		22. FEMALES ONLY: A. HAVE YOU EVER—		B. COMPLETE THE FOLLOWING:	
<input checked="" type="checkbox"/> WORN GLASSES	<input checked="" type="checkbox"/> ATTEMPTED SUICIDE	<input checked="" type="checkbox"/> BEEN PREGNANT	AGE AT ONSET OF MENSTRUATION		
<input checked="" type="checkbox"/> WORN AN ARTIFICIAL EYE	<input checked="" type="checkbox"/> BEEN A SLEEP WALKER	<input checked="" type="checkbox"/> HAD A VAGINAL DISCHARGE	INTERVAL BETWEEN PERIODS		
<input checked="" type="checkbox"/> WORN HEARING AIDS	<input checked="" type="checkbox"/> LIVED WITH ANYONE WHO HAD TUBERCULOSIS	<input checked="" type="checkbox"/> BEEN TREATED FOR A FEMALE DISORDER	DURATION OF PERIODS		
<input checked="" type="checkbox"/> STUTTERED OR STAMMERED	<input checked="" type="checkbox"/> COUGHED UP BLOOD	<input checked="" type="checkbox"/> HAD PAINFUL MENSTRUATION	DATE OF LAST PERIOD		
<input checked="" type="checkbox"/> WORN A BRACE OR BACK SUPPORT	<input checked="" type="checkbox"/> BLED EXCESSIVELY AFTER INJURY OR TOOTH EXTRACTION	<input checked="" type="checkbox"/> HAD IRREGULAR MENSTRUATION	QUANTITY: <input type="checkbox"/> NORMAL <input type="checkbox"/> EXCESSIVE <input checked="" type="checkbox"/> SCANTY		
23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS? 2	24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS? MONTHS 33	25. WHAT IS YOUR USUAL OCCUPATION? MILL WORK	26. ARE YOU (Check one) <input checked="" type="checkbox"/> RIGHT HANDED <input type="checkbox"/> LEFT HANDED		

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
	<input checked="" type="checkbox"/>	27. HAVE YOU BEEN UNABLE TO HOLD A JOB BECAUSE OF: A. SENSITIVITY TO CHEMICALS, DUST, SUNLIGHT, ETC.
	<input checked="" type="checkbox"/>	B. INABILITY TO PERFORM CERTAIN MOTIONS
	<input checked="" type="checkbox"/>	C. INABILITY TO ASSUME CERTAIN POSITIONS
	<input checked="" type="checkbox"/>	D. OTHER MEDICAL REASONS (If yes, give reasons)
	<input checked="" type="checkbox"/>	28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?
	<input checked="" type="checkbox"/>	29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (If yes, give details)
	<input checked="" type="checkbox"/>	30. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH? (If yes, state reason and give details)
	<input checked="" type="checkbox"/>	31. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (If yes, state reason and give details)
	<input checked="" type="checkbox"/>	32. HAVE YOU HAD, OR HAVE YOU BEEN ADVISED TO HAVE, ANY OPERATIONS? (If yes, describe and give age at which occurred)
	<input checked="" type="checkbox"/>	33. HAVE YOU EVER BEEN A PATIENT (committed or voluntary) IN A MENTAL HOSPITAL OR SANATORIUM? (If yes, specify when, where, why, and name of doctor, and complete address of hospital or clinic)
	<input checked="" type="checkbox"/>	34. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (If yes, specify when, where, and give details)
	<input checked="" type="checkbox"/>	35. HAVE YOU CONSULTED OR BEEN TREATED BY CLINICS, PHYSICIANS, HEALERS, OR OTHER PRACTITIONERS WITHIN THE PAST 5 YEARS? (If yes, give complete address of doctor, hospital, clinic, and details)
	<input checked="" type="checkbox"/>	36. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? (If yes, which illnesses)
	<input checked="" type="checkbox"/>	37. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (If yes, give date and reason for rejection)
	<input checked="" type="checkbox"/>	38. 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)
	<input checked="" type="checkbox"/>	39. HAVE YOU EVER RECEIVED, IS THERE PENDING, HAVE YOU APPLIED FOR, OR DO YOU INTEND TO APPLY 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: ROSCOE ANTHONY WHITE SIGNATURE: Roscoe Anthony White

40. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician shall comment on all positive answers in items 20 through 39)

Childhood Diseases, No Sequela

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER: A P BEATRICE DATE: 18 Feb 57 SIGNATURE: [Signature] NUMBER OF ATTACHED SHEETS: 1

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME WHITE, Rosecoe Anthony		2. GRADE AND COMPONENT OR POSITION APP USMC		3. IDENTIFICATION NO. 1686106	
4. HOME ADDRESS (Number, street or R.F.D., city or town, zone and State)			5. PURPOSE OF EXAMINATION Enl - USMC		6. DATE OF EXAMINATION 18 Feb 57
7. SEX male	8. RACE cauc	9. TOTAL YRS. GOVT. SERVICE MILITARY CIVILIAN	10. DEPARTMENT, AGENCY, OR SERVICE		11. ORGANIZATION UNIT
12. DATE OF BIRTH 18 Nov 35		13. PLACE OF BIRTH Glenwood, Arkansas		14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN Mrs Geneva Ruth WHITE (W)	
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS AFES, Dallas, Texas			16. OTHER INFORMATION Religion: Baptist		

17. RATING OR SPECIALTY

TIME IN THIS CAPACITY: TOTAL LAST SIX MONTHS

CLINICAL EVALUATION		NOTES.—Describe every abnormality in detail. (Enter pertinent item number before each comment; continue in item 73 and use additional sheets if necessary.)
NORMAL	ABNORMAL	
<input checked="" type="checkbox"/>	(Check each item in appropriate column; enter "N.E." if not evaluated)	<p>39: ANT: sl" lt upper lip; s$\frac{1}{2}$"d lt chest; sl" rt knwe. POST: m mid lumbar; vsula.</p>
<input checked="" type="checkbox"/>	18. HEAD, FACE, NECK, AND SCALP	
<input checked="" type="checkbox"/>	19. NOSE	
<input checked="" type="checkbox"/>	20. SINUSES	
<input checked="" type="checkbox"/>	21. MOUTH AND THROAT	
<input checked="" type="checkbox"/>	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)	
<input checked="" type="checkbox"/>	23. DRUMS (Perforation)	
<input checked="" type="checkbox"/>	24. EYES—GENERAL (Visual acuity and refraction under items 69, 69, and 61)	
<input checked="" type="checkbox"/>	25. OPHTHALMOSCOPIC	
<input checked="" type="checkbox"/>	26. PUPILS (Equality and reaction)	
<input checked="" type="checkbox"/>	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
<input checked="" type="checkbox"/>	28. LUNGS AND CHEST (Include breasts)	
<input checked="" type="checkbox"/>	29. HEART (Thrust, size, rhythm, sounds)	
<input checked="" type="checkbox"/>	30. VASCULAR SYSTEM (Varicosities, etc.)	
<input checked="" type="checkbox"/>	31. ABDOMEN AND VISCERA (Include hernia)	
<input checked="" type="checkbox"/>	32. ANUS AND RECTUM (Hemorrhoids, fistulas) (Prostate if indicated)	
<input checked="" type="checkbox"/>	33. ENDOCRINE SYSTEM	
<input checked="" type="checkbox"/>	34. G-U SYSTEM	
<input checked="" type="checkbox"/>	35. UPPER EXTREMITIES (Strength, range of motion)	
<input checked="" type="checkbox"/>	36. FEET	
<input checked="" type="checkbox"/>	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
<input checked="" type="checkbox"/>	38. SPINE, OTHER MUSCULOSKELETAL	
<input checked="" type="checkbox"/>	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
<input checked="" type="checkbox"/>	40. SKIN, LYMPHATICS	
<input checked="" type="checkbox"/>	41. NEUROLOGIC (Equilibrium tests under item 72)	
<input checked="" type="checkbox"/>	42. PSYCHIATRIC (Specify any personality deviation)	
Females only		(Continue in item 73)
<input type="checkbox"/>	43. PELVIC (Check how done) <input type="checkbox"/> VAGINAL <input type="checkbox"/> RECTAL	

44. DENTAL (Place appropriate symbols above or below number of upper and lower teeth, respectively)																REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES	
O.—Restorable teeth X.—Missing teeth (6 X 6).—Fixed bridge, brackets to include abutments /.—Nonrestorable teeth X.Y.X.—Replaced by dentures																	
R I G H T	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L E F T
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

45. URINALYSIS: SP. GR. 1.020			46. CHEST X-RAY (Place, date, film number, result)			47. SEROLOGY (Specify test used and result)		
ALBUMIN	SUGAR	MICROSCOPIC	ND			ND		
NEG	NEG	ND						
48. EKG		49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS			ND		
ND		ND						

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT 69 1/4	52. WEIGHT 148	53. COLOR HAIR Brown	54. COLOR EYES Blue	55. BUILD: SLENDER <input type="checkbox"/> MEDIUM <input checked="" type="checkbox"/> HEAVY <input type="checkbox"/> OBESE <input type="checkbox"/>	56. TEMP. 98.6
57. BLOOD PRESSURE (Arm at heart level): SITTING SYS. 144 DIAS. 80 RECUM-BENT SYS. ND DIAS. ND			58. PULSE (Arm at heart level): SITTING 78 AFTER EXERCISE ND 2 MIN. AFTER ND RECUMBENT ND AFTER STANDING 3 ND		
59. DISTANT VISION RIGHT 20/20 CORR. TO 20/ LEFT 20/20 CORR. TO 20/		60. REFRACTION BY S CX BY S GN		61. NEAR VISION CORR. TO BY CORR. TO BY	
62. HETEROPHORIA: (Specify distance) ES° EX NSA R. H. L. H. PRISM DIV. PRISM CONV. PC PD					
63. ACCOMMODATION RIGHT LEFT ND		64. COLOR VISION (Test used and result) NORMAL		65. DEPTH PERCEPTION (Test used and score) UNCORRECTED ND CORRECTED	
66. FIELD OF VISION ND		67. NIGHT VISION (Test used and score) ND		68. RED LENS ND	
69. INTRAOCULAR TENSION NFT		70. HEARING RIGHT WV 15 /15 SV 15 /15 LEFT WV /15 SV /15			
71. AUDIOMETER 200 500 1000 2000 3000 4000 8000 250 315 1025 2015 3395 4395 8195 RIGHT LEFT				72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score) ND	

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets of plain paper if necessary)

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

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

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

77. EXAMINEE (Check) ENL & ACT DY AT SEA OR ON FGN SVC
 IS QUALIFIED FOR
 IS NOT

76. PHYSICAL CATEGORY			
A	B	C	E
X			

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

79. TYPED OR PRINTED NAME OF PHYSICIAN A P BRATRUE, LT MC USNR	SIGNATURE
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

F ORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME WHITE, Roscoe Anthony		2. GRADE AND COMPONENT OR POSITION CPL		3. IDENTIFICATION NO. 1666106	
4. HOME ADDRESS (Number, street or R.F.D., city or town, zone and State)		5. PURPOSE OF EXAMINATION DISCHARGE & IMMEDIATE REENLISTMENT		6. DATE OF EXAMINATION 12-19-59	
7. SEX Male	8. RACE Cauc	9. TOTAL YEARS GOVERNMENT SERVICE MILITARY 3 Yrs CIVILIAN		10. AGENCY USN	11. ORGANIZATION UNIT E-2-11
12. DATE OF BIRTH 11-8-35		13. PLACE OF BIRTH Glenwood, Arkansas		14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN Geneva White (Wife) Same as #4.	
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS 11th Mar Disp 1st Mar Div (Reinf) FMF Camp Pendleton, Calif.				16. OTHER INFORMATION RELIGION: Baptist	
17. RATING OR SPECIALTY 3516				TIME IN THIS CAPACITY (Total) 2 Yrs LAST SIX MONTHS	

CLINICAL EVALUATION		
NOR-MAL	(Check each item in appropriate column; enter "NE" if not evaluated.)	ABNOR-MAL
X	18. HEAD, FACE, NECK, AND SCALP	
X	19. NOSE	
X	20. SINUSES	
X	21. MOUTH AND THROAT	
X	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)	
X	23. DRUMS (Perforation)	
X	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
	25. OPHTHALMOSCOPIC	
X	26. PUPILS (Equality and reaction)	
X	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
X	28. LUNGS AND CHEST (Include breasts)	
X	29. HEART (Thrust, size, rhythm, sounds)	
X	30. VASCULAR SYSTEM (Varicosities, etc.)	
X	31. ABDOMEN AND VISCERA (Include hernia)	
X	32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate, if indicated)	
X	33. ENDOCRINE SYSTEM	
X	34. G-U SYSTEM	
X	35. UPPER EXTREMITIES (Strength, range of motion)	
X	36. FEET	
X	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
X	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	X
X	40. SKIN; LYMPHATICS	
X	41. NEUROLOGIC (Equilibrium tests under item 72)	
X	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done)	
	<input type="checkbox"/> VAGINAL <input type="checkbox"/> RECTAL	

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

#39. MARKS AND SCARS
 VS 1/2" dia. lt. deltoid.
 1/4" s smooth lt. upper lip.
 LS 1" top of head.
 3/4" s smooth lateral rt. arm.
 Puncture s 1/8" dia. rt. elbow.

(Continue in item 73)

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

O—Restorable teeth		X—Missing teeth		(6 X 8)—Fixed bridge, brackets to include abutments													
/—Nonrestorable teeth		XXX—Replaced by dentures															
R	1	2	3	4	5	6	0	0	9	10	11	12	13	14	15	16	L
I																	E
G	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	F
H	0	0															O
T																	T

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

DENTALLY QUALIFIED

45. URINALYSIS: A. SPECIFIC GRAVITY 1.025		46. CHEST X-RAY (Place, date, film number and result) Mobile Unit 1st Mar Div (einf) FMF Camp Pen 11-2-59 #082362 Negative	
B. ALBUMIN Negative	D. MICROSCOPIC		
C. SUGAR Negative			
47. SEROLOGY (Specify test used and result) VDRL Negative	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT 69 1/4"	52. WEIGHT 165	53. COLOR HAIR Brown	54. COLOR EYES Brown	55. BUILD: <input type="checkbox"/> SLENDER <input checked="" type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE	56. TEMPERATURE 98.4
57. BLOOD PRESSURE (Arm at heart level)			58. PULSE (Arm at heart level)		
A. SITTING SYS. 132 DIAS. 80	B. RECUMBENT SYS. 112 DIAS. 84	C. STANDING (3 min.) SYS. 110 DIAS. 84	D. SITTING 96	E. AFTER EXERCISE 132	F. 2 MIN. AFTER 84
59. DISTANT VISION			60. REFRACTION		
RIGHT 20/	CORR. TO 20/	BY	S.	OX	
LEFT 20/	CORR. TO 20/	BY	S.	OX	

62. HETEROPHORIA (Specify distance)

ES°	EX°	R. H.	L. H.	PRISM DIV.	PRISM CONV. CT	PC	PD
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63. ACCOMMODATION RIGHT _____ LEFT _____	64. COLOR VISION (Test used and result) AOC 1946 18/18	65. DEPTH PERCEPTION (Test used and score) UNCORRECTED _____ CORRECTED _____	69. INTRAOCULAR TENSION
66. FIELD OF VISION	67. NIGHT VISION (Test used and score)	68. RED LENS TEST	

70. HEARING	71. AUDIOMETER	72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)																											
RIGHT WV 15 /15 SV 15 /15	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td>250 256</td> <td>500 512</td> <td>1000 1024</td> <td>2000 2048</td> <td>3000 2896</td> <td>4000 4096</td> <td>5000 5144</td> <td>8000 8192</td> </tr> <tr> <td>RIGHT</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>LEFT</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	5000 5144	8000 8192	RIGHT									LEFT									
	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	5000 5144	8000 8192																					
RIGHT																													
LEFT																													

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets if necessary)

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

[Faint, illegible text]

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

77. EXAMINEE (Check)

IS QUALIFIED FOR Discharge and immediate re-enlistment in the U.S. Marine Corps.

IS NOT QUALIFIED FOR

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

A	B	C	E
XXXXX			

79. TYPED OR PRINTED NAME OF PHYSICIAN
W. H. FAGAN LT MC USNR

SIGNATURE *W. H. Fagan*

80. TYPED OR PRINTED NAME OF PHYSICIAN

SIGNATURE

81. TYPED OR PRINTED NAME OF DENTIST OR APPROVING AUTHORITY
G. E. SCHERER CAPT DC USN

SIGNATURE *G. E. Scherer*

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY

SIGNATURE

NUMBER OF ATTACHED SHEETS

REPORT OF MEDICAL EXAMINATION

4282-62/r1s

1. LAST NAME—FIRST NAME—MIDDLE NAME WHITE, Roscoe Anthony		2. GRADE AND COMPONENT OR POSITION SGT USMC		3. IDENTIFICATION NO. 166 61 06	
4. HOME ADDRESS (Number, street or RFD, city or town, zone and State)			5. PURPOSE OF EXAMINATION Discharge		6. DATE OF EXAMINATION 5 DEC 1962
7. SEX Male	8. RACE Cauc	9. TOTAL YEARS GOVERNMENT SERVICE MILITARY 6 CIVILIAN -		10. AGENCY USMC	11. ORGANIZATION UNIT MARPO, USNAS, DALLAS, TEXAS
12. DATE OF BIRTH 18 NOV 1935		13. PLACE OF BIRTH Glenwood, Arkansas		14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN Geneva R. WHITE (W) Same as #4	
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS U. S. NAVAL AIR STATION, DALLAS, TEXAS				16. OTHER INFORMATION Religion: Protestant	
17. RATING OR SPECIALTY			TIME IN THIS CAPACITY (Total)		LAST SIX MONTHS

CLINICAL EVALUATION

NOR- MAL	(Check each item in appropriate column; enter "NE" if not evaluated.)	ABNOR- MAL
X	18. HEAD, FACE, NECK, AND SCALP	
X	19. NOSE	
X	20. SINUSES	
X	21. MOUTH AND THROAT	
X	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)	
X	23. DRUMS (Perforation)	
X	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
X	25. OPHTHALMOSCOPIC	
X	26. PUPILS (Equality and reaction)	
X	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
X	28. LUNGS AND CHEST (Include breasts)	
X	29. HEART (Thrust, size, rhythm, sounds)	
X	30. VASCULAR SYSTEM (Varicosities, etc.)	
X	31. ABDOMEN AND VISCERA (Include hernia)	
X	32. ANUS AND RECTUM (Hemorrhoids, fistulas) (Prostate, if indicated)	
X	33. ENDOCRINE SYSTEM	
X	34. G-U SYSTEM	
X	35. UPPER EXTREMITIES (Strength, range of motion)	
X	36. FEET	
X	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
X	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	XX
X	40. SKIN, LYMPHATICS	
X	41. NEUROLOGIC (Equilibrium tests under item 78)	
X	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done)	
	<input type="checkbox"/> VAGINAL <input type="checkbox"/> RECTAL	

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

#39. Marks & Scars
VS 1/2" lt. deltoid
S 1/2" lt. upper lip
LS 1" top of head
S 3/4" lateral rt. arm
Puncture S 1/8" d rt. elbow

(Continue in item 73)

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

○—Restorable teeth
—Nonrestorable teeth
X—Missing teeth
XXX—Replaced by dentures
(6 X 8)—Fixed bridge, brackets to include abutments

R I G H T	NO MISSING TEETH											L				
	1	2	3	4	5	6	7	8	9	10	11		12	13	14	15
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

TYPE III
QUALIFIED

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY 1.030		46. CHEST X-RAY (Place, date, film number and result) USNAS, DALLAS, TEXAS 5 DEC 62 FILM #4585 NEGATIVE 70MM	
B. ALBUMIN Negative	D. MICROSCOPIC Normal	47. SEROLOGY (Specify test used and result) VDRL: Negative	49. BLOOD TYPE AND RH FACTOR "A"
C. SUGAR Negative	48. EKG -	50. OTHER TESTS None	

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT 70"	52. WEIGHT 190	53. COLOR HAIR Brown	54. COLOR EYES Brown	55. BUILD: <input type="checkbox"/> SLENDER <input checked="" type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESSE	56. TEMPERATURE 98.6
-------------------	-------------------	-------------------------	-------------------------	--	-------------------------

57. BLOOD PRESSURE (Arm at heart level)					58. PULSE (Arm at heart level)					
A. SITTING	SYS. 120	B. RECUMBENT	SYS.	C. STANDING (3 min.)	SYS.	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.
	DIAS. 68		DIAS.		DIAS.					

59. DISTANT VISION			60. REFRACTION			61. NEAR VISION		
RIGHT 20/	20	CORR. TO 20/	BY	S.	OX.	CORR. TO	BY	
LEFT 20/	20	CORR. TO 20/	BY	S.	OX.	CORR. TO	BY	

62. HETEROPHORIA (Specify distance)

ES°	EX°	R. H.	L. H.	PRISM DIV.	PRISM CONV. CT	PC	PD
-----	-----	-------	-------	------------	----------------	----	----

63. ACCOMMODATION		64. COLOR VISION (Test used and result) Passed Falant	65. DEPTH PERCEPTION (Test used and score)	
RIGHT	LEFT		UNCORRECTED	CORRECTED
66. FIELD OF VISION Normal		67. NIGHT VISION (Test used and score)	68. RED LENS TEST	
			69. INTRAOCULAR TENSION Normal	

70. HEARING				71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)		
RIGHT WV	15	/15 SV	15	/15		250	500	1000	2000	3000	4000	6000	8000	
						250	500	1000	2000	3000	4000	6000	8000	
LEFT WV	15	/15 SV	15	/15	RIGHT	20	5	5	5	5	10	10	5	
					LEFT	5	5	5	5	5	5	20	10	

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

I Certify That I Have Read and Understood the Provisions of BuMED Instruction 6120.6

Laruelle White

(Use additional sheets if necessary)

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

None

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify) None	76. A. PHYSICAL PROFILE					
	P	U	L	H	E	S

77. EXAMINEE (Check)

A. IS QUALIFIED FOR Discharge from The U. S. Marine Corps.
 B. IS NOT QUALIFIED FOR

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

A	B	C	E
---	---	---	---

79. TYPED OR PRINTED NAME OF PHYSICIAN R. H. MERSHON CAPT MC USN	SIGNATURE 
---	--

80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
--	-----------

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which) D. W. DODDS CAPT DC USN	SIGNATURE <i>D. W. Dodds</i>
---	---------------------------------

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE	NUMBER OF ATTACHED SHEETS
---	-----------	---------------------------

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

ABSTRACT OF SERVICE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)	
2-20-57	MURD SAN DIEGO, CALIFORNIA	MAY 18 57
MAY 21 1957	CAMP SAN ONOFRE DISPENSARY CAMP PENDLETON CALIFORNIA	JUN 25 1957
AUG 1 1957	MCAS, EL TORO, CAL.	AUG 21 1957
9-19-57	VMA-2 3 MAR DIV.	
OCT 16 1958	Regimental Dispensary 11th Marines 1st MarDiv (Reinf) FMF Camp Pendleton, California	22 December 1959 TERMINATED THIS DATE BY REASON OF DISCHARGE AND IMMEDIATE REENLISTMENT IN THE USMC.
12-23-59	1st Battery, 2nd Bn, 11th Mar 1st Mar Div (Reinf) FMF Camp Pendleton, Calif. Reenlisted on this date.	2-7-61
2-28-61	MCB, 29 PALMS, CALIF.	JUL 10 1961
AUG 1 1961		
AUG 1 1961	"STAGBN, MCB, CAMPEN, CALIF."	SEP 7 1961
OCT 4, 1961	1st Bn, 12th Mar 3d Mar Div, FMF, c/o FPO, SF, CAL	9-20-62

SEX M	RACE CAU	GRADE, RATING, OR POSITION PVT	ORGANIZATION UNIT	COMPONENT OR BRANCH	SERVICE, DEPT. OR AGENCY USMC
PATIENT'S LAST NAME - FIRST NAME - MIDDLE NAME WHITE, ROSCOE ANTHONY			DATE OF BIRTH (DAY-MONTH-YEAR) 18 NOV. 1935	IDENTIFICATION NO. 1666106	

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
FEB 25 57	<p>U. S. MARINE CORPS RECRUIT DEPOT, SAN DIEGO 40, CALIFORNIA</p> <p>Physical examination for active duty conducted this date.</p> <p>Blood Kahn: Negative</p> <p>70mm Photohrographic Chest Film No. KP102/ 05090</p> <p>Interpretation: Negative</p> <p>Defects Noted: NCD</p> <p>Physical Profile. Physical Category (A)</p> <p>PULHES 111111</p> <p><i>[Handwritten Signature]</i></p>
1-7 MAY 1957	<p>U.S. MARINE CORPS RECRUIT DEPOT, SAN DIEGO 40, CALIFORNIA</p> <p>Examined this man in accordance with article 15-50, MMR 1947 and found to be physically qualified for transfer.</p> <p><i>[Handwritten Signature]</i></p> <p>CAMP SAN ONOFRE DISPENSARY</p> <p>DATE JUN 25 1957</p> <p>EXAMINED AND FOUND PHYSICALLY QUALIFIED FOR TRANSFER</p> <p>NOV 8 1957</p> <p>Marine Corps Base Camp Pendleton California</p>
DEC 19 1958	<p>Photohrographic examination of chest.</p> <p>Film No.: 067522 <i>[Handwritten]</i> Thrash</p> <p>Report: <i>[Handwritten]</i> Aug 2</p> <p>Regimental Dispensary</p> <p>11th Marines 1st MarDiv (Reinf) FMF Camp Pendleton, California</p>
11-2-59	<p>Marine Corps Base Camp Pendleton California</p> <p>Photohrographic examination of chest.</p> <p>Film No.: 082362</p> <p>Report: <i>[Handwritten]</i> J. Bellamy</p>

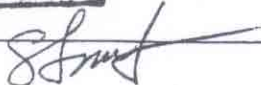
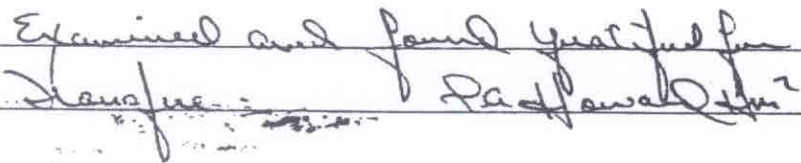
SEX M	RACE C	GRADE, RATING, OR POSITION PFC	ORGANIZATION UNIT	COMPONENT OR BRANCH USMC	SERVICE, DEPT. OR AGENCY
PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME WHITE, ROSCOE ANTHONY				DATE OF BIRTH (DAY-MONTH-YEAR) 11-18-35	IDENTIFICATION NO. 1666106

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	11th Marines, 1st Marine Division (Reinf) FMF Regimental Dispensary 16103 Camp Pendleton, California
12-19-59	Examined this date and found physically qualified for: discharge and immediate reenlistment in the USMC.
	Chest X-R. # 082362 of 11-2-59 is negative. STG: 12-18-59 Negative. Dental: Dentally Qualified Defects: None. PULSES CATEGORY 111111 (A)
	<i>W.H. Fagan</i> W. H. FAGAN LT MC USNR
	Fluoroscopic examination of chest.
	Film No: 098104
	Report: <i>neg 23d</i>
	2nd Bn. 11th Marines 1st MarDiv (Reinf) FMF Camp Pendleton, Cal.
2-7-61	Examined this date and found to be physically qualified for transfer.
	<i>W.L. Kather</i> W.L. Kather HM2/USN
APR 21 1961	STATION HOSPITAL MARINE CORPS BASE TWENTYNINE PALMS, CALIFORNIA
	APR 21 1961 Date of X-ray examination this date of <i>left foot</i>
	Film # <i>1865</i> reveals the following information:
	<i>there is a minute chip fracture through the tufted portion of distal phalanx of the left 2nd toe.</i>

SEX M	RACE C	GRADE, RATING, OR POSITION CPL	ORGANIZATION UNIT E-2-11	COMPONENT OR BRANCH USMC	D. R. DTORTS LT MC USNR SERVICE, DEPT. OR AGENCY USN
PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME WHITE, Rosecoe Anthony			DATE OF BIRTH (DAY—MONTH—YEAR) 11-8-35	IDENTIFICATION NO. 1666196	

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	STATION HOSPITAL MARINE CORPS BASE 29 PALMS, CALIFORNIA DATE <u>7-11-61</u> Examined this date and found physically qualified for <u>TRA NS</u> 
	Marine Corps Base Camp Pendleton, California Date <u>SEP 7 1961</u> Examined this date and found physically qualified for transfer overseas. J. J. WEINSTOCK LT MC USNR
	

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

5 DEC 1962

U. S. NAVAL AIR STATION, DALLAS, TEXAS

Examined this date and found physically qualified for Discharge from the U. S. Marine Corps.

VPRP: Negative

Chest X-Ray #4585 7012 Negative

Defects Noted: None


R. H. MERSHON CAPT MC USN

SEX	RACE	GRADE, RATING, OR POSITION	ORGANIZATION UNIT	COMPONENT OR BRANCH	SERVICE, DEPT. OR AGENCY
M	C	SGT USMC	MARTD, MAD	USNAS, DALLAS, TEX	USMC
PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME				DATE OF BIRTH (DAY-MONTH-YEAR)	IDENTIFICATION NO.
WHITE, Roscoe Anthony				18 NOV 1935	166 61 06

S.U #1

Sgt

SICK CALL TREATMENT RECORD
NAVVED 10 (REV. 3-58) FRONT

(TYPE OR PRINT BELOW IDENTIFICATION DATA)

(LAST NAME) <i>White</i>	(FIRST NAME) <i>Rosco</i>	(MIDDLE NAME) <i>A.</i>	FILE/SERVICE NUMBER <i>1666 106</i>	DATE OF BIRTH <i>11-18-35</i>	<input type="checkbox"/> USN <input checked="" type="checkbox"/> USMC
-----------------------------	------------------------------	----------------------------	--	----------------------------------	---

DATE	NAME OF TREATING FACILITY, COMPLAINT, TREATMENT ADMINISTERED, SIGNATURE AND RANK/RATE OF PERSON ADMINISTERING TREATMENT
------	---

<i>10-18-62</i>	<p><i>To see about having a serology and a rash</i></p> <p><i>Serology to be drawn. Has trica curis.</i></p> <p><i>Rx @ Serology</i></p> <p><i>② Head rash lotion</i></p> <p><i>DB Padmanee</i></p>
-----------------	---

HEALTH RECORD

DENTAL

SECTION I. DENTAL EXAMINATION

1. PURPOSE OF EXAMINATION

INITIAL SEPARATION OTHER (Specify) REENLISTMENT

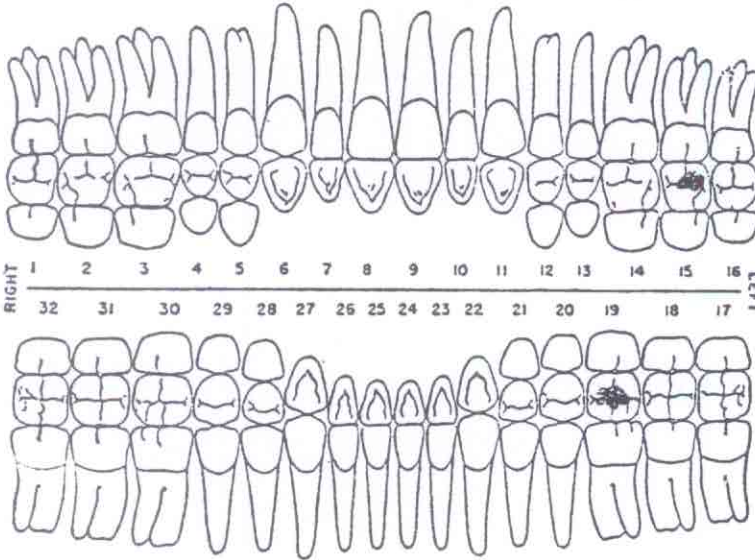
2. TYPE OF EXAM.

1 2 3 4

3. DENTAL CLASSIFICATION

1 2 3 4 5

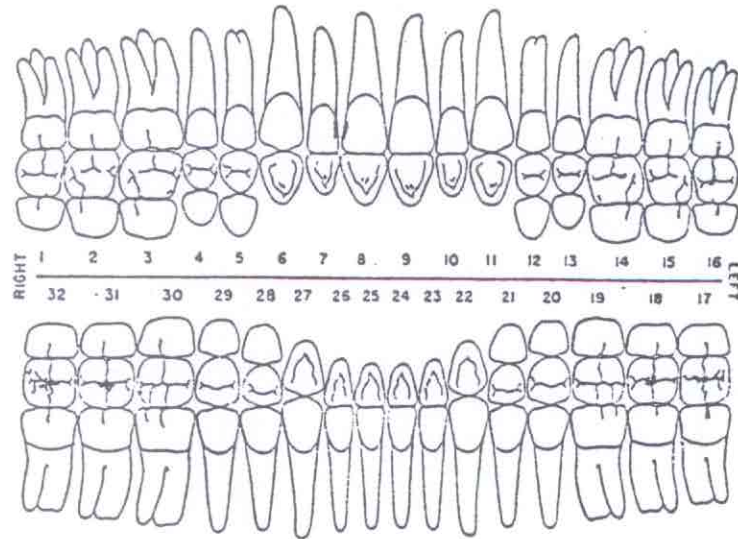
4. MISSING TEETH AND EXISTING RESTORATIONS



REMARKS

PLACE OF EXAMINATION DENT CLINIC CAMP PENDLETON DATE 18 DEC 59
 SIGNATURE OF DENTIST COMPLETING THIS SECTION G.F. SCHERER
 G.F. SCHERER CAPT USN

5. DISEASES, ABNORMALITIES, AND X-RAYS



A. CALCULUS
 SLIGHT MODERATE HEAVY
 B. PERIODONTOKLASIA
 LOCAL GENERAL
 INCIPIENT MODERATE SEVERE
 C. STOMATITIS (Specify)
 GINGIVITIS VINCENT'S
 D. DENTURES NEEDED
 (Include dentures needed after indicated extractions)
 FULL PARTIAL
 U L U L
 ABNORMALITIES OF OCCLUSION—REMARKS

E. INDICATE X-RAYS USED IN THIS EXAMINATION

FULL MOUTH PERIAPICAL POSTERIOR BITE-WINGS OTHER (Specify)

DATE 18 DEC 1959 PLACE OF EXAMINATION DENT CLINIC CAMP PENDLETON
 SIGNATURE OF DENTIST COMPLETING THIS SECTION G.F. SCHERER
 G.F. SCHERER CAPT DC USN

SECTION II. PATIENT DATA

6. SEX M 7. RACE Cau 8. GRADE, RATING, OR POSITION CPL E4 9. ORGANIZATION UNIT 10. COMPONENT OR BRANCH USMC 11. SERVICE, DEPT., OR AGENCY USN
 12. PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME WHITE, Roscoe, A. 13. DATE OF BIRTH (DAY—MONTH—YEAR) 18 NOV 1935 14. IDENTIFICATION NO. 1666106

HEALTH RECORD

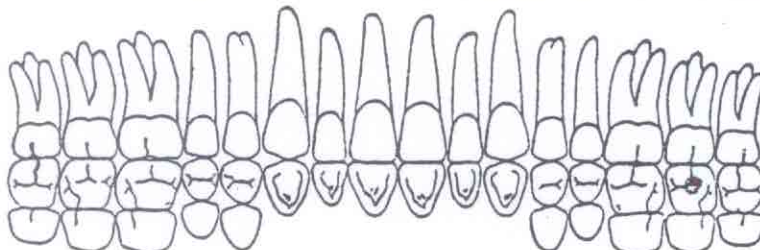
DENTAL

121

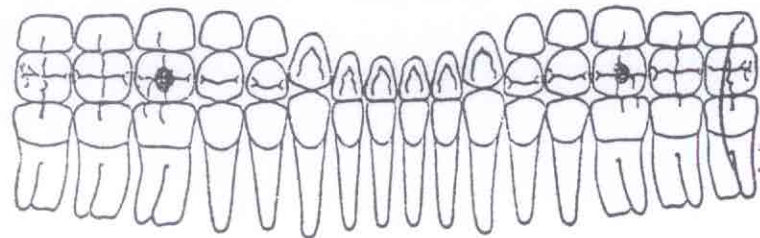
SECTION I. DENTAL EXAMINATION

1. PURPOSE OF EXAMINATION			2. TYPE OF EXAM.			3. DENTAL CLASSIFICATION				
<input checked="" type="checkbox"/> INITIAL	<input type="checkbox"/> SEPARATION	<input type="checkbox"/> OTHER (Specify)	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

4. MISSING TEETH AND EXISTING RESTORATIONS



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

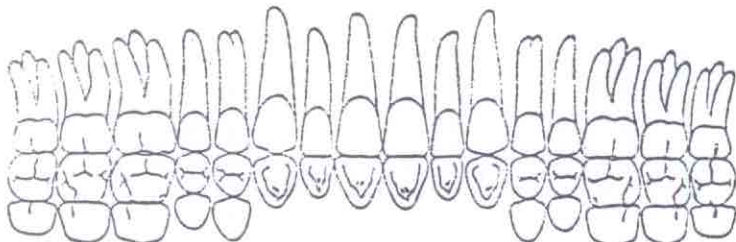


REMARKS

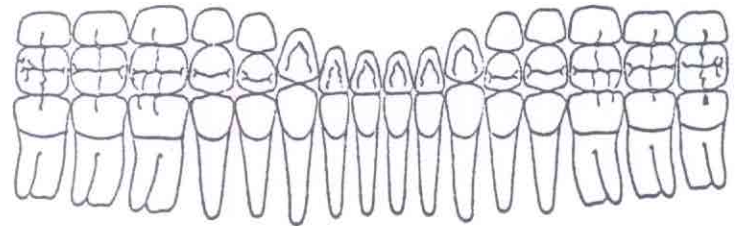
PLACE OF EXAMINATION _____ DATE _____

SIGNATURE OF DENTIST COMPLETING THIS SECTION
D. J. Fineston

5. DISEASES, ABNORMALITIES, AND X-RAYS



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



A. CALCULUS
 SLIGHT MODERATE HEAVY

B. PERIODONTITIS
 LOCAL GENERAL
 INCIPIENT MODERATE SEVERE

C. STOMATITIS (Specify)
 GINGIVITIS VINCENT'S

D. DENTURES NEEDED
 (Include dentures needed after indicated extractions)
 FULL PARTIAL
 U L U L

ABNORMALITIES OF OCCLUSION—REMARKS

E. INDICATE X-RAYS USED IN THIS EXAMINATION
 FULL MOUTH PERIAPICAL POSTERIOR BITE-WINGS OTHER (Specify)

DATE _____ PLACE OF EXAMINATION _____ SIGNATURE OF DENTIST COMPLETING THIS SECTION
D. J. F.

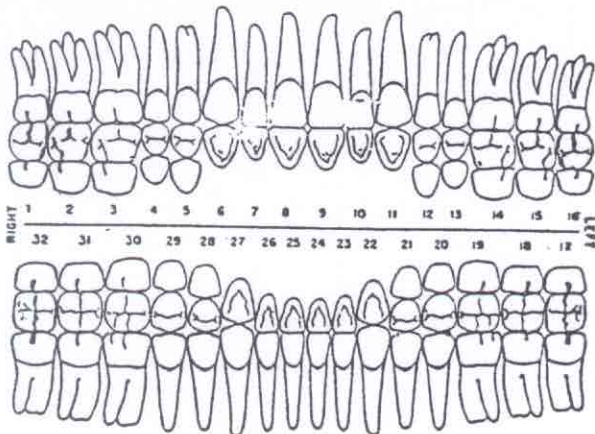
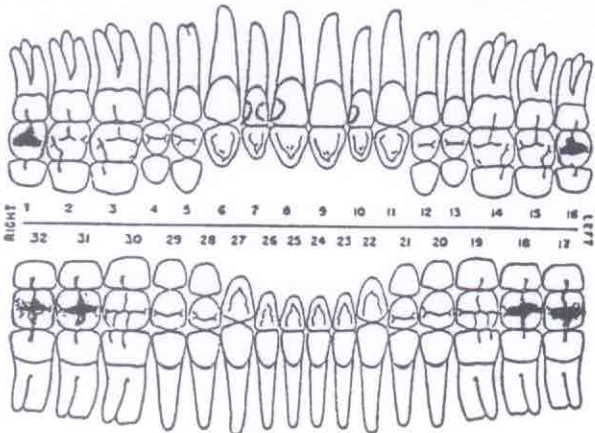
SECTION II. PATIENT DATA

6. SEX M	7. RACE C	8. GRADE, RATING, OR POSITION PVT	9. ORGANIZATION UNIT	10. COMPONENT OR BRANCH USMC	11. SERVICE, DEPT., OR AGENCY
12. PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME WHITE ROSCOE ANTHONY			13. DATE OF BIRTH (DAY—MONTH—YEAR) 18 Nov 1935		14. IDENTIFICATION NO. 1666106

SECTION III. ATTENDANCE RECORD

15. RESTORATIONS AND TREATMENTS (Completed during service)

16. SUBSEQUENT DISEASES AND ABNORMALITIES



REMARKS

REMARKS

17. SERVICES RENDERED

DATE	DIAGNOSIS—TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS
26 Oct 61	Type III Exam		L. B. FRANTZ Capt. DC USN	MJK
27 OCT 61	32, 0 31, 0 CAVAIN AM ANES		J. E. KUHAR 3rd Dent Co	
26 Nov 61	1-ALLEN O-830 THIS DATE		J. E. KUHAR, LT (DC)	
25 Nov 61	#12 Pans #19 Cavit Cement C. Anes.		C. J. Stallman 3rd Dent Co	
28 Nov 61	#7 Mandib #8 Mand #10 Mand		C. J. Stallman 3rd Dent Co	
5 Dec. 61	#1 + #16 - O - Com Bsc. - Anes. - Anes.		W. H. EBERT 3rd Dent Co.	

PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME

HEALTH RECORD

IMMUNIZATION RECORD

All entries in ink to be made in block letters

VACCINATION AGAINST SMALLPOX (Number of previous vaccination scars)

DATE	ORIGIN	BATCH NUMBER	RESULT*		STATION	PHYSICIAN'S NAME
			2-3 DAYS	7-10 DAYS		
MAR 4 57	Cutter	7037	SA		MCRD, SAN DIEGO, CAL.	H. L. GOFF
5-2-57						RV Camp
7-11-61	NATIONAL DRUG	558 A/S			MCB 29 PALMS, CALIF.	
6-8-62					1-12 3rd MAR. ST.	CB Dodge

*ENTER RESULTS AS: IMMEDIATE REACTION (of immunity); ACCELERATED REACTION (Vaccinoid); TYPICAL PRIMARY VACCINA

TRIPLE TYPHOID VACCINE

DATE	DOSE	UNTOWARD REACTION	PHYSICIAN'S NAME	DATE	DOSE	UNTOWARD REACTION	PHYSICIAN'S NAME
MAR 4 57				7			
MAR 13 57			H. L. GOFF	8			
MAR 20 57				9			
5-14-58				10			RV Camp
7-11-61	A/S		SA	11			
8-15-62	O.S		SA	12			

TETANUS TOXOID AND DIPH. TOX. COMB.

DATE	DOSE	UNTOWARD REACTION	PHYSICIAN'S NAME	DATE	DOSE	UNTOWARD REACTION	PHYSICIAN'S NAME
MAR 5 57				4			
APR 23 57			H. L. GOFF	5			
7-11-61	O.S		SA	6			

SCHICK TESTING AND DIPHTHERIA IMMUNIZATION

DATE	DOSE	REACTION	PHYSICIAN'S NAME	DATE	DOSE	REACTION	PHYSICIAN'S NAME
TEST				TEST			
1				5			
2				6			
3				7			
4				8			

TYPHUS VACCINE

DATE	DOSE	REACTION	PHYSICIAN'S NAME	DATE	DOSE	REACTION	PHYSICIAN'S NAME
8/1/57	1cc		Church	4	2cc		SA
8/1/57	1cc		Church	5	8-11-62		SA
7-11-61	1cc		SA	6			

CHOLERA VACCINE

DATE	ORIGIN	BATCH NO.	PHYSICIAN'S NAME	DATE	ORIGIN	BATCH NO.	PHYSICIAN'S NAME
8/1/57	O.Scc		Church	7			
8/1/57	1cc		Church	8			
7-11-61	NDC	5127	SA	9			
8-11-62	NDC		SA	10			
8-11-62			ROG	11			
				12			

YELLOW FEVER VACCINE

DATE	ORIGIN	BATCH NO.	STATION	PHYSICIAN'S NAME
MAR 24 1961	NDC	4760	STAGEN, MCB, CASPER, CALIF.	H. L. GOFF
				H. L. GOFF
				H. L. GOFF

SEX	RACE	GRADE, RATING OR POSITION	ORGANIZATION UNIT	COMPONENT OR BRANCH	SERVICE, DEPT. OR AGENCY
M	C	PRC		USMC	
PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME			DATE OF BIRTH (DAY—MONTH—YEAR)	IDENTIFICATION NO.	
WHITE, ROSCOE ANTHONY			11-18-35	16-66106	

OTHER IMMUNIZATIONS

DATE	TYPE	DOSE	REACTION	REMARKS	PHYSICIAN'S NAME
MAR 6 57					H. L. GOFF
10-30-57	Influenza	1 CC			<i>W. King</i>
5-22-58	Polio				<i>R. V. King</i>
7-30-58	Polio				<i>J. J. King</i>
11-5-58	Diph. A+B	1 CC			<i>J. J. King</i>
6-19-59	Polio Complete	1 CC			<i>J. J. King</i>
10-28-59	INFLU.	1 CC	A+B # 3B-50 C	Lot No. 43038	<i>H. M. Daniel</i>
7-11-61	Polio #4	1 CC			<i>H. Thrapp, M.D.</i>
2-21-62	Anti-HO	1 CC			<i>H. Thrapp</i>
8-11-62	Polio	1 CC			<i>H. Thrapp</i>

SENSITIVITY TESTS (Tuberculin, etc.)

DATE	TYPE	DOSE	ROUTE	RESULTS	PHYSICIAN'S NAME
FEB 25 57		T.B. 0.0001 mgm	Intradermal		H. L. GOFF

REACTIONS (To transfusions, drugs, sera, foods, allergens, etc.)

DATE	AGENT	TYPE OF REACTION	SEVERITY	PHYSICIAN'S NAME

BLOOD TYPING

DATE	TYPE (International)	Rh FACTOR	PHYSICIAN'S NAME
			H. L. GOFF
FEB 25 57			

REMARKS AND RECOMMENDATIONS (Including history of diseases for which any of the above immunizing agents were given with year and place of attack)

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