FORM 93
OBER 1974
ed by GSA/ICMR
R (41CFR) 201-45.505

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.
LAKE, Michael John	[redacted]
3. HOME ADDRESS *(No. street or RFD, city or town, State, and ZIP CODE)*	**4. POSITION** *(title, grade, component)*
539 Lansdale Pl. Pittsburgh, PA 15228	E-3
5. PURPOSE OF EXAMINATION	**6. DATE OF EXAMINATION**
CHAPTER 5-13	AUG 21 1990

PHYSICAL EXAMINATION SECTION

7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Include ZIP Code)*
Womack Army Community Hospital
Fort Bragg, North Carolina 28307

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

ER 635-200

I am in average Health MJL
I am (am) ~~not~~ taking
MEDICATION

9. HAVE YOU EVER *(Please check each item)*

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

10. DO YOU *(Please check each item)*

YES	NO	(Check each item)
✓		Wear glasses or contact lenses
✓		Have vision in both eyes
	✓	Wear a hearing aid
	✓	Stutter or stammer habitually
	✓	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)
	✓		Scarlet fever, erysipelas	✓			Cramps in your legs			✓	"Trick" or locked knee
	✓		Rheumatic fever		✓		Frequent indigestion		✓		Foot trouble
✓			Swollen or painful joints		✓		Stomach, liver, or intestinal trouble		✓		Neuritis
	✓		Frequent or severe headache		✓		Gall bladder trouble or gallstones		✓		Paralysis (include infantile)
	✓		Dizziness or fainting spells		✓		Jaundice or hepatitis		✓		Epilepsy or fits
✓			Eye trouble		✓		Adverse reaction to serum, drug, or medicine		✓		Car, train, sea or air sickness
	✓		Ear, nose, or throat trouble		✓					✓	Frequent trouble sleeping
	✓		Hearing loss		✓		Broken bones	✓			Depression or excessive worry
	✓		Chronic or frequent colds	✓			Tumor, growth, cyst, cancer			✓	Loss of memory or amnesia
	✓		Severe tooth or gum trouble		✓		Rupture/hernia			✓	Nervous trouble of any sort
	✓		Sinusitis		✓		Piles or rectal disease			✓	Periods of unconsciousness
	✓		Hay Fever		✓		Frequent or painful urination				
	✓		Head injury		✓		Bed wetting since age 12				
	✓		Skin diseases		✓		Kidney stone or blood in urine				
	✓		Thyroid trouble		✓		Sugar or albumin in urine				
	✓		Tuberculosis		✓		VD—Syphilis, gonorrhea, etc.				
	✓		Asthma		✓		Recent gain or loss of weight				
	✓		Shortness of breath		✓		Arthritis, Rheumatism, or Bursitis				
	✓		Pain or pressure in chest		✓		Bone, joint or other deformity				
	✓		Chronic cough		✓		Lameness				
	✓		Palpitation or pounding heart		✓		Loss of finger or toe	**12. FEMALES ONLY: HAVE YOU EVER**			
	✓		Heart trouble		✓		Painful or "trick" shoulder or elbow				Been treated for a female disorder
	✓		High or low blood pressure	✓			Recurrent back pain				Had a change in menstrual pattern

13. WHAT IS YOUR USUAL OCCUPATION?
Electronic Tech. 33T10

14. ARE YOU *(Check one)*
☑ Right handed ☐ Left handed

93-103-01

CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT

	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.	(16) ACOA ~~MJL~~ started in fall of 1988 and Depressive Mood Disorder currently being treated with Lithium - started in fall of 1989.
✓	B. Inability to perform certain motions.	
✓	C. Inability to assume certain positions.	
✓	D. Other medical reasons (If yes, give reasons.)	
✓	16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details).	(18) Had a cyst removed from left top hand at Ft. Knox during the early 1980's. mr. sequelae.
✓	17. Have you ever been denied life insurance? (If yes, state reason and give details.)	
✓	18. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)	(19) ~~All~~ MJL ~~me~~ Have only been a patient at Armed Forces Hospitals. ~~Once~~ during Basic Training at Ft. Dix for a Fever and for Strep Throat. Once at Ft. Bragg in ward 4A. Aug 15-17. Dx. Personality Disorder.
✓	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.)	
✓	20. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	
✓	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.)	
✓	22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)	
✓	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.)	
✓	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
Lake, Michael J.	Michael J. Lake

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.)*

Painfull Knees.
Wear corrective glasses

WILLIAM L RICHARDSON M D

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
E. BROOKHART Physician Assistant	AUG 21 1990		

REVERSE OF STANDARD FORM 93

☆ U.S.G.P.O.: 1988- 201-424/80360