104-10175-10181

Standard Form 89
Prescribed by Bureau of the Budget
Circular A-64

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	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
[redacted]		
[redacted] Mexico, D. F.	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION

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7. SEX	8. RACE	9. ARMED FORCES OR COAST SERVICE	10. DEPARTMENT, AGENCY, OR SERVICE	11. ORGANIZATION UNIT
M	White	VOLUNTARY 6 CONSCRIPTION 1 1/2		

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
[redacted]	Mex[redacted]	- Wife - Same as above.

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15. EXAMINING FACILITY OR EXAMINER'S ADDRESS	16. OTHER INFORMATION
66	Wt - 185 Ht - 6'3" (2/17/53)

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS. (*Follow by description of past history, if complaints exist*)

Health normal - feel fine - no complaints.

18. FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DEAD, CAUSE OF DEATH	AGE AT DEATH
FATHER			Pneumonia	86
MOTHER			"	76
SPOUSE	46	Normal		
	53	"		
BROTHERS AND SISTERS	54		Tuberculosis	52
	51	"		
	50	"		
			Combat W.W II	33
CHILDREN	22	Excellent		
	19	"		
	14	"		
	12	"		
	8	"		

19. HAS ANY BLOOD RELATION (*Parent, brother, sister, other than husband or wife*)

YES	NO	(Check each item)	RELATION(S)
X		HAD TUBERCULOSIS	Sister
	X	HAD SYPHILIS	
X		HAD DIABETES	Mother
	X	HAD KIDNEY TROUBLE	
	X	HAD HEART TROUBLE	
	X	HAD STOMACH TROUBLE	
	X	HAD RHEUMATISM	
	X	HAD ASTHMA, HAY FEVER, HIVES	
	X	HAD EPILEPSY (*Fits*)	
	X	COMMITTED SUICIDE	
	X	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)
X		SCARLET FEVER, ERYSIPELAS		X	GOITER		X	TRICK OR LOCKED KNEE
X		DIPHTHERIA		X	TUBERCULOSIS		X	FOOT TROUBLE
X		RHEUMATIC FEVER		X	SCARING BURNS (*Not recent*)		X	NEURITIS
X		SWOLLEN OR PAINFUL JOINTS		X	ASTHMA		X	PARALYSIS (*Inc. infantile*)
X		MUMPS		X	SHORTNESS OF BREATH		X	EPILEPSY OR FITS
	X	WHOOPING COUGH		X	PAIN OR PRESSURE IN CHEST		X	CAR, TRAIN, SEA, OR AIR SICKNESS
X		FREQUENT OR SEVERE HEADACHE		X	CHRONIC COUGH		X	FREQUENT TROUBLE SLEEPING
	X	DIZZINESS OR FAINTING SPELLS		X	PALPITATION OR POUNDING HEART		X	FREQUENT OR TERRIFYING NIGHTMARES
	X	EYE TROUBLE	X		HIGH OR LOW BLOOD PRESSURE		X	DEPRESSION OR EXCESSIVE WORRY
X		EAR, NOSE OR THROAT TROUBLE		X	CRAMPS IN YOUR LEGS		X	LOSS OF MEMORY OR AMNESIA
	X	PLANNING EARS		X	FREQUENT INDIGESTION		X	BED WETTING
	X	CHRONIC OR FREQUENT COLDS		X	STOMACH, LIVER OR INTESTINAL TROUBLE		X	NERVOUS TROUBLE OF ANY SORT
	X	SEVERE TOOTH OR GUM TROUBLE		X	GALL BLADDER TROUBLE OR GALL STONES		X	USE OF DRUG OR NARCOTIC HABIT
	X	SINUSITIS		X	JAUNDICE		X	EXCESSIVE DRINKING HABIT
	X	HAY FEVER	X		ANY REACTION TO SERUM, DRUG OR MEDICINE		X	HOMOSEXUAL TENDENCIES

21. HAVE YOU EVER (Check each item)				22. FEMALES ONLY. A. HAVE YOU EVER—		B. COMPLETE THE FOLLOWING
X	WORN GLASSES	X	ATTEMPTED SUICIDE		BEEN PREGNANT	AGE AT ONSET OF MENSTRUATION
X	WORN AN ARTIFICIAL EYE	X	BEEN A SLEEP WALKER		HAD A VAGINAL DISCHARGE	INTERVAL BETWEEN PERIODS
X	WORN HEARING AIDS	X	LIVED WITH ANYONE WHO HAD TUBERCULOSIS		BEEN TREATED FOR A FEMALE DISORDER	DURATION OF PERIODS
X	STUTTERED OR STAMMERED	X	COUGHED UP BLOOD		HAD PAINFUL MENSTRUATION	DATE OF LAST PERIOD
X	WORN A BRACE OR BACK SUPPORT	X	NECK INJURY OR BROKEN JAW		HAD IRREGULAR MENSTRUATION	QUANTITY ☐ NORMAL ☐ EXCESSIVE ☐ SCANTY

23. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	24. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS?	25. WHAT IS YOUR USUAL OCCUPATION?	26. AGE (Check one)
1	MONTHS 14	Business Management	X RIGHT HANDED ☐ LEFT HANDED

4/25

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE OR RIGHT	
	X	27. HAVE YOU BEEN UNABLE TO HOLD A JOB BECAUSE OF A. SENSITIVITY TO CHEMICALS DUST SUNLIGHT ETC.	
	X	B. INABILITY TO PERFORM CERTAIN MOTIONS	
	X	C. INABILITY TO ASSUME CERTAIN POSITIONS	
	X	D. OTHER MEDICAL REASONS (*If yes, give reasons*)	
	X	28. HAVE YOU EVER WORKED WITH RADIOACTIVE SUBSTANCE?	
	X	29. DID YOU HAVE DIFFICULTY WITH SCHOOL STUDIES OR TEACHERS? (*If yes, give details*)	
	X	30. HAVE YOU EVER BEEN REFUSED EMPLOYMENT BECAUSE OF YOUR HEALTH? (*If yes, state reason and give details*)	
	X	31. HAVE YOU EVER BEEN DENIED LIFE INSURANCE? (*If yes, state reason and give details*)	
	X	32. HAVE YOU HAD OR HAVE YOU BEEN ADVISED TO HAVE ANY OPERATIONS? (*If yes, describe and give age at which occurred*)	
	X	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*)	
	X	34. HAVE YOU EVER HAD ANY ILLNESS OR INJURY OTHER THAN THOSE ALREADY NOTED? (*If yes, specify when, where, and give details*)	
X		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, etc.*)	Routine Check-Ups. Dr. Ernesto Chavez, Jr. Reforma 510-102 Mexico, D.F. Mexico 06 10
	X	36. HAVE YOU TREATED YOURSELF FOR ILLNESSES OTHER THAN MINOR COLDS? (*If yes, which illnesses*)	
	X	37. HAVE YOU EVER BEEN REJECTED FOR MILITARY SERVICE BECAUSE OF PHYSICAL, MENTAL, OR OTHER REASONS? (*If yes, give date and reason for rejection*)	
	X	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*)	
	X	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	SIGNATURE
Al. R. Wichtrich 03	

40. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (*Physician shall comment on all positive answers to items 26 thru 39*)

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

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