JUL 11 1974

318/21
SS [redacted]

[redacted]
211 East Calhoun St.
Whiteville, NC 28472

We have received and very carefully reviewed your claim for compensation benefits. To establish entitlement to this benefit, the evidence must show that you have a disability incurred in or aggravated by service, in line of duty, and it must be 10 percent or more disabling. Regretably, the evidence, including your service records and a report of your recent physical examination, does not meet these requirements. Service connection is established for your chronic low back pain evaluated as 0 percent disabling. You are entitled to necessary treatment by the Veterans Administration for this condition. Application for necessary treatment can be made at the nearest Veterans Administration office. If you apply in person, you should present this letter; if by letter, please include your Social Security number which is now also your Veterans Administration claim number.

Service connection is denied for tension headaches, a fractured right wrist, and a fractured right clavicle as these disabilities were not incurred in or aggravated by your military service. Residuals of viral hepatitis are not shown on the last examination. Your nervous condition is not a disability under the law for which compensation may be paid.

Be assured that every possible effort was made in your case, with the hope that you might be granted the benefits you wanted. However, the Veterans Administration is bound by legislation, passed by Congress for the benefit of all veterans. The evidence in your case, when considered within this framework of controlling law, was not strong enough to sustain a favorable determination.

[redacted]
Adjudication Officer

Enclosure
VA Form 21-4107

CC: DAV(2)

ADallas:jws 6/27/74 211
6/27/74 10:05

STANDARD FORM 93
JANUARY 197 1
GSA FPMR 101—11.8

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.
Foster, Kenneth Wayne	FR [redacted]
3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE)	**4. POSITION (Title, grade, component)**
3914 Wrightsville Ave. Wilmington, N.C. 28401	AB USAF
5. PURPOSE OF EXAMINATION	**6. DATE OF EXAMINATION**
Discharge Section 4	29 Jan 74
7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code)	
USAF CLINIC, LOWRY AFB, COLO.	

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

Good
NONE

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)
	✓		Scarlet fever, erysipelas
	✓		Rheumatic fever
✓			Swollen or painful joints
✓			Frequent or severe headache
	✓		Dizziness or fainting spells
	✓		Eye trouble
✓			Ear, nose, or throat trouble
	✓		Hearing loss
✓			Chronic or frequent colds
✓			Severe tooth or gum trouble
✓			Sinusitis
✓			Hay Fever
	✓		Head injury
	✓		Skin diseases
	✓		Thyroid trouble
	✓		Tuberculosis
	✓		Asthma
✓			Shortness of breath
✓			Pain or pressure in chest
✓			Chronic cough
	✓		Palpitation or pounding heart
	✓		Heart trouble
	✓		High or low blood pressure

YES	NO	DON'T KNOW	(Check each item)
✓			Cramps in your legs
	✓		Frequent indigestion
	✓		Stomach, liver, or intestinal trouble
	✓		Gall bladder trouble or gallstones
	✓		Jaundice or hepatitis
	✓		Adverse reaction to serum, drug, or medicine
	✓		Broken bones
	✓		Tumor, growth, cyst, cancer
	✓		Rupture/hernia
	✓		Piles or rectal disease
✓			Frequent or painful urination
	✓		Bed wetting since age 12
	✓		Kidney stone or blood in urine
		✓	Sugar or albumin in urine
	✓		VD—Syphilis, gonorrhea, etc.
	✓		Recent gain or loss of weight
✓			Arthritis, Rheumatism, or Bursitis
	✓		Bone, joint or other deformity
	✓		Lameness
	✓		Loss of finger or toe
✓			Painful or "trick" shoulder or elbow
✓			Recurrent back pain

YES	NO	DON'T KNOW	(Check each item)
	✓		"Trick" or locked knee
	✓		Foot trouble
	✓		Neuritis
	✓		Paralysis (include infantile)
	✓		Epilepsy or fits
	✓		Car, train, sea or air sickness
✓			Frequent trouble sleeping
✓			Depression or excessive worry
	✓		Loss of memory or amnesia
✓			Nervous trouble of any sort
	✓		Periods of unconsciousness

12. FEMALES ONLY: HAVE YOU EVER

	Been treated for a female disorder
	Had a change in menstrual pattern

13. WHAT IS YOUR USUAL OCCUPATION?

Student

14. ARE YOU (Check one)

☑ Right handed ☐ Left handed

93–101

YES	NO	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.
	✓	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).*
	✓	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. 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.*)

M

Measles, Mumps R. wrist 1960
R. collarbone 1968

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
[redacted]	[redacted]

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.*)

Measles, mumps, childhood, no comp or seq. Fractured right wrist, 1960, no comp or seq. Fractured collar bone, 1968, treated, no comp or seq. Swollen painful joints, hands, shoulder, patient believes it is arthritis, joint pains attributed to trauma to involved joints when patient was speed skater, no evidence of arthritis. Frequent severe headaches,attributed to sinusitis, self treats, no comp or seq. Throat trouble refers to occasional sore throat, no comp or seq. Frequent colds, self treats, no comp or seq. Treated for Gengivitis, until Nov 73, asymptomatic. Hay fever, mild, seasonal, no comp or seq. Shortness of breath, pain in chest, chronic cough, attributed to smoking, no treatment sought. Cramps in legs attributed to lack of exercise, no treatment required. Frequent urination, no treatment sought. Patient doesn't know if there has ever been sugar or albumin in his urine. Recurrent back pain, treated at USAF Clinic, Lowry, attributed to tension. Trouble sleeping, depression, worry, nervousness attributed to present situation, no comp or seq. Examinee denies family history of diabetes or psychosis, use of contact lenses or drugs, history of motion sickness or disturbances of consciousness, and all other significant medical or surgical history.

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
[redacted], Capt, USAF, MC	29 Jan 74		

REVERSE OF STANDARD FORM 93

☆ GPO : 1971 O - 419-271