DEPARTMENT OF VETERANS AFFAIRS
Records Management Center
P. O. Box 5020
St. Louis, Missouri 63115

Date: 02/29/2012

In Reply Refer To: 376/27sa
SS#[redacted]

[redacted]

Dear Sir/Madam :

In response to the request received in our office, we have photocopied and enclosed the following:

- ☐ DD-214 (Military Separation Document)
- ☐ VA Rating Decision/Award Letter
- ☐ Immunization Record
- ☐ Military Medical Records
- ☒ VA Claim Folder
- ☐ Referral To Another Agency (see attachment)

If the "Referral To Another Agency" is checked, a review of our holdings indicates our agency does not have some or all of the information you requested. Please be advised, if applicable, we have provided you with the best copy available from our Center. If we can be of further assistance, please call our Customer Service number at 1-888-533-4558. We trust our actions will be helpful to you.

Sincerely yours,

Kathy Austin

Kathy Austin
Chief, Customer Service Division

Enclosure (s)

The Privacy Act of 1974 does not permit the release of a social security number or other personal information to the public without the authorization of the veteran concerned. Therefore, if applicable, personal data pertaining to other individuals have been deleted from the enclosed documents.

059

Form Approved: OMB No. 2900-0028
Respondent Burden: 7.5 minutes

Department of Veterans Affairs

REQUEST FOR AND CONSENT TO RELEASE OF INFORMATION FROM INDIVIDUAL'S RECORDS

PRIVACY ACT STATEMENT: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, United States Code, and will authorize release of the information you specify. The information may also be disclosed outside VA as permitted by law to include disclosure as stated in the "Notices of Systems of VA Records" published in the Federal Register in accordance with the Privacy Act of 1974.

RESPONDENT BURDEN: VA may not conduct or sponsor, and the respondent is not required to respond, to this collection of information unless it displays a valid OMB Control Number. The Privacy Act of 1974 (5 U.S.C. 552a) and VA's confidentiality statute (38 U.S.C. 5701) as implemented by 38 CFR 1.526(a) and 38 CFR 1.576(b) require individuals to provide written consent before documents or information can be disclosed to third parties not allowed to receive records or information under any other provision of law. The information requested is approved under OMB Control Number 2900-0028 and is necessary to ensure that the statutory requirements of the Privacy Act and VA's confidentiality statute are met.

Responding to this collection of information is voluntary. However, if the information is not furnished, we may not be able to comply with your request. Public reporting burden for this collection is estimated to average 7.5 minutes per respondent, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspects of this collection of information, including suggestions for reducing this burden, to the VA Clearance Officer (005E3), 810 Vermont Avenue, NW, Washington, DC 20420. **Send comments only. Do not send** this form or requests for benefits to this address.

TO	Department of Veterans Affairs VA Records Management Center P.O. Box 5020 4300 Goodfellow Blvd., Bldg. 104 St. Louis, MO 63120	NAME OF INDIVIDUAL *(Type or print)* [redacted]
		VA FILE NO. *(Include prefix)* [redacted]
		SOCIAL SECURITY NUMBER [redacted]

NAME AND ADDRESS OF ORGANIZATION OR INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

[redacted]

VETERAN'S REQUEST

I hereby request and authorize the Department of Veterans Affairs to release the following information from the records identified above to the organization, agency, or individual named hereon:

NAME [redacted]

INFORMATION REQUESTED *(Number each item requested and give the dates or approximate dates - period from and to - covered by each.)*

I am requesting a copy of all files: papers, digital media, and artifacts which are now contained in my Compensation and Benefits Claim folder.

RMC ST. LOUIS
APR 27 2011
MAIL ANALYZER #6

RECEIVED
2011 OCT 21 P 1:31

PURPOSE(S) FOR WHICH THE INFORMATION IS TO BE USED.

I wish to review my Claim File.

SMRS COPIED 10.17.11
VA RMC ST LOUIS (376)

NOTE: Additional information may be listed on the reverse side of this form.

SIGNATURE OF INDIVIDUAL OR PERSON AUTHORIZED TO SIGN FOR INDIVIDUAL *(Attach authority to sign, e.g., POA)*: [redacted]

DATE: 10/14/2010

VA FORM OCT 1995(R) **3288** AdobeFormsDesigner

COPY MADE BY VA RMC, ST LOUIS, FROM A RECORD IN THE POSSESSION

D VETERAN IDENTIFICATION DATA SEQ NO 3110521560014357 11-07-1990

LE NO [redacted] PN 00 BR NAME [redacted]

N INS NO SVC NO STUB NAME

LE NO [redacted] PAYEE NO 00 NAME [redacted]

SSIGN FILE NO AS CLAIM OR SSN CLAIM FOLDER LOCATION 372 WASHINGT

CIAL SECURITY NO [redacted] DATE OF DEATH

SURANCE FILE NO CAUSE OF DEATH

SURANCE POLICY NO DEATH IN SVC

TE OF BIRTH 11-11-1966 POSITIVE INDICATION

X F POWER OF ATTORNEY 000

RVICE NO(S) [redacted]

OD 11-05-1985

AD 01-20-1990

RANCH OF SVC M

HARACTER OF SVC HON

EP REASON CODE SAT

AY GRADE E-3

ON-PAY DAYS 77

CONTESTED DATA DELETE RECORD VADS Y VERIFIED

NEXT SCREEN DMB

SR,VID

COPY MADE BY VA RMC, ST LOUIS, FROM A RECORD IN ITS POSSESSION

Department of Veterans Affairs

RATING DECISION

1. REGIONAL OFFICE NUMBER	2. TYPE OF RATING	3. ORIGINAL DISABILITY RATING	4. VETERAN'S FILE NUMBER
372	DISABILITY	YES	[redacted]

5. VETERAN'S INITIALS AND SURNAME	6. COPY TO	7. VETERAN'S SOCIAL SECURITY NUMBER
[redacted]		

8. DATE OF CLAIM	9. DATE OF THIS RATING	10. DATE OF BIRTH	11. DATE OF DEATH
10-9-90	7-19-91	11-11-66	

12. ACTIVE DUTY (Mo., day, yr.)				13. ADDITIONAL SERVICE CODE
EOD 11-5-85	RAD 1-28-90 D	EOD	RAD	

14. COMBAT STATUS	15. DATE OF LAST EXAMINATION	16. DATE OF FUTURE PHYSICAL EXAMINATION (Mo./yr.)	17. EMPLOYABLE (Compensation only)
1	12-11-90	NO EXAM	YES

18. COMPETENT	19. SPECIAL PROVISION CODE	20. NUMBER OF ADDITIONAL DIAGNOSTICS	21. NUMBER OF ADDITIONAL S/C DIAGNOSTICS
YES			

22. SPECIAL MONTHLY COMPENSATION

A. STATUS	B. BASIC SMC	C. HOSPITAL SMC	D. LOSS OF USE	E. ANAT LOSS	F. OTHER LOSS
CURRENT					
FUTURE					

23. NARRATIVE

J. Original claim, VA Form 21-526 dated 10-9-90.

I. Service connection for fracture little finger left hand; and nocturnal bruxism, clinching with TMJ pain.

E. Service medical records for enlistment November 1985 to January 1990; Department of Veterans Affairs examination 12-11-91.

F. Enlistment exam of 3-9-85 is negative. Clinical record of 1-29-88 notes dislocation fifth digit left hand secondary to playing ball. X-ray showed avulsion fracture PIP. Department of Veterans Affairs examination reveals no evidence of any abnormality left pinky finger.

Clinical record of 7-22-88 notes referred to dental clinic for repeat evaluation for possible mouth guard. Veteran is in environmental stress that increased teeth grinding. Has TMJ secondary to grinding teeth secondary to stress. On Department of Veterans Affairs examination, veteran complains of sore jaw in morning upon waking. Grinding and clinching teeth. Examination shows soft tissue is within normal limits. No muscle soreness found with definite effect to local positive response. Examiner indicates that veteran has developmental, functional occlusion without overt pathology. Patient's stress (own admission) may have increased level and/or awareness of bruxism. Do not consider condition secondary to military duty.

D. Service connection is established for fractured little finger left hand and a zero percent evaluation assigned because no evidence of residual effects found on Department of Veterans Affairs examination. Service

Department of Veterans Affairs

RATING DECISION CONTINUATION SHEET	NAME OF VETERAN	FILE NUMBER
	[redacted]	[redacted]

PAGE 2 OF RATING DATED: 7-19-91

connection for nocturnal bruxism, clinching teeth with TMJ pain is denied because in the absence of trauma in service, this is considered a congenital or developmental abnormality.

1. SC (PTE INC)

5227 Avulsion fracture little finger left hand
0% from 1-21-90

8. NSC (PTE)

9999-9905 Nocturnal bruxism, clinching teeth with TMJ pain (constitutional or developmental abnormality)

211R/200/4538I DO:vb

24. MEDICAL RATING SPECIALIST	25. RATING SPECIALIST	26. RATING SPECIALIST	27. PA
CHP. ☐	CHP. ☐	CHP. ☐	28. R.B. NUMBER 211R

DATE OF CLAIM OR ISSUE	END PRODUCT	TRANSACTION	R.O. NO.	POWER OF ATTORNEY	FID. R.O.	PAYEE NO.	PAYEE NAME	FILE NUMBER
10-15-90	110	27L-DISA	372			00	[redacted]	[redacted]

SOCIAL SECURITY NUMBERS: VETERAN [redacted] SPOUSE PAYEE

BIRTH: VETERAN 11-11-66 SPOUSE WIDOW FATHER MOTHER

NAME AND ADDRESS - PAYEE

[redacted]

NAME OF VETERAN	SEX	NAME OF SPOUSE
[redacted]	F	

BR.	EOD	RAD	PAY GR.
C	11-05-85	01-20-90	

ASC	SERVICE NO.	CROSS REFERENCE NO.
	[redacted]	

CHAR. DIS	SEP. RSN.	DATE OF DEATH	AGE AT DEATH	VET. SPOUSE
HON	SAT			

PRIOR NET AWARD DATA

MONTHLY RATE	EFFECTIVE DATE	WITHHOLD-RECOUP TYPE	WITHHOLD-RECOUP AMOUNT

ZIP CODE	CONS. PAY NO.		CODE	AMOUNT
22304		COLLECTION ▶		

DIRECT DEPOSIT

DISALLOWANCE ▶ CODE-REASON 05-ZERO PCT SC DISABILITY

EFFECTIVE DATE	RSN CODE	NET MONTHLY RATE	WITHHOLDING TYPE	WITHHOLDING AMOUNT	OFFSET/RECOUP TYPE	OFFSET/RECOUP AMOUNT	ENT CODE	DISABILITY ENTITLEMENT	INCOME	DEPENDENCY TOT	DEPENDENCY THIS	SCHL/HLP	SPECIAL LAW/MISC

RATING

EFFECTIVE DATE	COMB DEG	SMC BAS	SMC HOS	SPL PRO	EMPL	W-PCT.	LOSSES USE	LOSSES ANAT	LOSSES OTH	CONTROLS MO	CONTROLS YR	CONTROLS RSN	OFFSET - RECOUPMENT TYPE	BALANCE	DEDUCTION
						COMPETENCY RATING	COMPETENCY PAYMENT								

INCOME AND DEPENDENCY

	NET WORTH	MO. SOC. SEC.	ANN. SOC. SEC.	ANN. EARNING	MO. CIVIL SERV.	MO. MILITARY	MO. BLACK LUNG	MO. RAILROAD	MO. OTHER RET.	ANN. OTH. INC.
PAYEE SPOUSE										

NAME OF CHILD	BIRTH DATE	STAT	NW	MO. SOC. SEC.	ANN. SOC. SEC.	ANN EARNINGS	ANN. OTH. INC.	FUTURE DATE	RSN

DEDUCTIBLE EXPENSES

MEDICAL	
LAST	
FAMILY	
SOC. SEC.	
OTH. RET.	
WAIVER	
EDUCATION	

ADDL. CHILDREN ▶ TOTAL: THIS: ▶ IVAP:

BURIAL

DESCRIPTION	AMOUNT	PERSON TO BE NOTIFIED
S/C BURIAL	5227	01 000
NSC BURIAL	4999	08 000
PLOT/INTER.		
HDST./MARKER		
TRANSPORTATION		
TOTAL		

ACCRUED

BASIS FOR PAYMENT:
AMOUNT PAYABLE:
SHARE:
AMOUNT THIS PAYEE:
LESS COLLECTION:
NET PAY:

REMARKS

DICTATED LETTER REQUIRED - NO FREE TEXT
06-DIS/DTH NOT DUE TO SVC
rtg dtd 7-19-91

ENTERED BY	DATE	AUTHORIZED BY	DATE
1134 COATES A	07-26-91		7/26/91

COPY MADE BY VA RMC, ST LOUIS, FROM A RECORD IN ITS POSSESSION

=I J101 INFORMATION REQUEST DATE OF REQUEST 11-07-90

FILE NUMBER [redacted]-00 END PRODUCT 110 NAME [redacted]

TYPE REQUEST ORIGINAL SEP FORMS ON FILE NO
ADDRESS CODE 13/ BRANCH OF SERVICE M

CLAIM TYPE DISABILITY

DATA REQUESTED SERVICE MEDICAL

CONDITIONS PINKY FINGER/BROKEN

SPECIAL INFORMATION
DD 214 VERIFY SVC PHYSICAL EOD
PHYSICAL RAD

LEASE FURNISH ALL AVAILABLE SERVICE MEDICAL RECORDS FOR THE ABOVE PERIOD
F SERVICE. VERIFY SERVICE AND CHARACTER OF DISCHARGE.

REQUESTED BY BOYD D

COPY MADE BY VA RMC, ST LOUIS, FROM A RECORD IN ITS POSSESSION

U-88402

T/COLOR-CODE.....C/O DATE.....SEARC R.....ADDRESS-CODE 13
SSAN/SN * NAME SVC-CODE REGISTRY-NO.
[redacted] N O T F O U N D

RUN DATE 11/09/90
RUN TIME 10.31
RUN PAGE 00718
ING PAGE 00001

REQUEST FOR INFORMATION VA FORM 70-3101-4 JUL 1986

DATE 11-08-90 VA-INS-NO. VA-FILE-NO. [redacted]
E-OF-REQUEST ORIGINAL 1.NAME [redacted]
R-OF-CLAIM DISABILITY 2.SSAN [redacted]
3.SERVICE-BRANCH MARINE CORPS
A-REQUESTED SERVICE 4.DATE-OF-BIRTH 11-11-66
MEDICAL 5.PLACE-OF-BIRTH [redacted]
6.DATE-OF-DEATH

TERANS ADMINISTRATION (372)
L NORTH CAPITOL ST., NE
SHINGTON DC 20421 ORIGINATING-UNIT ADJUDICATION 2113

7. ENT ACT DUTY	8. SEP ACT DUTY	9. CHAR	10.SVC NUMBER	11. LAST GRADE, RATE, RANK, AND/OR ORGANIZATION	12.SEP/FOR ON FIL
11-05-85	01-20-90	UNV	[redacted]	E-3 M MCAS EL TORO ST DRA CA	NO

.SUBSEQUENT-RES/RET-STATUS NONE 14.TERMINAL-DATE 15.RET-STATUS

.ALLEGED DISEASE/INJURY	17.TREATMENT-DATES	18.PLACE-OF-TREATMENT	19.TYPE
PINKY FINGER/BROKEN	01-01-88 - 12-31-88	NRMC MCASEL TORO	HOSP

.PLEASE FURNISH ALL AVAILABLE SERVICE MEDICAL RECORDS FOR THE ABOVE PERIOD
OF SERVICE. VERIFY SERVICE AND CHARACTER OF DISCHARGE.
COPY OF ANY SEPARATION DOCUMENTS.
COMPLETE VERIFICATION OF SERVICE.
COPY OF PHYSICAL EXAM AT INDUCTION.
COPY OF PHYSICAL EXAM AT DISCHARGE.

( ) AVAILABLE ( ) ITEMS 1. AND 2 OR 10 (X) ITEMS 1. AND 2 OR 10
EQUESTED RECORDS (WHICHEVER WAS THE IDENTIFIER) (WHICHEVER WAS THE IDENTIFIER)
ORWARDED. AND 7-9 VERIFIED CORRECT. AND 7-9 VERIFIED CORRECT. EXCE

A HON

Separation document is not on file.

1070
MMRB-1

ICLOSURES ( )X-RAYS ( )CLINICAL RECORDS . SIGNATURE AND TITLE . DATE
)HEALTH RECORDS ( )DENTAL RECORDS .
)ENTRANCE PHYSICAL ( )MEDICAL RECORDS .
)SEPARATION PHYSICAL ( )OTHER RECORDS .

COPY MADE BY VA RMC, ST LOUIS, FROM A RECORD IN ITS POSSESSION

0-88402 alc

/COLOR-CODE.....C/O DATE.....SERVICE.....ADDRESS-CODE 13
SSAN/SN * NAME SVC-CODE REGISTRY-NO.
[redacted] N O T F O U N D

RUN DATE 11/09/90
RUN TIME 10.31
RUN PAGE 00718
INC PAGE 00001

2/B LM-12/10/90
12/21/90

REQUEST FOR INFORMATION VA FORM 70-3101-4 JUL 1986

DATE 11-08-90 VA-INS-NO. VA-FILE-NO. [redacted]
-OF-REQUEST ORIGINAL 1.NAME [redacted]
-OF-CLAIM DISABILITY 2.SSAN [redacted]
3.SERVICE-BRANCH MARINE CORPS
A-REQUESTED SERVICE 4.DATE-OF-BIRTH 11-11-66
MEDICAL 5.PLACE-OF-BIRTH [redacted]
6.DATE-OF-DEATH

BRANS ADMINISTRATION (372)
NORTH CAPITOL ST., NE
HINGTON DC 20421 ORIGINATING-UNIT ADJUDICATION 2113

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11-05-85	01-20-90	UNV	[redacted]	E-3 M MCAS EL TORO ST URA CA	NO

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ALLEGED DISEASE/INJURY	17.TREATMENT-DATES	18.PLACE-OF-TREATMENT	19.TYP
FIRKY FINGER/BROKEN	01-01-88 - 12-31-88	NRMC MCASEL TORO	HOSP

COPY MADE BY VA RMC, ST LOUIS, FROM A RECORD IN ITS POSSESSION

PLEASE FURNISH ALL AVAILABLE SERVICE MEDICAL RECORDS FOR THE ABOVE PERIOD OF SERVICE. VERIFY SERVICE AND CHARACTER OF DISCHARGE.
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COPY OF PHYSICAL EXAM AT DISCHARGE.

( ) AVAILABLE REQUESTED RECORDS FORWARDED.

( ) ITEMS 1, AND 2 OR 10 (WHICHEVER WAS THE IDENTIFIER) AND 7-9 VERIFIED CORRECT.

(X) ITEMS 1, AND 2 OR 10 (WHICHEVER WAS THE IDENTIFIER) AND 7-9 VERIFIED CORRECT, EXCE

A HON

Your original request has been forwarded to the Marine Corps Reserve Support Center, 10950 El Monte, Overland Park, KS. for reply.

4070
MMRB-1

Separation document is not on file

D R Harper
D. R. HARPER
Head, Medical Records Unit
Records Service Section, Records Branch
Personnel Management Division
By direction of the Commandant of the Marine Corps

12/10/90

ENCLOSURES ( ) X-RAYS ( ) CLINICAL RECORDS
( ) HEALTH RECORDS ( ) DENTAL RECORDS
( ) ENTRANCE PHYSICAL ( ) MEDICAL RECORDS
( ) SEPARATION PHYSICAL ( ) OTHER RECORDS

SIGNATURE AND TITLE DATE

LLC

T/COLOR-CODE.....C/O DATE.....SEARCHER.....ADDRESS-CODE 13

SSAN/SN	NAME	SVC-CODE	REGISTRY-NO.
[redacted]	N O T F O U N D		

RUN DATE 11/09/90
RUN TIME 10.31
RUN PAGE 00718
INQ PAGE 00001

==========REQUEST FOR INFORMATION VA FORM 7[illegible]-3101-4 JUL 1986==========

DATE 11-08-90
E-OF-REQUEST ORIGINAL
E-OF-CLAIM DISABILITY
A-REQUESTED SERVICE
MEDICAL

VA-INS-NO.
VA-FILE-NO. [redacted]
1.NAME [redacted]
2.SSAN [redacted]
3.SERVICE-BRANCH MARINE CORPS
4.DATE-OF-BIRTH 11-11-66
5.PLACE-OF-BIRTH [redacted]
6.DATE-OF-DEATH

==========

ERANS ADMINISTRATION (372)
NORTH CAPITOL ST., NE
SHINGTON DC 20421

ORIGINATING-UNIT ADJUDICATION 2113

==========

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11-05-85	01-20-90	UNV	[redacted]	E-3 M MCAS EL TORO ST ORA CA	NO

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.SUBSEQUENT-RES/RET-STATUS NONE 14.TERMINAL-DATE 15.RET-STATUS

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INKY FINGER/BROKEN	01-01-88 TO 12-31-88	NRMC MCASEL TORO	HOSP

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COPY OF PHYSICAL EXAM AT DISCHARGE.

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(X) ITEMS 1, AND 2 OR 10 (WHICHEVER WAS THE IDENTIFIER) AND 7-9 VERIFIED CORRECT, EXCEPT

A HON

Reply concerning medical records will be a matter of separate correspondence

Separation document is not on file.

1070
MMRB-L
03 DEC 1990

CLOSURES ( )X-RAYS ( )CLINICAL RECORDS
)HEALTH RECORDS ( )DENTAL RECORDS
)ENTRANCE PHYSICAL ( )MEDICAL RECORDS
)SEPARATION PHYSICAL ( )OTHER RECORDS

SIGNATURE AND TITLE A DATE

A. J. CLEVELAND
Head, Unit #5, Records Service Section
Records Branch, Personnel Management Division
By direction of the Commandant of the Marine Corp

COPY MADE BY VA RMC, ST LOUIS, FROM A RECORD IN ITS POSSESSION

MEDICAL RECORD

CONSULTATION SHEET

REQUEST

TO: Dental

FROM: (Requesting physician or activity) USC

DATE OF REQUEST: 22 July 85

REASON FOR REQUEST (Complaints and findings)

Pt has severe problem c̄ grinding teeth at night A 2° unresolvable stress. Please fit for night mouthguard to see if that would help relieve some of the discomfort

PROVISIONAL DIAGNOSIS

TMJ 2° grinding teeth 2° Stress

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	☐ ROUTINE ☐ TODAY
JOHN E. LEFFERT CW04, PA-C, USN [redacted]		☐ BEDSIDE ☐ ON CALL	☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

(Continued on reverse side)

SIGNATURE AND TITLE			DATE
IDENTIFICATION NO.	ORGANIZATION	REGISTER NO	WARD NO

PATIENT'S IDENTIFICATION (For typed or written entries give Name—last, first, middle, grade, rank, rate, hospital, or medical [illegible]

[redacted]

CONSULTATION SHEET
STANDARD FORM 513 (Rev. 9-77)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
513-108

DATE
8 JUL 1988
0915

BRANCH MEDICAL CLINIC
MONS EL TORO, SANTA ANA, CA 92709
APPOINTMENT WITH: 0915/1166
CHECK IN TIME: 0910
AGE 21 TEMP 97.5 PULSE 64
RESP 10 BP 90/50 WT 133
ALLERGIES: NKDA
CURRENT MEDICATIONS: Motrin, CTM
CHECK OUT TIME:

N. P.S.

C/C - Requests full P.E. Mbr states feeling tired/run-down x few months HHR [redacted]

S) 21 yo WM c/o 2-3 mo h/o awakening feeling tired despite 7-10 hr. sleep. Also has difficulty falling asleep + frequent early AM awakening ≈ 0430. Presently no other med probs ~~x takes CTM for seasonal rhinitis~~. Admits difficulty concentrating, but denies wt loss Δ appetite, diarrhea/constip. Has had bitemporal HA's ~~possibly related to~~ nocturnal bruxism. Relates dissatisfaction c̄ USMC - was ~~adv~~ rec for admin D/C but denied by C.O.

PMHx as above.

[redacted]

PHx ∅ HTN, MI, CVA, DM, TB, CA
∅ ψ ds, thyroid ds.

SHx single, lives in BKS, USMC x 2 yr 8 mo

Habits Job + PTD x 2½ yr
ETOH weekends 3-4 drinks [redacted]

meds Norm CTM.

NKDA

Menst. LMP 11 JUL 88 G, P0 Ab,

ROS GEN ∅ fever/chills wt
HEENT ∅ sinusitis, rhinitis, blurry eyes.
RESP ∅ SOB, cough. (+) frequent sighs
CV ∅ orthop, dyspnea, palpit.
GI ∅ D/M/NV
GU ∅ & urinary habits
MS ∅ weakness.
NEURO SEE HPI.
ENDOCR ∅ heat/cold intolerance.
SKIN ∅ rashes.

O) AVSS WDWN WG NAD A+O x 3.
MSE Thought content appropr. Thought proc linear. Recent + remote memory intact. Admits memory sx above (HPI). ∅ suicidal or homicidal ideation. ∅ drugs. Intell. at least avg

HEENT Unremarkable
NECK supple ∅ thyromegaly/masses.
LUNGS CTA CV RRR S GM ABD benign EXTR FULL ROM. ∅ C,C,E.
NEURO CN II - XII intact sensory intact motor strength 5+/5 bilat (+) coordination. RAM done well. Normal gait + station. Romberg neg.
LYMPH ∅ adenopathy. SKIN ∅ lesions.

A.) AM tiredness/malaise - prob 2° dissatisfaction c̄ present life situation. Will R/o thyroid ds, anemia, mono, glucose intol.

P) 1. Lytes, BUN, gluc, CBC, Monospot, UA, T3, T4, TSH

2. Multivits + po QD (#100)

3. F/U 1-2 weeks.

[signature]

R. A. WEINER
LCDR MC USN
[redacted]

STANDARD FORM 600 BACK (REV. 5-84)

U.S. Government Printing Office: 1987—181-247/60095

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
2 JUL 1988	BRANCH MEDICAL CLINIC MCAS EL TORO, SANTA ANA, CA 92709 APPOINTMENT WITH: 166/ CHECK-IN TIME AGE 21 TEMP ~~[illegible]~~ PULSE 64 RESP 16 B/P 87/52 WT 135 ALLERGIES: NKDA CURRENT MEDICATIONS: NONE CHECK OUT TIME:

Pt requesting more refills, Motrin for HA due to teeth grinding.

Steve D. McLaughlin HM1(FMF) [redacted]

NFS

56

Refer to Dental for repeat eval for pos mouthguard, pt in environment that stress & thereby ↑ teeth grinding. Refill Motrin 600 mg TID #30 Refills

PATIENT VERBALIZES/ DEMONSTRATES
UNDERSTANDING OF PLAN AND INSTRUCTIONS
R. CARR

JOHN. E. LEFFERT
CW04, PA-C, USN
[redacted]

2118

FORM APPROVED
OMB NO. 2900-0001

Veterans Administration

VETERAN'S APPLICATION FOR COMPENSATION OR PENSION

IMPORTANT: Read attached General and Specific Instructions before completing this form. Type, print or write plainly.

(DO NOT WRITE IN THIS SPACE)
VA DATE STAMP

RECEIVED
271A
OCT 09 1990
WRO, VACO UNIT
WASH. DC

1A. FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN: [redacted]

1B. TELEPHONE NO. *(Incl. Area Code)*: [redacted]

2. MAILING ADDRESS OF VETERAN *(Number and street or rural route, city or P.O., State and ZIP Code)*: [redacted]

3A. VETERAN'S SOC. SECURITY NO.: [redacted]

3B. SPOUSE'S SOC. SECURITY NO.:

4. DATE OF BIRTH: 11/11/66

5. PLACE OF BIRTH: [redacted]

6. SEX: Female

7. RAILROAD RETIREMENT NO.:

8. HAVE YOU EVER FILED A CLAIM FOR COMPENSATION FROM THE OFFICE OF WORKERS' COMPENSATION PROGRAMS? *(Formerly the U.S. Bureau of Employees Compensation)*

☐ YES ☒ NO

9A. VA FILE NUMBER

C–

RECEIVED

9B. HAVE YOU PREVIOUSLY FILED A CLAIM FOR ANY BENEFIT WITH THE VETERANS ADMINISTRATION?

☒ NONE
☐ HOSPITALIZATION OR MEDICAL CARE
☐ WAIVER OF NSLI PREMIUMS
☐ DISABILITY COMPENSATION OR PENSION
☐ VOCATIONAL REHABILITATION *(Chapter 31)*
☐ VETERANS EDUCATIONAL ASSISTANCE *(Chapter 33 or 34)*
☐ WAR ORPHANS OR DEPENDENTS EDUCATIONAL ASSIST. *(Chap. 35)*
☐ DENTAL OR OUTPATIENT TREATMENT
☐ OTHER *(Specify)*

9C. VA OFFICE HAVING YOUR RECORDS *(If known)*

OCT 10 1990
Vets. Svcs. Div.
VARO, Wash., D.C.

SERVICE INFORMATION

NOTE: Enter complete information for each period of active duty including Reservist or National Guard Status. Attach Form DD 214 or other separation papers for all periods of active duty to expedite processing of your claim. If you do NOT have your DD 214 or other separation papers check (√) here ☐

10A. ENTERED ACTIVE SERVICE		10B. SERVICE NO.	10C. SEPARATED FROM ACTIVE SERVICE		10D. GRADE, RANK OR RATING, ORGANIZATION OR BRANCH OF SERVICE
DATE	PLACE		DATE	PLACE	
11/05/85	Parris Island/SC		01/20/90	EL Toro, Ca.	LCpl, USMC

10E. HAVE YOU EVER BEEN A PRISONER OF WAR? ☐ YES ☒ NO *(If "Yes," complete Items 10F and 10G)*

10F. NAME OF COUNTRY: N/A

10G. DATES OF CONFINEMENT: N/A

11. IF YOU SERVED UNDER ANOTHER NAME, GIVE NAME AND PERIOD DURING WHICH YOU SERVED AND SERVICE NO.: N/A

12. IF RESERVIST OR NATIONAL GUARDSMAN, GIVE BRANCH OF SERVICE AND PERIOD OF ACTIVE OR INACTIVE TRAINING DUTY DURING WHICH DISABILITY OCCURRED: N/A

13A. IF YOU ARE NOW A MEMBER OF THE RESERVE FORCES OR NATIONAL GUARD GIVE THE BRANCH OF SERVICE: USMC

13B. RESERVE STATUS
☐ ACTIVE ☐ RESERVE OBLIGATION
☒ INACTIVE

13C. RESERVE OR NATIONAL GUARD UNIT ADDRESS: N/A

14A. ARE YOU NOW RECEIVING OR WILL YOU RECEIVE RETIREMENT OR RETAINER PAY FROM THE ARMED FORCES?
☐ YES ☒ NO *(If "Yes," complete Item 14B, 14C, and 14D)*

14B. BRANCH OF SERVICE:

14C. MONTHLY AMOUNT: $

14D. RETIRED STATUS
☐ PERMANENT
☐ TEMPORARY DISABILITY RETIRED LIST

15A. HAVE YOU EVER APPLIED FOR OR RECEIVED DISABILITY SEVERANCE PAY FROM THE ARMED FORCES?
☐ YES ☒ NO *(If "Yes," complete Item 15B)*

15B. AMOUNT: $

16A. HAVE YOU RECEIVED LUMP SUM READJUSTMENT OR SEPARATION PAY FROM THE ARMED FORCES?
☐ YES ☐ NO *(If "Yes," complete Item 16B)*

16B. AMOUNT: $

MARITAL AND DEPENDENCY INFORMATION

17A. MARITAL STATUS *(Check one)*
☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☒ NEVER MARRIED *(If so, do not complete Items 17B through 21D)*

17B. SPOUSE'S BIRTHDATE:

17C. NUMBER OF TIMES YOU HAVE BEEN MARRIED:

17D. NUMBER OF TIMES YOUR PRESENT SPOUSE HAS BEEN MARRIED:

17E. IS YOUR SPOUSE ALSO A VETERAN?
☐ YES ☐ NO *(If "Yes," complete Item 17F, if known)*

17F. SPOUSE'S VA FILE NO.: C– 00

18A. DO YOU LIVE TOGETHER?
☐ YES ☐ NO *(If "No," complete Items 18B through 18D)*

18B. REASON FOR SEPARATION:

18C. PRESENT ADDRESS OF SPOUSE:

18D. AMOUNT YOU CONTRIBUTE TO YOUR SPOUSE'S SUPPORT MONTHLY: $

19. CHECK (√) WHETHER YOUR CURRENT MARRIAGE WAS PERFORMED BY:
☐ CLERGYMAN OR AUTHORIZED PUBLIC OFFICIAL ☐ OTHER *(Explain)*

PIF
EP: 1/1 INTE.
DISP: Pwld
DATE: 22 OCT 1990
INITIALS: Jc

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VA FORM 21-526 SEP 1984 — SUPERSEDES VA FORM 21-526, JUL 1982, WHICH MAY BE USED.

NOTE: Furnish the following information about each of your marriages. A certified copy of the public or church record of your CURRENT marriage is required.

20A. DATE AND PLACE OF MARRIAGE	20B. TO WHOM MARRIED	20C. TERMINATED *(Death, Divorce)*	20D. DATE AND PLACE TERMINATED

FURNISH THE FOLLOWING INFORMATION ABOUT EACH PREVIOUS MARRIAGE OF YOUR PRESENT SPOUSE

21A. DATE AND PLACE OF MARRIAGE	21B. TO WHOM MARRIED	21C. TERMINATED *(Death, Divorce)*	21D. DATE AND PLACE TERMINATED

IDENTIFICATION OF CHILDREN AND INFORMATION RELATIVE TO CUSTODY

NOTE: Furnish the following information for each of your unmarried children. A certified copy of the public or church record of birth or court record of adoption is required.

22A. NAME OF CHILD *(First, middle initial, last)*	22B. DATE OF BIRTH *(Month, day, year)*	22C. SOCIAL SECURITY NUMBER OF CHILD	22D. CHECK EACH APPLICABLE CATEGORY				
			MARRIED PREVIOUSLY	STEPCHILD OR ADOPTED	ILLEGITIMATE	OVER 18 ATTENDING SCHOOL	SERIOUSLY DISABLED

22E. NAME(S) OF ANY CHILD(REN) NOT IN YOUR CUSTODY	22F. NAME AND ADDRESS OF PERSON HAVING CUSTODY	22G. MONTHLY AMOUNT YOU CONTRIBUTE TO CHILD'S SUPPORT
		$

23A. IS YOUR FATHER DEPENDENT UPON YOU FOR SUPPORT? ☐ YES ☒ NO *(If "Yes," complete 23B)*	23B. NAME AND ADDRESS OF DEPENDENT FATHER	23C. IS YOUR MOTHER DEPENDENT UPON YOU FOR SUPPORT? ☐ YES ☒ NO *(If "Yes," complete 23D)*
23D. NAME AND ADDRESS OF DEPENDENT MOTHER	23E. NAME AND ADDRESS OF NEAREST RELATIVE [redacted]	23F. RELATIONSHIP OF NEAREST RELATIVE Mother

NATURE AND HISTORY OF DISABILITIES

24. NATURE OF SICKNESS, DISEASE OR INJURIES FOR WHICH THIS CLAIM IS MADE AND DATE EACH BEGAN

Nocturnal Bruxism, Clenching, TMJ pain.
Broken left pinky finger

25A. ARE YOU NOW OR HAVE YOU BEEN HOSPITALIZED OR FURNISHED DOMICILIARY CARE WITHIN THE PAST 3 MONTHS? ☐ YES ☒ NO *(If "Yes," complete 25B and 25C)*	25B. DATES OF HOSPITALIZATION OR DOMICILIARY CARE	25C. NAME AND ADDRESS OF INSTITUTION

NOTE: Items 26, 27, and 28 need NOT be completed unless you are now claiming compensation for a disability incurred in service.

IF YOU RECEIVED ANY TREATMENT WHILE IN SERVICE, COMPLETE THE FOLLOWING INFORMATION

26A. NATURE OF SICKNESS, DISEASE OR INJURY	26B. DATES OF TREATMENT	26C. NAME, NUMBER OR LOCATION OF HOSPITAL, FIRST-AID STATION, DRESSING STATION OR INFIRMARY	26D. ORGANIZATION AT TIME SICKNESS, DISEASE OR INJURY WAS INCURRED
Bruxism, Clenching TMJ Pain	Nov 1985 to Jan 1990	NRMC, MCAS El Toro Dental, MCAS EL Toro	MCAS EL Toro Santa Ana, California 92709
Broken pinky Finger	Jan 1988	NRMC, MCAS EL Toro	MCAS EL Toro Santa Ana, Ca. 92709

COPY MADE BY VA RMC, ST LOUIS, FROM A RECORD IN ITS POSSESSION

LIST CIVILIAN PHYSICIANS AND HOSPITALS WHERE YOU WERE TREATED FOR ANY SICKNESS, INJURY OR DISEASE SHOWN IN ITEM 26A, BEFORE, DURING OR SINCE YOUR SERVICE, AND ANY MILITARY HOSPITALS SINCE YOUR LAST DISCHARGE

27A. NAME	27B. PRESENT ADDRESS	27C. DISABILITY	27D. DATE
J. E Tueller, LCDR, MC, USN	NRMC MCAS El Toro Santa Ana, Ca. 92709		May 1988
John E. Leffert, CWO4, PA-C USN	NRMC MCAS El Toro Santa Ana, Ca 92709		June - Oct 1988
Gregg M. Baringoldz, LT MSC, USNR	Naval Hospital Long Beach, Ca		Jan 88 - Nov 89

LIST PERSONS OTHER THAN PHYSICIANS WHO KNOW ANY FACTS ABOUT ANY SICKNESS, DISEASE OR INJURY SHOWN IN ITEM 26A, WHICH YOU HAD BEFORE, DURING OR SINCE YOUR SERVICE

28A. NAME	28B. PRESENT ADDRESS	28C. DISABILITY	28D. DATE

IF YOU CLAIM TO BE TOTALLY DISABLED *(Complete Items 29A through 32E)*

29A. ARE YOU NOW EMPLOYED?

29B. IF YOU WERE SELF-EMPLOYED BEFORE BECOMING TOTALLY DISABLED, WHAT PART OF THE WORK DID YOU DO?

29C. DATE YOU LAST WORKED

29D. IF YOU ARE STILL SELF-EMPLOYED WHAT PART OF THE WORK DO YOU DO NOW?

30A. EDUCATION *(Circle highest year completed)*

1 2 3 4 5 6 7 8 (GRADE SCHOOL) 1 2 3 4 (HIGH SCHOOL) 1 2 3 4 (COLLEGE)

30B. NATURE OF AND TIME SPENT IN OTHER EDUCATION AND TRAINING

LIST ALL YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, FOR ONE YEAR BEFORE YOU BECAME TOTALLY DISABLED

31A. NAME AND ADDRESS OF EMPLOYER	31B. KIND OF WORK	31C. MONTHS WORKED	31D. TIME LOST FROM ILLNESS	31E. TOTAL EARNINGS

LIST ALL YOUR EMPLOYMENT, INCLUDING SELF-EMPLOYMENT, SINCE YOU BECAME TOTALLY DISABLED

32A. NAME AND ADDRESS OF EMPLOYER	32B. KIND OF WORK	32C. MONTHS WORKED	32D. TIME LOST FROM ILLNESS	32E. TOTAL EARNINGS

NET WORTH OF VETERANS AND DEPENDENTS *(See attached Instructions for Items 33A to 33E inclusive)*

NOTE: Items 33A through 33E should be completed ONLY if you are applying for non-service-connected pension.

ITEM NO.	SOURCE	AMOUNTS				
		VETERAN	SPOUSE	NAME OF CHILD(REN)		
33A.	STOCKS, BONDS, BANK DEPOSITS	$	$	$	$	$
33B.	REAL ESTATE *(Do not include residence)*					
33C.	OTHER PROPERTY					
33D.	TOTAL DEBTS					
33E.	NET WORTH	$	$	$	$	$

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INCOME RECEIVED AND EXPECTED FROM ALL SOURCES

NOTE: Items 34A through 39B should be completed ONLY if you are applying for non-service-connected pension.

34A. HAVE YOU OR YOUR SPOUSE APPLIED FOR OR ARE YOU RECEIVING OR ENTITLED TO RECEIVE ANY BENEFITS FROM THE SOCIAL SECURITY ADMINISTRATION (OTHER THAN SSI) OR RAILROAD RETIREMENT BOARD?	34B. MONTHLY AMOUNT (Include Medicare Deduction)		34C. BEGINNING DATE	34D. DATE YOU EXPECT BENEFITS TO BEGIN
	VETERAN	$		
	SPOUSE	$		
☐ YES ☐ NO (If "Yes," complete Items 34B through 34F as applicable)	34E. WILL YOU OR YOUR SPOUSE APPLY FOR EITHER BENEFIT DURING THE NEXT 12 MONTHS? ☐ YES ☐ NO		34F. DATE OF INTENTION TO APPLY	
			VETERAN	SPOUSE

35A. HAVE YOU OR YOUR SPOUSE APPLIED FOR OR ARE YOU RECEIVING OR ENTITLED TO RECEIVE ANNUITY OR RETIREMENT BENEFITS OR ENDOWMENT INSURANCE FROM ANY OTHER SOURCE?

☐ YES ☐ NO *(If "Yes," complete Items 35B through 35E, as applicable)*

35B. MONTHLY AMOUNT		35C. BEGINNING DATE	35D. DATE OF INTENTION TO APPLY	35E. SOURCE OF BENEFIT
VETERAN	$			
SPOUSE	$			

SOURCE OF VETERAN AND DEPENDENTS INCOME (Specify source for Items 36F, 37F and 38F "ALL OTHER INCOME" in Item 40, "REMARKS")		AMOUNT OF INCOME				
		VETERAN	SPOUSE	NAME OF CHILD/REN		
36. AMOUNT RECEIVED FROM JAN 1 TO THE DATE YOU SIGN THIS STATEMENT	A. EARNINGS	$	$	$	$	$
	B. SOCIAL SECURITY (GREEN CHECK)					
	C. OTHER ANNUITIES AND RETIREMENTS					
	D. DIVIDENDS AND INTEREST, ETC.					
	E. SUPPLEMENTAL SECURITY INCOME (GOLD CHECK)					
	F. ALL OTHER INCOME					
37. AMOUNT EXPECTED FROM DATE YOU SIGN THIS STATEMENT TO END OF THIS CALENDAR YEAR	A. EARNINGS					
	B. SOCIAL SECURITY (GREEN CHECK)					
	C. OTHER ANNUITIES AND RETIREMENTS					
	D. DIVIDENDS AND INTEREST, ETC.					
	E. SUPPLEMENTAL SECURITY INCOME (GOLD CHECK)					
	F. ALL OTHER INCOME					
38. AMOUNT EXPECTED FOR THE NEXT CALENDAR YEAR	A. EARNINGS					
	B. SOCIAL SECURITY (GREEN CHECK)					
	C. OTHER ANNUITIES AND RETIREMENTS					
	D. DIVIDENDS AND INTEREST, ETC.					
	E. SUPPLEMENTAL SECURITY INCOME (GOLD CHECK)					
	F. ALL OTHER INCOME					

39A. GROSS AMOUNT OF FINAL PAY RECEIVED	39B. DATE FINAL PAY WAS RECEIVED
$	

40. REMARKS *(Identify your statements by their applicable item number. If additional space is required, attach separate sheet and identify your statements by their item numbers)*

NOTE: Filing of this application constitutes a waiver of military retired pay in the amount of any VA compensation to which you may be entitled. See instructions for Items 14A and 14 D inclusive, Retired Pay.

CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION - I certify that the foregoing statements are true and complete to the best of my knowledge and belief. I CONSENT that any physician, surgeon, dentist or hospital that has treated or examined me for any purpose, or that I have consulted professionally, may furnish to the VETERANS ADMINISTRATION any information about myself, and I waive any privilege which renders such information confidential.

41. DATE SIGNED	42. SIGNATURE OF CLAIMANT
9 October 90	SIGN HERE [redacted]

WITNESSES TO SIGNATURES OF CLAIMANT IF MADE BY "X" MARK

NOTE: Signature made by mark must be witnessed by two persons to whom the person making the statement is personally known, and the signatures and addresses of such witnesses must be shown.

43A. SIGNATURE OF WITNESS	44A. SIGNATURE OF WITNESS
43B. ADDRESS OF WITNESS	44B. ADDRESS OF WITNESS

PENALTY - The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

COPY MADE BY VA RMC ST LOUIS, FROM A RECORD IN ITS POSSESSION

Department of Veterans Affairs

STATUS OF REQUEST FOR MEDICAL EXAMINATION

DATE 2/12/91

TO	CHIEF, MEDICAL ADMINISTRATION SERVICE VAMC 688/136	FROM	ADJUDICATION OFFICER VETERANS ADMINISTRATION Regional Office 941 North Capitol Street, N.E. Washington, DC 20421

FIRST NAME-MIDDLE NAME-LAST NAME OF VETERAN	SOCIAL SECURITY NUMBER	VA FILE NUMBER
[redacted]	[redacted]	[redacted]

(✓)	We did not receive results of this veteran's examination. Please give us a status report in the space provided below. Our records concerning the examination request show:		DATE
X	VA FORM 21-2507 ISSUED	OTHER (Indicate how requested)	11-14-90
	PREVIOUS FOLLOW-UP BY ADJUDICATION DIVISION		

ADJUDICATION OFFICER J. Jensen

TO	ADJUDICATION OFFICER	DATE

EXAMINATION STATUS

PROJECTED COMPLETION DATE	SIGNATURE OF CHIEF, MEDICAL ADMINISTRATION SERVICE

VA FORM APR 1990 **21-4199**

EXISTING STOCK OF VA FORM 21-4199, AUG 1977, WILL BE USED.

☆ U.S.G.P.O.: 1990- 262-755/16974

COPY MADE BY VA RMC, ST LOUIS, FROM A RECORD IN ITS POSSESSION

Form Approved
OMB No. 2900-0052

Veterans Administration

REPORT OF MEDICAL EXAMINATION FOR DISABILITY EVALUATION

1A. FILE NO. C-

1B. VETERANS SOCIAL SECURITY NO. [redacted]

2. INSURANCE FILE NO. *(V.H.K., ect., if pertinent)*

INSTRUCTIONS TO THE VETERAN: Please complete all unshaded items on Page 1 of this form. Bring this form with you when reporting for the examination.

PRIVACY ACT INFORMATION - The information requested by this form is authorized by existing law (38 U.S.C. 210(C)(1)) and is considered relevant and necessary to determine entitlement to maximum benefits applied for under the law. Responses may be disclosed outside the VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22, Compensation, Pension, Education and Rehabilitation Records - VA, published in the Federal Register.

3. FIRST, MIDDLE, LAST NAME OF VETERAN *(Type or print)* [redacted]

4. PURPOSE OF EXAMINATION

5. DATE OF EXAMINATION

6. HOME ADDRESS *(Street or RFD Number, City, State, and ZIP Code)* [redacted]

7. PLACE OF EXAMINATION

8. AGE 24

SECTION A – OCCUPATIONAL HISTORY SINCE LATEST DISCHARGE FROM MILITARY SERVICE OR LATEST VA EXAMINATION

9. NAME AND ADDRESS OF EMPLOYER *(If unemployed enter "None")*	10. TYPE OF WORK	11. MONTHLY WAGES	12. DATES OF EMPLOYMENT FROM	TO	13. TIME LOST IN PAST 12 MONTHS
None					

14. REASON FOR TIME LOST *(If any)*

SECTION B – MEDICAL HISTORY SINCE LATEST VA EXAMINATION AS RELATED BY PERSON EXAMINED

15. NARRATIVE HISTORY *(Include manner and date of origin)*

Teeth grinding since 1986 and throughout service. ~~and~~

NAME AND ADDRESS OF DOCTOR OR HOSPITAL	CONDITION TREATED	FROM	TO
16A.			
16B.			
16C.			

17. PRESENT COMPLAINT *(Symptoms only, not diagnosis)*

Headaches, sore jaw, sleeplessness, toothaches

I HEREBY CERTIFY that the entries under Occupational and Medical History are complete and correct to the best of my knowledge.

18. DATE SIGNED [redacted]

19. SIGNATURE OF PERSON EXAMINED *(Do not print)*

PENALTY - The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

SECTION C – EXAMINATION (Examinee must be stripped)

INSTRUCTIONS TO THE EXAMINING PHYSICIAN: This report must be completely executed. Describe the results of a general examination of every system and body parts including but not restricted to the systems and body parts involved in the history and present complaints. Wherever indicated specialists' examinations, X-rays, laboratory examinations, ect., should be recommended. If additional space is needed, comments may be continued in Item 44 or on separate sheets attached to this form.

20. HEIGHT	21. WEIGHT	22. MAX. WT. PAST YEAR	23. BUILD AND STATE OF NUTRITION	24. TEMPERATURE
5' 11"	136 LBS.	136 LBS.	Well built and nourished	
25. CARRIAGE	**26. POSTURE**	**27. GAIT**	**28. RIGHT-OR LEFT-HANDED-HOW DETERMINED**	AT AM PM
N	N	N	Rt. Handed	

29. SKIN-INCLUDING APPENDAGES *(Describe type, area, and extent of lesions. Report injuries, including burns, under Item 41)*

Normal

30. LYMPHATIC AND HEMIC SYSTEMS *(Describe local or generalized adenopathy, enlargement, tenderness, suppuration, blocking of lymphatic circulation, etc.)*

No lymphadenopathy

31. HEAD, FACE, AND NECK

Normal

32. NOSE, SINUSES, MOUTH, AND THROAT *(Include gross dental findings)*

No sinusitis

33A. EARS *(Describe canals, drums, perforations, discharge)*

WNL

33B. HEARING LOSS NOTED

☐ YES

☑ NO

34A. EYES *(Describe external eye, pupil reaction, movements and field of vision)*

Pupils equal and react to light
Fundi normal

34B. DISTANT VISION

R 20/ CORRECTED TO 20/

L 20/ CORRECTED TO 20/

35A. CARDIOVASCULAR SYSTEM *(Describe thrust, size, rhythm, sounds, and condition of peripheral vessels)*

Heart Sounds L ✓ ¼ ✓ no murmur

Peripheral Pulses are normal

	(L)	(R)
Femoral	3+	3+
Popliteal	3+	3+
Dorsalis Pedis	3+	3+
Post. tibial	3+	3-

	35B. PULSE	35C. BLOOD PRESSURE	35D. RESPIRATION	35E. IF NOT EXERCISED, GIVE REASON
SITTING	78	S 116 D 74	16	
RECUMBENT	78	S 116 D 74	16	
STANDING	78	S 116 D 74	16	
SITTING AFTER EXERCISE		S D		
2 MIN. AFTER EXERCISE		S D		

36A. VARICOSE VEINS *(Describe location, size, extent, ulcers, scars, and competency of deep circulation)*

No Varicose Veins

36B. ARE ELASTIC STOCKINGS NECESSARY?

36C. IS OPERATION RECOMMENDED?

Attach Continuation Sheets, Specialists' Reports, Laboratory Reports, etc., in this space.

37A. RESPIRATORY SYSTEM *(Describe cough, expectoration, mobility, palpation, percussion, and auscultation and specify area)*

Lungs are Clear.

37B. SHAPE OF CHEST

N

37C. EXPIRATION

2 INCHES

37D. INSPIRATION

2 INCHES

38. DIGESTIVE SYSTEM *(Describe findings on inspection and palpation, enlargements, masses, tenderness, rigidity, hemorrhoids (internal or external), fissures, stricture, prolapse, etc.)*

Abd. Soft. Liver span 8 cm.
Bowel sounds are heard

39. HERNIA *(Describe type, location, size, whether complete, reducible, recurrent, retained by truss, and whether operable)*

no hernia

40. GENITO-URINARY SYSTEM *(Describe kidneys, bladder, prostate, seminal vesicles, testes, cord, penis, and appendages; evidence of past or present veneral disease; in females report pelvic exam., if indicated)*

41. MUSCULO-SKELETAL SYSTEM

(A-DISEASES and INJURIES, include effect of gunshot wounds and other injuries on skin and underlying structures. N

B-SCARS, describe location, measurements, depression, type of tissue loss, adherence, disfigurement, and tenderness. N

C-FUNCTIONAL EFFECTS, describe location, swelling, astrophy, tenderness, degree of limitation of flexion and extension, angle of fixation, fracture disease, fibrous or bony residual, and specify mechanical aid used and benefit. N

No Weakness
of any abnormality
(Lt) Pink toe

D-FEET, describe objective evidence of pain at rest and on manipulation, rigidity, spasm, circulatory disturbance, swelling, callus, strength, mobility of ankles, feet, toes, and limitation in degrees and indicate whether right or left, acquired or congenital. N

E-BURNS, degree and area in square inches.) N.

42. ENDOCRINE SYSTEM *(Describe disease of thyroid, pituitary, adrenals, pancreas, gonads, etc.)*

No endocrine abnormalities.

43. NERVOUS SYSTEM

(A-NEUROLOGICAL, describe motor status, coordination, reflexes, sensory status, equilibrium, and give exact location.

B- PSYCHIATRIC and PERSONALITY, describe behavior, comprehension, coherence of response, emotional reaction, orientation, memory, signs of tension and status as to social and industrial capacity.)

Motor Tone Reflex normal
Power

44. REMARKS *(Cite number of item continued in this space)*

Negative for Rt
Kernicterus
Ann A/L
1/9/91

45A. LABORATORY TESTS, X-RAYS, BMR, EKG, ETC.	45B. DATE MADE	45C. URINALYSIS		
		SPECIFIC GRAVITY	ALBUMIN	SUGAR
		MICROSCOPIC		

45D. OTHER TESTS RECOMMENDED, ETC.

46. DIAGNOSIS

Med. Physical examination normal
No Wideness of any Residual effect in (Lt) Pink Sign

47A. IS EXAMINEE BEDRIDDEN?	47B. IS HOSPITALIZATION NEEDED?	47C. WILL EXAMINEE ACCEPT HOSPITALIZATION?
48A. IS EXAMINEE ABLE TO TRAVEL?	47B. ALONE?	48C. WITH ATTENDANT?

49. SPECIALISTS EXAMINATIONS RECOMMENDED

50. SIGNATURE OF PHYSICIAN [signature] MD	NAME AND SPECIALTY *(Type or print)* M.A. MANIPADY Inter Medicine	DATE SIGNED 12-11 90.
51. SIGNATURE OF PHYSICIAN	NAME AND SPECIALTY *(Type or print)*	DATE SIGNED
52. SIGNATURE OF PHYSICIAN	NAME AND SPECIALTY *(Type or print)*	DATE SIGNED
53. SIGNATURE OF REVIEWING OFFICER	NAME AND TITLE *(Type or print)*	DATE SIGNED

54. ATTACHMENTS MADE A PART OF THIS EXAMINATION *(List by number or describe)*

☆ U.S. GPO: 1989-241-638/92593

Department of Veterans Affairs

NAME AND ADDRESS OF FACILITY

VETERANS ADMINISTRATION

ORAL EXAMINATION FINDINGS AND TREATMENT RECOMMENDATIONS

LEGEND

O – Caries Restorable
/ – Non-Restorable
X – Missing
XXX – Replaced by Denture
[3XX6] – Replaced by Bridge

RIGHT

1	2	3	A 4	B 5	C 6	D 7	E 8	F 9	G 10	H 11	I 12	J 13	14	15	16
32	31	30	T 29	S 28	R 27	Q 26	P 25	O 24	N 23	M 22	L 21	K 20	19	18	17

lost Alloy/E

LEFT

TOOTH NO.	SURFACES	TREATMENT RECOMMENDATIONS	CLINICAL FINDINGS AND REMARKS (Include statement of teeth extracted while in Service for Class II)
1	O	Alloy Prophylaxis	Rating Exam
2			A-24 Y.O.W.F C/o "sore jaws in AM upon
3			waking ... grinding and clinching teeth.
4			headaches". Pt states that problems bega
5			during "boot camp ... and never get
6			better." She describes and points to
7			bilateral temple and masseter areas
8			for AM pain and temples for HA.
9			Pt also claims that she now has
10			anterior open-bite and "overbite" on
11			(L) side that was not there before.
12			she states that the military treated
13			her w/ "grinding teeth on lower (12)"
14			and fabricating a "soft" nite guard
15	O	Alloy	furthermore she C/o still using nit.
16	DB	Alloy / Ext	guard made in 1988 and that it
17			causes her to "chew on it." Pt
18			denies Hx of ortho Tx or having
19			Dx or Tx outside military or since
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30	O, B	Alloy	
31	D	Alloy	
32			

ROENTGENOGRAMS (No. of exposures)			SIGNATURE OF EXAMINING DENTIST AND DATE
PERIAPICAL	BITE-WING	PANORAMIC	12/11/90 (Welch)
		1	

VA REGULATION 6123 CLASS _____

DENTAL TREATMENT NOT LINED OUT IS APPROVED
(Signature of Chief, Dental Service and date)

PRINT BENEFICIARY'S NAME, IDENTIFICATION NUMBER, CURRENT ADDRESS, ZIP CODE AND TELEPHONE NO.

[redacted]

DENTAL TREATMENT IS ☐ IS NOT ☐
CONSIDERED NECESSARY AS ADJUNCT TO MEDICAL DISABILITY OF:

SIGNATURE AND DATE

VA FORM OCT 1989 **10-2570** EXISTING STOCK OF VA FORM 10-2570, OCT 1980, WILL BE USED.

VA STAFF DENTAL OUTPATIENT RECORD

03266

DATE	RECORD OF TREATMENT BY VA STAFF DESCRIPTION OF TREATMENT	SIGNATURE
Contd.	DC in 1/90. Panograph indicates 32 teeth well formed w/o apparent bone loss or overt pathology. Both condyles are mostly visible and appear WNL. The Pt has 8 small to mod. alloy restorations. Examination shows soft tissues WNL. No muscle soreness found w/ definite effort to local (+) response. Caries and lost/Fx alloy #16 noted. Mobility (-) acute or chronic periodontitis (-) Oral care good w/ mild plaque and isolated mild bleeding upon probing. Occlusion: CO ≠ CR w/ (L) side centric prematurities. Bilat. group function w/ apparently even distribution of wear and anterior open bite 2nd to group function. (R) lat. movement w/ group function and 1° balancing side contacts. (L) lat. movement as pt. locked and unable to move completely to (L). Midline is off but no rotational deviation. No apparent TMJ noise or symptoms (pain etc) Some impression that (R) Masseter is more well developed. Impression: Developmental, functional occlusion w/o overt pathology. Pt stress (own admission) may have ↑ level and ↓ awareness of bruxism. Do not consider condition 2° to military duty. Recom. Tx. (1) Pt ed. as to situation (briefly done) (2) Conservative Tx only w/ caution about any recommended advanced Tx.	
	(Welch)	12/11/90

Diplomate, American Board of Prosthodontics

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