Reg 402
0381

NAVAL HOSPITAL, CAMP LEJEUNE — DIVISION, CAMP GEIGER, [illegible]
Personal data - Privacy Act of 1974 [illegible] — Automated Version of SF[illegible]
Printed [illegible] Sep 1990 [illegible]

CAMP GEIGER [illegible] MCDONNELL, JAMES A [illegible] Sep 1990 [illegible]
REF: UNIT [illegible]
RSN: SLEEPING DISORDER

BP: 100/72 PULSE: 84 RESP: 12 TEMP: 97.4 HT: — WT: —

ADDITIONAL COMMENTS (POC Sgt. Schroeder)

ALLERGIC TO: NKDA
MEDS: Ø

MOS: 0311

PATIENT/RESPONSIBLE OTHER: INSTRUCTED ON See below AND VERBALIZES UNDERSTANDING. COPY OF TEACHING STANDARD GIVEN TO PATIENT. YES ____ NO ____
PROVIDER ____ DATE ____

S/ 21 y.o. wm presents for c/o
(1) migraine
(2) ~~sleeping difficulty~~ daytime sleeping

states no difficulty sleeping at night and claims adequate hours of sleep, however state he easily falls asleep during daytime hours - states can occur while sitting, standing, etc. - never actually falls down (per patient)

Ø known Hx narcolepsy or sleep apnea; denies depression or past psych Hx; ⊕ Hx febrile seizures as infant, but none since then; Ø Hx head trauma c̄ LOC; Ø Hx cardiopulmonary disease

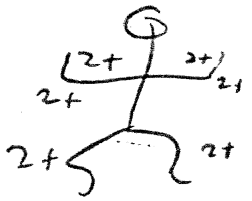
Fam Hx ⊖ for thyroid + cardiovascular disease; difficulty has occurred as long as the pt. can remember; denies dissatisfaction c̄ USMC

meds - rare ASA
ETOH - rare
tobacco - chews 3-4 cans per week
caffeine - rare

O/ A+O x4 in NAD
PERRLA EOMI Ø nystagmus fundi nl
TM's clear
mouth/throat - clear
neck - supple Ø CAD or thyromegaly
lungs - CTA
ht - reg rate; nl S_1, S_2 Ø S_3 S_4 or ⊖
abd - benign
skin - several raised, minimally erythematous patches on neck and abdomen
extr. Ø C/C/E

cont

Neuro - CN II - XII intact
motor 5/5
sensory intact
FTN normal



A/ ① daytime hypersomnolence - r/o exam
② narcolepsy

P/ ① will contact Sgt Schroeder (msg left) to get his input with the problem.
② Lotrisone cream AAA bid.
③ will F/u c pt after conversation c Sgt Schroeder

09 Sep 93
conversation c Sgt Schroeder states pt falls asleep briefly during P.T. (both over position), classes, in formation standing; never falls over or falls to ground.

10 Sep 93 - discussed c Dr. Yeskes - recommended consider absence seizures, consider sleep disorder (apnea) - recommend Neuro consult to consider EEG, sleep studies - consider speaking c parents to assess sleeping pattern / any problem as youngster - rec - labs to include TFT's, CBC, SMA 18, U/A
spoke c CpySgt Smith to have P.T. humble report to clinic next week.

J. McDonell MD
J. A. M[illegible]
LT [illegible]
S[illegible]

513–110 NSN 7540-00-634-4127

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: ENT

FROM: (Requesting physician or activity) 3/2

DATE OF REQUEST 14 Feb 95

REASON FOR REQUEST (Complaints and findings)

Daytime drowsiness, wakes up during nights (wife sometimes wakes him due to snoring). Chronic ↓ nasal passage air flow. Fam. Hx of airway related sleep apnea in father + brother. Please eval for sleep apnea.

PROVISIONAL DIAGNOSIS

Sleep apnea due to airway anatomy.

DOCTOR'S SIGNATURE: JAMES M. MICK, LT, MC, USNR, 2AA 286-72-2704

APPROVED

PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL

☑ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO

PATIENT EXAMINED ☐ YES ☐ NO 23 y/o

3 Apr 95 0930 Dr B.

DATE: 03 APR 95
APPT. TIME: 0930
TIME ARRIVED: 0905
DR: Bonacquisti
ENT CLINIC
NMC/CLNC

HPI: sleeps 4–8° (<8° x2/wk)
⊕ AM exhaustion
⊕ daytime hypersomnolence
⊕ falls asleep driving to/from work – pt has totalled a truck running off the road ~3y ago
⊖ ⊕ AM HAs
⊕ hard snorer.
* Pt has fallen asleep while marching 4/93 – neuro ⓒ rec'd but not done
Sm, except for snoring, have been present his whole life.

PMH – ∅
PSH ∅
Rx ∅
NKDA

SH – tob 1 can/day x [illegible]
EtOH. 2 glasses wine Q 2 months.

ROS – Wt 175#
Ht 6'0"

Focused PE – NC slows.
NR – clear
NP – nl short palate; tonsils 1+–2B/L; ~ Class ?
HP – nl with TVC

(Continue on reverse side)

A) ① snoring ? OSA
② the above suggests narcolepsy, absence sz, etc ... need to rule out c/ before eval for OSA

P/ ① pt advised not to drive, also op machinery.
② [illegible]

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 facility)

Kimble Ronnie L.
20/
USMC/AD/Lcpl
3/2 I co. 3rd plt

ph: 3968
Male
DOB: 17 1 ...

WH# 3948/2136

~~[illegible]~~

U.S. GPO: 1994-361-953

CONSULTATION SHEET
Medical Record
STANDARD FORM 513 (REV. 8-94)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

513-110

NSN 7540-00-634-4127

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: Neuro

FROM: (Requesting physician or activity) ORL

DATE OF REQUEST: 4/3/95

REASON FOR REQUEST (Complaints and findings): 23 yo (W) ♂ c lifelong an exhausting daytime fatigue (poss. c/w OSA) but also falls asleep while standing! ⊕ MVA 2° falling asleep while driving @ 19 yo. pt 6', 175# & nl pharyngeal anatomy.

PROVISIONAL DIAGNOSIS: ? narcolepsy, absomnia? x2181

DOCTOR'S SIGNATURE: K. A. BONACQUISTI LCDR, MC, USNR/OTO-HNS

APPROVED

PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL ☑ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT Recieved: 03APR95 HR Sherman

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO

Confirmed Appt Pt ē go to time of 2300 & Wake at 0515 (pt not late to work, uses 3 alarms when wife not with him). SL short. 1330 20 Apr 95. Wakes 0800-09 on weekends. [illegible] has fallen asleep [illegible]

Pt gives 5 yr+ Hx of some tendency to daytime sleepiness & he's unaware of any change; he thinks this is independent of TST at night. When he naps in the day he doesn't recall dreaming. In driving (trips) he will stop briefly. Pt has PMH of falling asleep x1 driving 4 years ago. No Hx sleep paralysis. H. halluc & ans. No Hx of cataplexy. Pt snores when sleeps on back, also pt has Hx of kicking wife in sleep; occ sitting up for which he has no recall (incl. if engaged in conversation).

Pt has occ tension HA & 4 syncopal episodes he related to sleep. PMH of febrile Sz as child. No other significant neuro Sx. Occ sl hand tremor (esp after working long day).

EXAM - alert ē normal station, gait, speech. CN - 0 ∑. Motor - trace tremor (B) hand on extension. RH pt. Sens/cerebellar ok. Reflexes symmetrical.

Imp 1) Excessive daytime sleepiness ē possible periodic limb movements. Doubt narcolepsy. 2) R/O positional apnea

Rec 1) Schedule for MSLT after PSG (bottle) PNH 2) Pt given sleep diary instructions and will return in 2 weeks. May allow pt to drive? Rec [illegible] schedule

(Continue 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 facility)

Kimble Ronnie L 17 JAN 72

201 GW Ph 3968

USMC/AD/LCPL H 7776

DE BECK, T.W., NEUROLOGIST
CDR, MC, USNR
217-34-0988
NAVHOSP CAMP LEJEUNE

U.S.GPO:1994-352-955

CONSULTATION SHEET
Medical Record
STANDARD FORM 513 (REV. 8-92)

513-110 NSN 7540-00-634-4127

MEDICAL RECORD — CONSULTATION SHEET

REQUEST

	FROM: (Requesting physician or activity)	DATE OF REQUEST
neurology, Seymour Johnson AFB	BS 3/2	7 Apr 95

REASON FOR REQUEST (Complaints and findings)

SVM TMO to your next Rec to Family Problems ~~AFSC~~. Sx suggestive of Narcolepsy or Absence Seizures. requires w/u prior to return to duty.

PROVISIONAL DIAGNOSIS

Narcolepsy vs. Absence S2.

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	
		☐ BEDSIDE ☐ ON CALL	☒ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO

(Continue 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 facility)*

Kimble Ronnie DOB: 17 Jan 72
1D cmc cupl
eg

3126

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 8-92)

...EUROLOGY CLINIC DEBECK,THOMAS W , 27 Jul 1995 1257 FU BAKA
...N CMT: 19B
...SN:

...P: PULSE: RESP: TEMP: HT: WT:

ADDITIONAL COMMENTS:

A has had MSLT/PSG. called PNH and results not yet done.

Sleep situation unchanged. no close calls on drive from greensboro to camp this evening. He states he knows when to stop.

Will see next week or whenever results are in hand.

T W DeBeck MD

...GY KIMBLE,RONNIE LEE M11
17 Jan 1972 MALE W:3210 H:910-697-2687
Spon: KIMBLE,RONNIE LEE CIC:

Personal Da - Privacy Act of 1974 (P 3-579)
L TIENT CUMULATIVE REPORT

IMBLE,RONNIE LEE M/23 ph# 910-697-2687

i /Spec: BLOOD --CBC & DIFFERENTIAL--

ate oll	27Jul95 @0909	Units	Normal Range
BC	4.4 L	K/CMM	4.5-11.0
BC	4.87	M/cmm	4.7-6.1
GB	13.9	g/dL	13.9-16.3
CT	41.3	%	39-55
CV	84.8	uG3	80-100
CH	28.5	pg	27-31
CHC	33.5	gm/dL	33-37
BC Distributn	12.6	%	11.5-14.5
ean PLT Volume	9.4	mu3	7.2-11.1
LATELET COUNT	245	K/cmm	145-450
eUT,%	47.9 L	%	50-70
YMPH,%	34.8	%	19.0-48.0
ONO,%	11.3 H	%	1-6
OS %	3.1	%	1-5
ASO,%	2.9 H	%	0-1.5

[illegible] WOODRUF
[illegible] Loc: A

[illegible] ,**5@0909
[illegible] Comment:
LBC Comment:
LIGHTHEADED, SLEEPY

ite/Spec: SERUM --GENERAL CHEMISTRY--

ate oll	27Jul95 @0909	Units	Normal Range
LUCOSE	82	mg/dL	75-110
REA NITROGEN	17	MG/DL	9-21
REATININE	1.10	mg/dL	.8-1.5
ODIUM	145	MMOL/L	138-146

Continued on next page

=NH CAMP LEJEU

=lo H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc

O/ KIMBLE,RONNIE LEE M/23
ec Loc: BLDG 15 - FILE
il.Unit: A COMPANY HQSPTBN
ank: LANCE CORPORAL OUTPATIENT

Personal Da - Privacy Act of 1974 (P 93-579)
D ATIENT CUMULATIVE REPORT

IMBLE,RONNIE LEE M/23 ph# 910-697-2687

/Spec: SERUM --GENERAL CHEMISTRY--

ate	27Jul95		
oll	@0909	Units	Normal Range
OTASSIUM	4.6	MMOL/L	3.6-5.0
HLORIDE	101	MMOL/L	101-111
ARBON DIOXIDE	30	MMOL/L	22-31

eq.
CP: WOODRUF
ab Loc: A

7 Jul 1995@0909
der Comment:
CHEM 7 Comment:
LIGHTHEADED, SLEEPY

terpretations: GLU
OB PATIENTS PANIC LOW IS 40 mg/dl AND PANIC HIGH IS 300 mg/dl.

NH CAMP LEJEU

lo H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc

/: KIMBLE,RONNIE LEE M/23
c Loc: BLDG 15 - FILE
l.Unit: A COMPANY H@SPTBN
nk: LANCE CORPORAL OUTPATIENT

MBLE,RONNIE LEE M/23 ph# 910-697-2687

te/Spec: SERUM --THYROID FUNCTION TESTS--

te 27Jul95 ll @0909	Units	Normal Range
H 0.89	uIU/ml	0-7.01

q.
P: WOODRUF
b Loc: A

Jul 1995@0909
der Comment:
THYROID Comment:
LIGHTHEADED, SLEEPY

ite/Spec: All --Misc. Results (Replaces SF 557)--

llected Test	Result	Units	Normal Range	Spec.	Req.P
Jul95@0909 FT4	1.30	NG/DL	0.71-1.85	SERUM	WOODR

Order Comment:
GHTHEADED, SLEEPY
aboratory Loc: NH CAMP LEJEUNE LAB

=lo H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc

0/ KIMBLE,RONNIE LEE M/23
ec Loc: BLDG 15 - FILE
il.Unit: A COMPANY HQSPTBN
k: LANCE CORPORAL OUTPATIENT

IBLE,RONNIE LEE M/24 ph# 910-697-2687

--BACTERIOLOGY REPORT--

Phys : MEYER,RAY A
t: THROAT CULTURE
lected: 01Apr96@0836
orted :

Acc #: 960401 MI 4552
Site/Spec: THROAT (PHARYNX)
Lab Location: NH CAMP LEJEUNE LAB

tus: FINAL
teriology Result(s): NORMAL ORAL FLORA. BMA

o H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc I=interm

VHOSP CAMP LEJEUNE NC 08 Mar 1996@0112
Personal Data - Privacy Act of 1974 (PL 93-579)
OUTPATIENT CUMULATIVE REPORT

MbLE,RONNIE LEE 20/240-47-9667 M/24 ph# 910-697-2687

---

ce/Spec: All --Misc. Results (Replaces SF 557)--

llected	Test	Result	Units	Normal Range	Spec.	Req.HCP

Order Comment:
BASE CHAPLIN
Laboratory Loc: NH CAMP LEJEUNE LAB

---

o H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc I=interm

==========

KIMBLE,RONNIE LEE M/24
c Loc: BLDG 15 - FILE
Unit: A COMPANY HQSPTBN
nk: LANCE CORPORAL OUTPATIENT

MBLE,RONNIE LEE 20/240-47-9667 M/23 ph# 910-697-2687

te/Spec: SERUM --THYROID FUNCTION TESTS--

te	27Jul95		
ll	@0909	Units	Normal Range
H	0.89	uIU/ml	0-7.01

q.
P: WOODRUF
b Loc: A

Jul 1995@0909
der Comment:
THYROID Comment:
LIGHTHEADED, SLEEPY

te/Spec: All --Misc. Results (Replaces SF 557)--

llected	Test	Result	Units	Normal Range	Spec.	Req.H
Jul95@0909	FT4	1.30	NG/DL	0.71-1.85	SERUM	WOODR

Order Comment:
l HTHEADED, SLEEPY
Laboratory Loc: NH CAMP LEJEUNE LAB

lo H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc

KIMBLE,RONNIE LEE M/23
c Loc: BLDG 15 - FILE
l.Unit: A COMPANY HQSPTBN OUTPATIENT
r LANCE CORPORAL

Personal Da' - Privacy Act of 1974 (PI 93-579)
Do ATIENT CUMULATIVE REPORT

MBLE,RONNIE LEE 20/240-47-9667 M/23 ph# 910-697-2687

Spec: SERUM --THYROID FUNCTION TESTS--

te 27Jul95
ll @0909 Units Normal Range

H 0.89 uIU/ml 0-7.01
q.
P: WOODRUF
b Loc: A

Jul 1995@0909
der Comment:
THYROID Comment:
LIGHTHEADED, SLEEPY

te/Spec: All --Misc. Results (Replaces SF 557)--

llected Test Result Units Normal Range Spec. Req.H

Jul95@0909 FT4 1.30 NG/DL 0.71-1.85 SERUM WOODR
Order Comment:
IGHTHEADED, SLEEPY
oratory Loc: NH CAMP LEJEUNE LAB

lo H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc

). KIMBLE,RONNIE LEE M/23
ec Loc: BLDG 15 - FILE
il.Unit: A COMPANY H@SPTBN
ank: LANCE CORPORAL OUTPATIENT

RADIOLOGIC EXAMINATION REPORT

Patient: KIMBLE,RONNIE LEE EMP/SSN: 20/240-47-9667

M _EJEUNE NAVAL HOSPITAL MAGNETIC RESONANCE IMAGING
ocedure: MRI,BRAIN (W W/O CONTRAST) Exam Date: 12 Jun 1996@1123
quested by: CZANDER,ERIC W Status: COMPLETE
d/Clinic: NEUROLOGY CLINIC Exam #: 96034241
Pregnant:

ison for Order:
yo male with increasing hypersomnolence without LOC

ler Comment:
mass

ult Code: See Report Text

ort:

BRAIN:
Magnetic resonance imaging of the brain was performed using routine protocol. Additionally, T-1 weighted axial images were obtained following intravenous gadolinium administration. The ventricles, sulci and cisterns are symmetric and normal in appearance for age. There is no intracranial mass or hemorrhage. No focal parenchymal abnormalities are identified. There are no areas of abnormal contrast enhancement. Posterior fossa contents including the brain stem and cerebellum are normal. Normal vertebrobasilar and internal carotid flow voids are identified.

IMPRESSION: 1. Normal MRI examination of the brain.

Transcription Date/Time: 13 Jun 1996@1046

Interpreted by: FRANCIS G. CURTIN, LCDR MC USNR

Approved by: FRANCIS G. CURTIN, LCDR MC USNR 13 Jun 1996@1241

KIMBLE,RONNIE LEE
17 Jan 1972 / MALE
Loc:
Spon: KIMBLE,RONNIE LEE
Unit: 3DBN 2NDMAR

USMC ACTIVE DUTY
H:910-697-2687 W:3210

Rank: LANCE COR D:3210
RR: BLDG 15 - FILE

-B

17 Mar 1997@2007

NAVMEDCEN PORTSMOUTH VA

Personal Data - Privacy Act of 1974 (PL 93-579)

OUTPATIENT CUMULATIVE REPORT Report ID:POUT_0317

KIMBLE,RONNIE 20/240-47-9667 M/25 ph# (910) 697-00

Site/Spec: All --Misc. Results (Replaces SF 557)--

Collected	Test	Result	Units	Normal Range	Spec.	Req.HCP
0Mar97@0957	CAT HAIR	0/I	CLASS	SeeBelow	SERUM	STOCK,M
0Mar97@0957	DOG DANDE	NEG	CLASS	SeeBelow	SERUM	STOCK,M
0Mar97@0957	SCOR SYST	SeeBelow			SERUM	STOCK,M
0Mar97@0957	GRASS MIX	NEG	CLASS	SeeBelow	SERUM	STOCK,M
0Mar97@0957	HSDUSTMIX	IV H	CLASS	SeeBelow	SERUM	STOCK,M
0Mar97@0957	MOLD MIX	NEG	CLASS	SeeBelow	SERUM	STOCK,M
0Mar97@0957	TREE MIX	NEG	CLASS	SeeBelow	SERUM	STOCK,M
0Mar97@0957	WEED MIX	NEG	CLASS	SeeBelow	SERUM	STOCK,M

Laboratory Loc: NMCP PATHOLOGY LABORATORY

Interpretations: SCOR SYST

F/N MRT Scoring System -- 5 Fold

CLASS	Adj Counts	Interpretation
NEG	< 501	Negative
0/I	501 - 750	Equivocal
I	751 - 1600	Positive with increasing amounts of specific IgE antibody.
II	1601 - 3600	"
III	3601 - 8000	"
	8001 - 18000	"
V	18001 - 40000	"
VI	> 40000	"

Test performed at: Commonwealth Medical Laboratories, Inc.
11150 Main Street, Suite 550
Fairfax, VA 22030

L=lo H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc I=interm

KIMBLE,RONNIE M/25

O/P Rec Loc: LOCATION IN AN

Unit: qqtrs supbatS 3RDMARDIV OUTPATIENT

Rank: CORPORAL

ommonwealth Medical Laboratories, Inc.
11150 Main Street, Suite 550
Fairfax, VA 22030

MODIFIED RAST ASSAY

Patient Kimble, RonniePB51

Patient ID	A125	Sample ID	
Cust. ID		Physician	Navy *NAVY
Age		Sex	M
Date Drawn		Time Drawn	
Date Recd.		Time Recd.	

	Allergen	Class	Adj Counts
GX2	Grass Mix.....	Neg	341
MX1	Mold Mix.....	Neg	140
HX2	House Dust Mix.....	IV	10413
E1	Cat Hair.....	0/I	667
E2	Dog Epithelium.....	Neg	197
TX1	Tree Mix.....	Neg	393
WX2	Weed Mix.....	Neg	358

F/M MRT Scoring System — 5 Fold

Class	Adj Counts	Interpretation
Neg	(501	Negative.
0/I	501 - 750	Equivocal.
I	751 - 1500	Positive with
	1501 - 3500	increasing
.+I	3501 - 8000	amounts of
IV	8001 - 18000	specific IgE
V	18001 - 40000	antibody.
VI	) 40000	

Assay Documentation

Run ID	031397
Date	Mar 15,1997
Technologist	Brenda

Calibrator and Controls

Total Counts	39861
25 IU/ml Cal.	24999
Neg. Control	125
Pos. Control	19577
Cal. Factor	0.952
Neg. Cutoff	500

Personal Data - Privacy Act of 1974 (PL 93-579)

Lab Certified Result Notification

Report requested by: System Generated

[redacted],ACHNIE -- M/21 Mil. Unit: BASE, ALPHA CO, ITP Enr#

Entered by: KENDRICK,MARY S Col: 23 Sep 1993@1322 Acc#: 930923 BTG 25

Specimen: THROAT (PHARYNX) Pri: ROUTINE Src#: 930923-02040

Resulting Lab: LABCB Req Loc: LABCB

Order comment: R/O STREP POS. TREATMENT

THR C&S: Final Report

BACTERIOLOGY result(s): FINAL REPORT-NORMAL ORAL FLORA

MST

9248

BOICE SLEEP DISORDERS LABORATORY
BLDG ONE, SUITE 101
NAVAL MEDICAL CENTER, PORTSMOUTH
PORTSMOUTH, VA 23708-2197

FACSIMILE TRANSMISSION

Please deliver the following pages :

TO: Dr. W. Beck
OF: Neurology - Camp Lejeune

FROM: Iris Preiss
NUMBER OF PAGES (INCLUDING THE COVER SHEET): 4

Our fax number is (804) 398-7792. Please call (804)398-7781 if there are any problems with the transmission.

Thank you,
The Boice Sleep Lab Staff

MESSAGES:

SLEEP DISORDERS LABORATORY
NAVAL MEDICAL CENTER
PORTSMOUTH, VIRGINIA 23708-5100
(804) 398-7781

POLYSOMNOGRAPHY REPORT

Date: 31 July 95

Patient: KIMBLE, Ronnie
SSN:
Date of Study: 21 Jun 95

Referring Physician: Dr. DeBeck
Clinic: NEUROLOGY-Camp Lejeune
Ref: A950248 & X950250

Chief Complaint: "Daytime drowsiness."

Reason for Referral: Rule out Narcolepsy, Myoclonus.

Pre-study Data: The 23 year old man describes a history of excessive daytime sleepiness which he feels is independent of total sleep time. PLM's are suggested from history. No secondary symptoms of Narcolepsy. He has no significant medical problems listed. Medications: Sudafed.

Height: 72 inches **Weight:** 168 pounds

Psychometrics: The Beck Depression Inventory was normal.

Polysomnography Data: Overnight polysomnography was performed with EEG, EOG, EMG, EKG, respiratory effort, respiratory airflow, and pulse oximetry leads attached in standard fashion.

a. Sleep Quality. The subject went to bed at 2200 and arose at 0630, sleeping for 474 minutes out of 511 minutes in bed for a sleep efficiency of 93%. Sleep architecture was normal. Subjective assessment of sleep quality was "better than usual."

b. The technician noted the following: No snoring, hypopnea or Myoclonus. Some body movement was seen during slow-wave sleep, suggesting night terrors or sleep-walking.

c. Respiratory Events. There were no abnormal respiratory events. There were no events associated with oxygen desaturations below 90%. No unusual cardiac events.

d. A trial on nasal CPAP was not done.

e. Periodic leg movements. There were no PLM'S noted.

f. Multiple Sleep Latency Test (MSLT). An MSLT was performed the morning after his polysomnogram. This was normal. Over 5 naps, the mean sleep latency was 12.4 minutes (normal is greater than 10 minutes) with one REM sleep onset (normal is one or less).

Patient: KIMBLE, Ronnie
SSN:
Date of Study: 21 Jun 95
Ref: A950248 & X950250

Impression:

1. Normal overnight polysomnogram.

2. No evidence of Pathologic Sleepiness or multiple REM sleep onsets on his MSLT.

Recommend:

1. Review sleep hygiene (handout).

2. Try to increase allotted sleep time by 1-2 hours per night.

3. Follow up with Neurology at Camp Lejeune.

These findings were sent to the referring physician on 8/3/95

Andrew K. Vaaler, LCDR, MC, USNR

Sleep Hygiene Guidelines

Time in Bed
A person should stay in bed for as long as sleep is needed but no longer. Most patients with insomnia tend to stay in bed too long; the result is shallow and fragmented sleep with many awakenings. Some behavioral treatments (see page 20) severely curtail the time allowed in bed.[26]

Sleep-Wake Rhythm
Each day the internal oscillators that control the human circadian cycle must be synchronized with one another and "reset" to the rotation of the planet. For young persons, whose clocks are typically much slower than 24 hours, the most effective means of accomplishing these goals is to establish a regular wake-up time. In many elderly persons, with their often shorter than 24-hour clocks, a regular, somewhat delayed sleep-onset time is indicated to stretch the periodicity to 24 hours. The best way to maintain circadian cycling is to remain active and be exposed to bright light during the day, even after a night of poor sleep.[27]

Trying to Sleep
The more one tries to sleep, the less one is able to do so. Relaxation and sleep are promoted by quiet activities, such as reading, watching television, or listening to music. Investigators disagree about whether such activities should be done in bed or away from the bedroom. Whether a patient should engage in reading or TV-watching in bed depends on whether that individual finds the activity stimulating or soporific.

Exercise or a Hot Bath
Regular exercise in late afternoon or early evening seems to promote sleep,[28] but the effects may evolve slowly (over weeks). Intermittent strenuous exercise has little effect on sleep.[29] Exercise initially increases body temperature, but a rebound cooling 5 to 6 hours later seems to help sleep. Spending 20 minutes in a tub of hot water an hour or two before going to bed may have a similar effect.[30]

Napping
Individuals must determine for themselves whether a nap helps them. Some patients with insomnia "pay" for each daytime nap with more sleeplessness during the following night, whereas others are considerably refreshed by a daytime nap and seem to fall asleep more easily during the subsequent night.

Bedroom Environment
Both extreme heat and extreme cold can disturb sleep. In nearly all studies, a quiet environment is more soporific than a noisy one; in fact, even after subjects had seemingly habituated to an intermittent noise (eg, living near an airport), an EEG revealed partial arousal whenever the noise occurred.[31] When unavoidable, intermittent noises can be masked by background white noise, for example, from a fan or from an FM radio tuned between two stations. An illuminated bedroom clock can significantly contribute to anxiety when patients are unable to sleep.

Eating
A light bedtime snack, such as a glass of warm milk or cheese and crackers, can promote sleep.[32] Some researchers think digestive hormones have a sedative effect.[33] Others believe that the tryptophan in the snack might be involved.

NAVHOSP CAMP LEJEUNE NC   PERSONAL DATA - PRIVACY ACT OF 1974 (PL 93-579)   LOCATION: CAMP LEJEUNE NAVAL   Automated version of SF600
Printed: 14 Sep 1995@1437

NEUROLOGY CLINIC   DEBECK,THOMAS W   14 Sep 1995   1439   FU   BANA
CMT: 14B

BP: 116/74 PULSE: 80 RESP: 20 TEMP: 98.8 HT: 72" WT: 176 lbs

ADDITIONAL COMMENTS:

Pt's PSG/MSLT done + interpreted as normal. (Of interest pt had s. efficiency 93% c 8½ hr TIB, and c MSL of 12.4 there was 1 SOREM (which nap not stated).

Will focus on sleep hygiene. Pt may be a long sleeper. RTC late Oct.

TW DeBeck MD

951026 Pt doing ok. Still has difficulty c waking up but may be going back to other unit but I'm not sure that will work as he is a long sleeper.

Dup RTC 6 weeks

TW DeBeck

951121 Pt given note recommending he continue on present assignment.

RTC Feb 96

TW DeBeck MD

DE BECK, T.W., NEUROLOGIST
CDR, MC, USNR
217-34-0988
NAVHOSP CAMP LEJEUNE

KIMBLE,RONNIE LEE   M11
17 Jan 1972 MALE   W:3210
Spon: KIMBLE,RONNIE LEE   CIC:
DS: H:9

AVHOSP CAMP LEJEUNE NC D[illegible]ION: BUILDING 15, BR M
ersonal Data - Privacy Act of 1974 (PL 93-579) Automated Version of SF600
Printed: 27 Feb 1996@0713

.DG 15 - SICKCAL CAUCHON,PAUL R 27 Feb 1996 0740 SKCL BHAM
EF CMT: 06A
SN: REFERRAL TO UROLOGY CLINIC

P: PULSE: RESP: TEMP: HT: WT:

DDITIONAL COMMENTS:
Hlg: NKDA
Meds: Ø
119/70
57
18
T- 96.9

S. 24 y/o in for referral to urology. [illegible]
Wife beginning eval for infertility x 1 year of unsuccessful attempts to become pregnant. Neg. doctor request he get a sperm count as a first step.

A. infertility work up.

P. Order sperm count.

K.C. NANNEY PA-C
GS-11 230-65-2790

Patient/Responsible other:
Instructed on:

Verbalizes an understanding of instructions given
Yes No
Teaching standards given to patient: Yes No
Provider

KIMBLE,RONNIE LEE M11
17 Jan 1972 MALE W:3210 H:910-697-2687
Spon: KIMBLE,RONNIE LEE CIC:

VHOSP CAMP LEJEUNE NC 08 Mar 1996@0112
Personal Data - Privacy Act of 1974 (PL 93-579)
OUTPATIENT CUMULATIVE REPORT

MBLE,RONNIE LEE M/24 ph# 910-697-2687

te/Spec: SEMINAL FLUID --SEMEN ANALYSIS--

te	07Mar96		
ll	@0703	Units	Normal Range
SCOSCITY	SEMI LQ		
PEARANCE	OPAQUE		
LOR	YELLOW		
TIVITY	FULL		Moderat-Exclnt
TILITY	RAPID		
RPHOLOGY	90% NML		
CTERIA	NOT OBS		

q.
P: NANNEY,KENNE
b Loc: A

Mar 1996@0703
der Comment:
SEM ANAL Comment:
BASE CHAPLIN

te/Spec: All --Misc. Results (Replaces SF 557)--

llected	Test	Result	Units	Normal Range	Spec.	Req.HCP
Mar96@0703	WBC (SA)	5-10 H	/HPF		SEMINAL	NANNEY,
Order Comment: BASE CHAPLIN						
Mar96@0703	RBC (SA)	0-2	/HPF		SEMINAL	NANNEY,
Order Comment: BASE CHAPLIN						
Mar96@0703	VOL,SEME	2.6	ML		SEMINAL	NANNEY,
Order Comment: BASE CHAPLIN						
Mar96@0703	SPERM CNT	86.8	MILLION		SEMINAL	NANNEY,
Order Comment: BASE CHAPLIN						
Mar96@0703	SEMEN PH	8			SEMINAL	NANNEY,

Continued on next page

lo H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc I=interm

KIMBLE,RONNIE LEE M/24
ec Loc: BLDG 15 - FILE
nit: A COMPANY HQSPTBN
nk: LANCE CORPORAL OUTPATIENT

M :,RONNIE LEE M/24 ph# 910-697-2687

---

te/Spec: SEMINAL FLUID --SEMEN ANALYSIS--

te	07Mar96		
ll	@0703	Units	Normal Range
SCOSCITY	SEMI LQ		
PEARANCE	OPAQUE		
LOR	YELLOW		
TIVITY	FULL		Moderat-Exclnt
TILITY	RAPID		
RPHOLOGY	90% NML		
CTERIA	NOT OBS		

q.
P: NANNEY,KENNE
b Loc: A

Mar 1996@0703
der Comment:
SEM ANAL Comment:
BASE CHAPLIN

te/Spec: All --Misc. Results (Replaces SF 557)--

llected	Test	Result	Units	Normal Range	Spec.	Req.HCP
'Mar96@0703	WBC (SA)	5-10 H	/HPF		SEMINAL	NANNEY,
Order Comment: BASE CHAPLIN						
'Mar96@0703	RBC (SA)	0-2	/HPF		SEMINAL	NANNEY,
Order Comment: BASE CHAPLIN						
'Mar96@0703	VOL,SEME	2.6	ML		SEMINAL	NANNEY,
Order Comment: BASE CHAPLIN						
7Mar96@0703	SPERM CNT	86.8	MILLION		SEMINAL	NANNEY,
Order Comment: BASE CHAPLIN						
7Mar96@0703	SEMEN PH	8			SEMINAL	NANNEY,

Continued on next page

=lo H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc I=interm

==========

VHOSP CAMP LEJEUNE NC 08 Mar 1996@0112

Personal Data - Privacy Act of 1974 (PL 93-579)

OUTPATIENT CUMULATIVE REPORT

MB' E,RONNIE LEE M/24 ph# 910-697-2687

---

te/Spec: All --Misc. Results (Replaces SF 557)--

llected	Test	Result	Units	Normal Range	Spec.	Req.HCP

Order Comment:
BASE CHAPLIN
Laboratory Loc: NH CAMP LEJEUNE LAB

---

lo H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc I=interm

==========

IMBLE,RONNIE LEE M/24

Rec Loc: BLDG 15 - FILE

l.U t: A COMPANY HQSPTBN

ık: ANCE CORPORAL

OUTPATIENT

VHOSP CAMP LEJEUNE NC 08 Mar 1996@0112
Personal Data - Privacy Act of 1974 (PL 93-579)
OUTPATIENT CUMULATIVE REPORT

MF ,RONNIE LEE M/24 ph# 910-697-2687

---

te/Spec: All --Misc. Results (Replaces SF 557)--

llected Test Result Units Normal Range Spec. Req.HCP

Order Comment:
BASE CHAPLIN
Laboratory Loc: NH CAMP LEJEUNE LAB

=lo H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc I=interm

==========

KIMBLE,RONNIE LEE M/24
/P Rec Loc: BLDG 15 - FILE
i nit: A COMPANY HQSPTBN
ank: LANCE CORPORAL OUTPATIENT

BLE,RONNIE LEE M/24 ph# 910-697-2687

--BACTERIOLOGY REPORT--

Phys : MEYER,RAY A
t: THROAT CULTURE
lected: 01Apr96@0836
orted :

Acc #: 960401 MI 4552
Site/Spec: THROAT (PHARYNX)
Lab Location: NH CAMP LEJEUNE LAB

tus: FINAL
teriology Result(s): NORMAL ORAL FLORA. BMA

lo H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc I=interm

KIMBLE,RONNIE LEE M/24
P Rec Loc: BLDG 15 - FILE
l.Unit: 3DBN 2NDMAR
nk: LANCE CORPORAL

OUTPATIENT

Personal Dat - Privacy Act of 1974 (P[illegible]-579)
[illegible]ATIENT CUMULATIVE REPORT

MBLE,RONNIE LEE 7 M/24 ph# 910-697-2687

--BACTERIOLOGY REPORT--

q Phys : MEYER,RAY A
st: THROAT CULTURE
llected: 01Apr96@0836
ported :

Acc #: 960401 MI 4552
Site/Spec: THROAT (PHARYNX)
Lab Location: NH CAMP LEJEUNE LAB

atus: FINAL
cteriology Result(s): NORMAL ORAL FLORA. BMA

o H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc I=interm

KIMBLE,RONNIE LEE M/24
Rec Loc: BLDG 15 - FILE
.Unit: 3DBN 2NDMAR
k: LANCE CORPORAL

OUTPATIENT

HOSP CAMP LEJEUNE NC
sonal Data - Privacy Act of 1974 (PL 93-579)
Printed: 16 Apr 1996@0712

DIVISION: BUILDING 15, BR M
Automated Version of SF600

G 15 - SICKCAL BJORNSSON,GOTTSKALK T 16 Apr 1996 0900 SKCL BHAM
:
CMT: 18A
: DIFFICULTY BREATHING WHILE LYING DOWN DUE TO NOSE INJURY 1 YR AGO
98/56 PULSE: 60 RESP: 18 TEMP: 96.9 HT: WT:

==

ITIONAL COMMENTS: S. This pat. claims that his nose is not functioning right
Ø - NKDA
[illegible] - Ø
dates that he cannot breathe properly
[illegible] Ⓡ tonsil. Has repeated sinus problems, but probably not sinusitis. Not to many respiratory infections

O. [illegible]
VS as seen.
Sinuses: No tenderness.
Throat: WNL.
Nose: No acute inflammation in nose. Ⓡ nostril: Narrow.
Neck No glands
Chest: Lungs: CTA. Heart: Reg.

A. Narrow Ⓡ nostril.
Sleeping problem.

P. Ø Referred back to ENT (as by request.
② Appointment c̄ Neurologist.

Patient/Responsible other:
Instructed on: Dx + Plan

Verbalizes an understanding of instructions given
Yes No
Teaching standards given to patient: Yes No
Provider

G. T. BJORNSSON
CAPT MC USNR
047-42-9241

==

KIMBLE,RONNIE LEE M11
17 Jan 1972 MALE W:3210 H:910-697-2687
Spon: KIMBLE,RONNIE LEE [illegible]

513-110

NSN 7540-00-634-4127

MEDICAL RECORD — CONSULTATION SHEET

REQUEST

TO: ENT

FROM: (Requesting physician or activity) [illegible]

DATE OF REQUEST: 960116

REASON FOR REQUEST (Complaints and findings)

THIS 24 Y/O ♂ HAS PROBLEM BREATHING THRU Ⓡ NOSTRIL PLEASE EVALUATE.

PROVISIONAL DIAGNOSIS

NARROW Ⓡ NOSTRIL

DOCTOR'S SIGNATURE: G. T. BJORNSSON CAPT MC USNR

APPROVED

PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL

☒ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO

PATIENT EXAMINED ☐ YES ☐ NO

[redacted]

DATE: 13Dec96

APPT. TIME: 0855

TIME ARRIVED: 1015

PROVIDER: KNUDSEN

ENT CLINIC NRMC/CLNC

HPI 24 y/o WM c̄ Ⓡ nasal dyspnea. Hx nasal trauma; Hx intermittent nasal congestion

PMHx hypersomnolence syndrome? w/up neurology

PE WD, WN, WM

NOSE - NSD c̄ caudal septal shows Ⓡ

OC/OP - mucosa clear

IMP: NSD c̄ Ⓡ nasal dyspnea

PLAN - Will await final result of sleep eval

(Continue on reverse side)

SIGNATURE AND TITLE

- Pt c̄ neurology w/u.

- will need septoplasty

DATE

IDENTIFICATION NO.

ORGANIZATION

REGISTER NO. 4909 2225

WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

KIMBLE, ROMMEL L

20/

CONSULTATION SHEET

Medical Record

STANDARD FORM 513 (REV. 8-92)

NAVHOSP CAMP LEJEUNE NC
Personal Data - Privacy Act of 1974 (PL 93-579)
Printed: 15 May 1996 0808

DIVISION: CAMP LEJEUNE NAVA
Automated Version of SF600

NEUROLOGY CLINIC   OLANDER, ERIC W   15 May 1996   1400   FU   RAKA
CMT: 14A

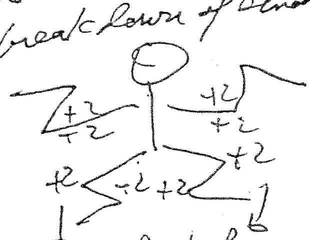
124/36 PULSE: 67 RESP: 16 TEMP: 98.7 HT: 72" WT: 131

ADDITIONAL COMMENTS:

24 y/o (R)H.O. → w/ long hx of falling asleep many times during day which he believes has occurred thru out his life. He believes, if anything, that this has progressively worsened over many years. He falls asleep while driving, standing, like sleeping. He knows when he's going to fall asleep. Caffeine no help. No trouble falling asleep or staying asleep. His wife has noticed him sitting up while sleeping. Slept walk as child. No naked sleep walking adult. Can't remember if wife has noticed apnea during sleep. Goes to sleep ~10PM → 7AM. Naps 0-1/day. No H/A's. No vision Δ's, diplopia, No dysarthria, dysphagia, weakness, numbness, tongue bites, No LOC, head trauma, sz activity, enuresis, soreness upon awakening. muscle last year - nl polysomnogram & MSLT

PMHx - Ø
Meds: Ø All: Ø
SHx: Married, kids, Base Chap
TOB - dip ... Tab/2days, EtOH - ...
Drugs - ...
FHx: Bro - ... problems

PE: WDWNWMNAD
A&Ox3, attn: mos, lang, general, nl, naming/comp/rep/fluent
vis spat nl
Fundi: sharp discs, PERRLA, EOMI, full fields, breakdown of smooth pursuit
Face symm, tongue/pal mid, nl sens, nl OKN
5/5 strength Ø drift, nl FFM, FTN
gait/tandem nl
nl Vib, T, PP



A: Hypersomnolence - pt w/ Hx not fully compatible w/ narcolepsy & w/ nl polysomnogram. normal exam.

P: (1) 4 consult & discuss considering Zoloft SSRI
(2) Breathe-right trial (3) MRI head w/ gado (4) Lab Daily Bowel (5) F/U 8 wks

E. Ganchar

KIMBLE, RONNIE LEE   M11

RADIOLOGIC EXAMINATION REPORT

[redacted]tient: KIMBLE,RONNIE LEE FMP/SSN:

P[redacted] EJEUNE NAVAL HOSPITAL
c [redacted]ure: MRI,BRAIN (W W/O CONTRAST)
uested by: CZANDER,ERIC W
d/Clinic: NEUROLOGY CLINIC

MAGNETIC RESONANCE IMAGING
Exam Date: 12 Jun 1996@1123
Status: COMPLETE
Exam #: 96034241
Pregnant:

son for Order:
yo male with increasing hypersomnolence without LOC

er Comment:
mass

ult Code: See Report Text

ort:

, BRAIN:
Magnetic resonance imaging of the brain was performed using routine tocol. Additionally, T-1 weighted axial images were obtained following ravenous gadolinium administration. The ventricles, sulci and cisterns are metric and normal in appearance for age. There is no intracranial mass or orrhage. No focal parenchymal abnormalities are identified. There are no as of abnormal contrast enhancement. Posterior fossa contents including the in stem and cerebellum are normal. Normal veretebrobasilar and internal otid flow voids are identified.

R SION: 1. Normal MRI examination of the brain.

nscription Date/Time: 13 Jun 1996@1046

erpreted by: FRANCIS G. CURTIN, LCDR MC USNR

oved by: FRANCIS G. CURTIN, LCDR MC USNR 13 Jun 1996@1241

Privacy Act [illegible] (PL 93-579) Printed [illegible]te: 13 Jun 1996@2108
Page: 1

RADIOLOGIC EXAMINATION REPORT

Patient: KIMBLE,RONNIE LEE FMP/SSN:

[illegible]JEUNE NAVAL HOSPITAL
Procedure: MRI,BRAIN (W W/O CONTRAST)
Requested by: CZANDER,ERIC W
Ward/Clinic: NEUROLOGY CLINIC

MAGNETIC RESONANCE IMAGING
Exam Date: 12 Jun 1996@1123
Status: COMPLETE
Exam #: 96034241
Pregnant:

Reason for Order:
r/o male with increasing hypersomnolence without LOC

Order Comment:
mass

Result Code: See Report Text

Report:

, BRAIN:
Magnetic resonance imaging of the brain was performed using routine protocol. Additionally, T-1 weighted axial images were obtained following intravenous gadolinium administration. The ventricles, sulci and cisterns are symmetric and normal in appearance for age. There is no intracranial mass or hemorrhage. No focal parenchymal abnormalities are identified. There are no areas of abnormal contrast enhancement. Posterior fossa contents including the brain stem and cerebellum are normal. Normal veretebrobasilar and internal carotid flow voids are identified.

IMPRESSION: 1. Normal MRI examination of the brain.

Transcription Date/Time: 13 Jun 1996@1046

Interpreted by: FRANCIS G. CURTIN, LCDR MC USNR

Approved by: FRANCIS G. CURTIN, LCDR MC USNR 13 Jun 1996@1241

KIMBLE,RONNIE LEE
17 Jan 1972 / MALE
Loc:
Spon: KIMBLE,RONNIE LEE
Unit: 3DBN 2NDMAR

USMC ACTIVE DUTY
H:910-697-2687 W:3210

Rank: LANCE COR D:3210
RR: BLDG 15 - FILE

19-B

VHOSP CAMP LEJEUNE NC 27 Jun 1996@0124

Personal Data - Privacy Act of 1974 (PL 93-579)

OUTPATIENT CUMULATIVE REPORT

E,RONNIE LEE	M/24	ph# 910-697-2687

---

te/Spec: SERUM --GENERAL CHEMISTRY--

te ll	26Jun96 @1054		Units	Normal Range
UCOSE	85.		mg/dL	75-110
EA NITROGEN	16.		MG/DL	9-21
EATININE	1.20		mg/dL	.8-1.5
DIUM	144.		mmol/L	138-146
TASSIUM	4.9		mmol/L	3.6-5.0
LORIDE	99.	L	MMOL/L	101-111
RBON DIOXIDE	30.		mmol/L	22-31
OSPORUS	3.7		mg/dL	2.5-4.5
IC ACID	6.7		mg/dL	3.5-8.5
OTEIN,TOTAL	6.0	L	g/dL	6.3-8.2
BUMIN	4.1		g/dL	3.9-5.0
LIRUBIN,TOTAL	0.8		mg/dL	0-1.2
OT/AST	21.		U/L	5-35
K PHOS	50.		U/L	38-126
H	347.		U/L	311-618
OLESTEROL	146.		mg/dL	107-239
.YCERIDE	64.		mg/dL	40-160

q.
P: CZANDER
b Loc: A

terpretations: GLU
B PATIENTS PANIC LOW IS 40 mg/dl AND PANIC HIGH IS 300 mg/dl.

te/Spec: SERUM --SEROLOGY--

ate ll	26Jun96 @1054	Units	Normal Range
R	NONREACT		NR

eq.
P: CZANDER,

Continued on next page

NH CAMP LEJEU

---

lo H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc I=interm

==========

KIMBLE,RONNIE LEE M/24

Rec Loc: BLDG 15 - FILE

..Unit: 3DBN 2NDMAR

nk: LANCE CORPORAL OUTPATIENT

MI ',RONNIE LEE ' M/24 ph# 910-697-2687

te/Spec: BLOOD --CBC & DIFFERENTIAL--

te ll	26Jun96 @1054	Units	Normal Range
C	5.9	K/CMM	4.5-11.0
C	5.37	M/cmm	4.7-6.1
B	15.6	g/dL	13.9-16.3
T	45.6	%	39-55
V	84.9	uG3	80-100
H	29.0	pg	27-31
HC	34.1	gm/dL	33-37
C Distributn	13.0	%	11.5-14.5
an PLT Volume	8.4	mu3	7.2-11.1
ATELET COUNT	294	K/cmm	145-450
JT,%	58.0	%	50-70
MPH,%	30.3	%	19.0-48.0
ND,%	8.9 H	%	1-6
S %	1.9	%	1-5
SD,%	0.9	%	0-1.5

CZANDER
Loc: A

erpretations: HCT

erpretations: WBC

e/Spec: BLOOD --HEMATOLOGY--

e l	26Jun96 @1054	Units	Normal Range
(WESTERGREN)	<1	mm/Hr.	0-9

Continued on next page

H CAMP LEJEU

o H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc I=interm

KIMBLE,RONNIE LEE M/24
ec Loc: BLDG 15 - FILE
nit: 3DBN 2NDMAR
k: LANCE CORPORAL OUTPATIENT

M E,RONNIE LEE M/24 ph# 910-697-2687

te/Spec: BLOOD --HEMATOLOGY--

te ll	26Jun96 @1054	Units	Normal Range
P:	CZANDER		
b Loc:	A		

te/Spec: URINE --URINALYSIS--

te ll	26Jun96 @1054	Units	Normal Range
LOR	YELLOW		
PEARANCE	CLEAR		CLEAR-TURBID
ECIFIC GRAV	1.025		1.003-1.031
INE PH	6.5		5.0-8
INE PROTEIN	NEGATIVE	mg/dL	Neg-1+
GLUCOSE	NEGATIVE	g/dL %	Neg-Trace
INE KETONES	NEGATIVE		Neg-Trace
INE BILI	NEGATIVE		Neg-Trace
INE BLOOD	NEGATIVE		Neg-Trace
INE NITRITE	NEGATIVE		Neg
INE UROBILINO	***	EU/dl	0-2.0
UKOCYTE	NEGATIVE		Neg-TRACE

q.
P: CZANDER,
b Loc: A

PANDED RESULT(S):
* RESULT FOR: 26 Jun 1996@1054 URINE UROBILINO: 0.2 EU/dl

te/Spec: SERUM --GENERAL CHEMISTRY--

te ll	26Jun96 @1054	Units	Normal Range

Continued on next page

VHOSP CAMP LEJEUNE NC 27 Jun 1996@0124

Personal Data - Privacy Act of 1974 (PL 93-579)

OUTPATIENT CUMULATIVE REPORT

M ,RONNIE LEE M/24 ph# 910-697-2687

---

te/Spec: SERUM --SEROLOGY--

te 26Jun96
ll @1054 Units Normal Range

b Loc: A

te/Spec: All --Misc. Results (Replaces SF 557)--

llected	Test	Result	Units	Normal Range	Spec.	Req.HCP
Jun96@1054	CA	9.6	mg/dl	8.5-10.5	SERUM	CZANDER
Jun96@1054	MONO	NEGATIVE			BLOOD	CZANDER
Jun96@1054	OB AMP	NEGATIVE			URINE	CZANDER
Jun96@1054	OB BAR	NEGATIVE			URINE	CZANDER
Jun96@1054	OB BZO	NEGATIVE			URINE	CZANDER
Jun96@1054	OB COC	NEGATIVE			URINE	CZANDER
Jun96@1054	OB OPI	NEGATIVE			URINE	CZANDER
J 96@1054	OB PCP	NEGATIVE			URINE	CZANDER
Jun96@1054	OB THC	NEGATIVE			URINE	CZANDER

aboratory Loc: NH CAMP LEJEUNE LAB

terpretations: CA

---

o H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc I=interm

==========

KIMBLE,RONNIE LEE M/24

ec Loc: BLDG 15 - FILE

nit: 3DBN 2NDMAR

k: LANCE CORPORAL OUTPATIENT

VHOSP CAMP LEJEUNE NC 29 Jun 1996@0409

Personal Data - Privacy Act of 1974 (PL 93-579)

OUTPATIENT CUMULATIVE REPORT

MBLE,RONNIE LEE M/24 ph# 910-697-2687

---

te/Spec: SERUM --MISCELLANEOUS (S3)--

te ll	26Jun96 @1054	Units	Normal Range
1 CONVERT.ENZ	35.0	U/L	8-52

q.
P: CZANDER
b Loc: A

te/Spec: All --Misc. Results (Replaces SF 557)--

llected	Test	Result	Units	Normal Range	Spec.	Req.HCP
Jun96@1054	MHA-TP	NON-REACTIVE		NONREACT-NONR	SERUM	CZANDER

Laboratory Loc: NH CAMP LEJEUNE LAB

---

lo H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc I=interm

==========

KIMBLE,RONNIE LEE M/24

P Rec Loc: BLDG 15 - FILE

] Unit: 3DBN 2NDMAR

LANCE CORPORAL OUTPATIENT

9/03 PULSE: 73 RESP: 20 TEMP: 97.6° HT: 72" WT: 178#

NKA

24 yo (R) H ♂ here for f/u of hypersomnolence. Seen by Psychology → no abnormals. Pt states he has noticed no Δ over past 6 weeks but notes that his hypersomnolence is actually greater than previously thought but no worse. He donates plasma 2x per week over past 3 months. MRI of head normal. Wife has noticed episodes of apnea during sleep.

ASS (1) Hypersomnolence - pt w/o change has been years. W/U √ labs. May try Zoloft if labs normal.

(2) pt to get septoplasty w/in next 2 mos.

Plan: (1) Chem 18, CBC, ESR, Mono ~~spot~~, ACE, RPR, U/A, UDS

(2) RTC

[signature]

E. W. CZANDER
LT, MC, USNR
68-8097
NEUROLOGIST

KIMBLE, RONNIE LEE
17 Jan 1972 MALE
Spon: KIMBLE, RONNIE LEE
Rank: [illegible]

UROLOGY CLINIC   CZANDER, ERIC W   17 JUL 1996   0920   F

CMT: 146

112/68 PULSE: 71   RESP: 16   TEMP: 98.3   HT: 72"   WT: 181

ADDITIONAL COMMENTS: NKDA

24 yo (R) H → here for f/u of hypersomnolence
Pt states he has noticed no change
except that it's worse during the
heat. Wondered if Allergies can do this
- has nasal blockage → no draining. No rash,
trouble breathing, sneezing. Wife has noticed
apnea during sleep.

PE: WDWNWM NAD
Alert, fluent speech
No sinus tenderness or pain on head shaking.
Gait nl

A&P: Hypersomnolence - has normal
MRI, labs (Chem 18, CBC, ESR, Mono,
ACE, RPR, MHA, U/A, U Drug Screen).
Also normal Polysom / MSLT 6/95.
- will try Zoloft as trial
to help   50 mg QD & ↑ in 2 weeks
to 100 (can go up to 200 mg)
- possible improvement after
Septoplasty to be done next month
in the next 2 months
- f/u 6-8 wks

E G[illegible]

E. W. CZANDER
LT, MC, USNR
[illegible]
NEUROLOGIST

KIMBLE, RONNIE LEE
17 Jan 1972 MALE
Spon: KIMBLE, RONNIE LEE
MI1
W: 3210
CIC: [illegible]
H: 910-[illegible]-2687

Date: 20-Sep-96Day: Friday SDS: X SDA: ROUT: Scheduled: X Emergency:
Hospital ID#: 150652 SSN:
Name(Last, First): KIMBLE, RONNIE Age: 24
AFAA: AEBA: ABAA: ACAA: ACBA: ABEA: ABGA: X ABKA: ABFA: AADA:
Pre Op DX: NSD/NASAL DEFORMITY
OP DX: SAA
OP Procedures: SEPTORHINOPLASTY

# of Procedures: 1
Surgeon: KEYSER Assistant:
Anesthesia Technique Used: MAC WITH LOCAL
Anesthetist: SMITH Assistant:
RN: JONES RN Relief:
Technician 1st Assistant: HUNT
Technicians: CARTER Scrub Tech:
Patient Pick Up Time: 07:00
Anesthesia Start Time: 07:30
Surgery Start Time: 07:45
Surgery Stop Time: 10:40
Anesthesia Stop Time: 10:55
Total Room Time: 205 Total Surgery Time: 175 Total Patient Care Time: 235

Sponge: Needle: Count: RN Signature: JONES
Correct: X2: X3: Aborted: Discrepancy:
Items Involved: Surgeon Notified: X-ray Taken: MVR:
Pathology Tissue to Lab N: X Y: (Specimen):

Lab Specimens:

Drains None: X Foley/Size: Hemovac: Jackson/Pratt: Other:
Wound Class: 2
X-rays (N): X Portable: Imaging: CSR: 36323 Flash Sets:
Excessive Personnel N: X Y: Steris: Individual Inst:
Total Tourniquet Time(Minutes):
Room No: 4

MC/AD: X	RET:	DEP/AD:	DEP/RET:
N/AD:	RET:	DEP/AD:	DEP/RET:
A/AD:	RET:	DEP/AD:	DEP/RET:
AF/AD:	RET:	DEP/AD:	DEP/RET:
CG/AD:	RET:	DEP/AD:	DEP/RET:
CIV HUM:	OTHER:		

Cesarean:Male: Female:
APGAR 1 min: APGAR 5 min: Pediatrician:
ID#:
Drugs Given:
Additional Remarks:

Implants:

SURGERY DATA COLLECTION WORKSHEET NHCLNC 6150/34 (3-94)

OUTPATIENT RECORD

MEDICAL RECORD - OPERATION REPORT (SF-516)

DATE OF SURGERY: 20 SEPTEMBER 1996

PREOPERATIVE DIAGNOSIS.
NASOSEPTAL DEFORMITY.

POSTOPERATIVE DIAGNOSIS.
SAME.

PROCEDURE:
SEPTORHINOPLASTY AND TURBINATE CRUSH AND CAUTERY.

COMPLICATIONS:
NONE.

ESTIMATED BLOOD LOSS:
MINIMAL.

FLUIDS.
600 CCs.

INDICATIONS.
This is a 24 year old male who has a nasal septal deformity with deviation of his septum and nasal dorsum to the right with right nasal dyspnea.

PROCEDURE
Consent was obtained. The patient was taken to the operating room where he underwent monitored anesthesia care. The nose was topically anesthetized with 4% cocaine. The nose was then locally injected with a 50/50 mixture of 2% lidocaine with 1:100,000 epinephrine and 0.5% Marcaine with 1:100,000 epinephrine. The patient was then prepped and draped in the standard fashion. Inverted gull wing incision was made, and the skin incision carried upwards. Marginal incisions were extended laterally. The dissection was carried up along the medial and alar cartilages. The septum was

Signature of Surgeon:

DATE:
09/21/96

J.S. KLYSER
LCDR MC USNR

PATIENT IDENTIFICATION:

REGISTER NO.:
150652

WARD NO.:
3A

KIMBLE, RONNIE L., ME3 AD

HQSPTBN MCB

NAVAL HOSPITAL, CAMP LEJEUNE, NC 28547-0100
dm 09/24/96

identified and the dissection carried back along the septum and over the bony dorsum. Next the septal angle was identified and a mucoperichondrial flap was elevated on the left side identifying the septum. There was a high right septal deviation in a right-ward curve of the caudal septum with protrusion of the caudal septum out the right nostril. The mucosa on the caudal portion of the right caudal septum was elevated to better visualize the septum. The most caudal portion was excised and the septum mobilized out off the tip of the maxillary crest. Next the OC junction was separated and a posterior-inferior portion of the septal cartilage removed removing the high septal deviation. The contralateral mucous flap was then elevated and the portion of the right-ward deviated nasal bone was moved making horizontal cuts in the bony septum. The caudal septum was then packed to a more midline position by placing 6-0 nylon suture through the inferior caudal portion and securing it to periosteum on the left nasal sill. The upper lateral cartilages were then released preserving the inner mucosal attachment. This allowed further straightening of the septum. The bony dorsum was gently rasped and then medial osteotomies were performed to correct the bony deviation. Attention was then turned to the tip which showed asymmetry of the dome. The left alar cartilage had a concaved deformity to it. A cartilaginous strut was placed between the medial crus and secured with a 4-0 chromic suture. A 6-0 clear nylon suture was placed just anterior and posterior to the dome to provide better tip definition and symmetry. Next a portion of the harvested septal cartilage was placed to fill the left alar concavity defect. This was secured with 4-0 chromic. The columellar incision was then reapproximated with 5-0 Vicryl. The incision was closed with 6-0 Prolene. Next the inferior turbinates were lateralized. The right inferior turbinate was cauterized with a bipolar cautery. Next lateral osteotomies with a curved osteotome were performed. The right osteotomy was incomplete and a 3 mm straight chisel was used to postage stamp and complete the osteotomy. The nasal pyramid was straightened. Next, bilateral Telfa packs coated with Bacitracin ointment were placed. The nose was taped in a standard fashion followed by a splint. The patient tolerated the procedure well and was transferred to the recovery room for postoperative monitoring.

Signature of Surgeon:

DATE:
09/21/96

J.S. KEYSER
LCDR MC USNR

PATIENT IDENTIFICATION:

REGISTER NO.:
150652

WARD NO.:
3A

KIMBLE, RONNIE L., ME3 AD

HQSPTBN MCB

NAVAL HOSPITAL, CAMP LEJEUNE, NC 28547-0100
dm 09/24/96

NEUROLOGY CLINIC CZANDER,ERIC W 29 NOV 1995 0830 FU BAMA
F: CMT: 14B
P

11/26/95 PULSE: 71 RESP: 16 TEMP: 98.7 HT: 72" WT: 182

ADDITIONAL COMMENTS: NKDA

24yo (R)HO here for f/u of hypersomnolence. Pt underwent Septoplasty approx 2 months ago. He can already better but he hasn't shown any improvement in terms of his sleepiness. Goes to bed 22-2300 - wakes 0700. ~~Hobbs in ago~~ Appetite has been sporadic. No sleep paralysis. Has had ? of hypnapompic hallucinations. Taking 1-2 naps/day. He believes he will fall asleep if he doesn't do anything. -anhedonia. Recently wife had miscarriage.

SS: ? Hypersomnolence w/ ? hypnagogic hallucination
- Wife has noticed apneic episodes in past
- ? narcolepsy

Plan: (1) Repeat Poly/MSLT
(2) Return after studies

E. W. CZANDER
LT MC USNR
439-8087
NEUROLOGIST

KIMBLE,RONNIE LEE
17 Jan 1972 MALE
SSN: KIMBLE,RONNIE LEE
CS:

M11
W:3210
CIC: HBK
Rank: LTJG

H:910-697-2687

GLUCOPHAGE®
(METFORMIN HYDROCHLORIDE TABLETS) 500 mg

FAX
451-4537
Neurology / Internal
Medicine
Clinic
American Sleep Disorders
Assoc. (ASDA)
507 287-6006

Please see accompanying full prescribing information
including BOXED WARNING regarding Lactic Acidosis

F5-A049

POLYSOMNOG

Name: Ronnie Kimble, Date of Study: 22 JAN 97
Referring Provider: Dr Czander, NHCL Neurology

Type of Study: Full polysomnography, overnight, attended by a sleep technologist.

Beck Depression Inventory: Normal.

Sleep Architecture: Normal.

Subjective Impression of Sleep Quality: "Worse than usual."
Technologist's Notes: "Snoring noted."

Respiratory Events: There were 34 respiratory events, consisting of 7 hypopneas, 2 obstructive apneas, 15 central apneas, and 10 mixed apneas. The apnea + hypopnea index was 4 events per hour, while the apnea index was 3 events per hour. Number of oxygen desaturations < 90%: 1. Minimal SaO2: 89%. Most respiratory events occurred while the patient was supine, or on his stomach.

CPAP titration: Not performed.
Remarkable cardiac events: None.
Periodic limb movements (PLM's): None noted.
MSLT: Was performed, with a mean sleep latency of 10.4 min and no sleep-onset REM noted over 4 naps.

IMPRESSION: 1) Primary snoring, with no evidence of significant OSA, narcolepsy, or pathologic sleepiness.

RECOMMENDATION: 1) Consider "snore ball", dental device, and/or ENT consult to address snoring, if problematic. 2) Further management per Neurology Clinic.

A. S. Panettiere, M.D.
LCDR MC USN (FS)
Director, Sleep Lab

BOICE SLEEP DISORDERS LABORATORY
BLDG ONE, SUITE 101
NAVAL MEDICAL CENTER, PORTSMOUTH
PORTSMOUTH, VA 23708-2197

FACSIMILE TRANSMISSION

Please deliver the following pages :

TO: ENT Clinic - P.O. Hunt
OF: Camp Lejeune

FROM: Lisa Prinz
NUMBER OF PAGES (INCLUDING THE COVER SHEET): 4 Many

Our fax number is (804) 398-7792. Please call (804)398-7781 if there are any problems with the transmission.

Thank you,
The Boice Sleep Lab Staff

MESSAGES:

Boice Sleep Disorders Lab
Naval Medical Center
Building One
Portsmouth VA 23708

POLYSOMNOGRAPHY REPORT

Name: Ronnie Kimble, [illegible] Date of Study: 22 JAN 97
Referring Provider: Dr Czander, NHCL Neurology

Type of Study: Full polysomnography, overnight, attended by a sleep technologist.

Beck Depression Inventory: Normal.

Sleep Architecture: Normal.

Subjective Impression of Sleep Quality: "Worse than usual."
Technologist's Notes: "Snoring noted."

Respiratory Events: There were 34 respiratory events, consisting of 7 hypopneas, 2 obstructive apneas, 15 central apneas, and 10 mixed apneas. The apnea + hypopnea index was 4 events per hour, while the apnea index was 3 events per hour. Number of oxygen desaturations < 90%: 1. Minimal SaO2: 89%. Most respiratory events occurred while the patient was supine, or on his stomach.

CPAP titration: Not performed.
Remarkable cardiac events: None.
Periodic limb movements (PLM's): None noted.
MSLT: Was performed, with a mean sleep latency of 10.4 min and no sleep-onset REM noted over 4 naps.

IMPRESSION: 1) Primary snoring, with no evidence of significant OSA, narcolepsy, or pathologic sleepiness.

RECOMMENDATION: 1) Consider "snore ball", dental device, and/or ENT consult to address snoring, if problematic. 2) Further management per Neurology Clinic.

A. S. Panettiere, M.D.
LCDR MC USN (FS)
Director, Sleep Lab

Patient Name: RONNIE KIMBLE
Test Date: 01/23/97

Staging Summary:

Recording start time :	21:40:23	Recording end time :	05:51:47
Analysis start time :	21:40:23	Analysis end time :	05:51:23
Total number of epochs :	982	Epoch size (sec) :	30
Total recording time (hr) :	8.2	Total sleep time (hr) :	7.7
Number of Awakenings :	16	Total wake time (hr) :	0.5
Sleep Efficiency (%) :	94.4	Sleep Maintenance Effic(%):	97.8
Sleep onset latency (min) :	17.5	Stage REM latency (min) :	154.0

Oximetry Summary:

Total number of desaturations	47
Desaturation Index (/hr)	6
Basal O2 during sleep	95.9

Heart Rate Summary:

Basal heart rate during sleep (bpm)	61.9
Slowest heart rate (bpm)	45.5
Fastest heart rate (bpm)	128.6
Number of Bradycardic events	0
Number of Tachycardic events	0

Respiratory Summary:

	Total #	Min time	Max time	Mean	Total hrs
Apneas+Hypopneas	34	10	25	16	0.1
Apneas	27	10	25	16	0.1
Hypopneas	7	11	25	16	0.0

	REM	Non-REM	Sleep
Apneas	4	23	27
Hypopneas	4	3	7
Apneas+Hypopneas	8	26	34
% time in Apnea+Hypopnea	2	2	2
Apnea Index (/hr)	2	4	3
Apnea Arousal Index (/hr)	2	3	3

PLMs and Arousal Summary:

	Number of Movements	Index/hr
Sleep	14	1.8
Wake	0	0.0
Respiratory event related movements	3	

	Arousals	Possible Arousals
Number	234	0
Index (/hr)	30.3	0.0

MEDICAL RECORD

CONSULTATION SH

REQUEST

FROM: Camp Lejeune - Neurology

DATE OF REQUEST 20 NOV 96

REASON FOR REQUEST (Complaints and findings)

Hispanic - Polysomnogram [illegible]
Eyo male with excessive daytime sleepiness
causing [illegible] w/ episodes of uncontrollable sleep [illegible]
any event while driving. Wife denies episodes of sleep
Apnea. He also had had hypnagogic hallucinations
& cataplexy, sleep paralysis. He had inconclusive PSG/MSLT
[illegible] 9/26 - no improvement

PROVISIONAL DIAGNOSIS

R/O Narcolepsy, Obstructive Sleep Apnea

PHYSICIAN'S SIGNATURE

E. W. CRANDON
LT, MC, USNR
68-8097
NEUROLOGIST

APPROVED

PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL

☒ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

PATIENT INFORMED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO

11/26/96 left message at work
for Patient to call.
1 auto accident - falling asleep

appt Wednesday Jan 22 @ 2100.

(Continue on reverse side)

SIGNATURE AND TITLE

DATE

Tod 910-451-4633

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 facility)

KIMBLE, Ronnie W: 910 451-3240 5646

17 Jan 72
AD/USMC/ECBL

H: 910 [illegible] 2654
non-published

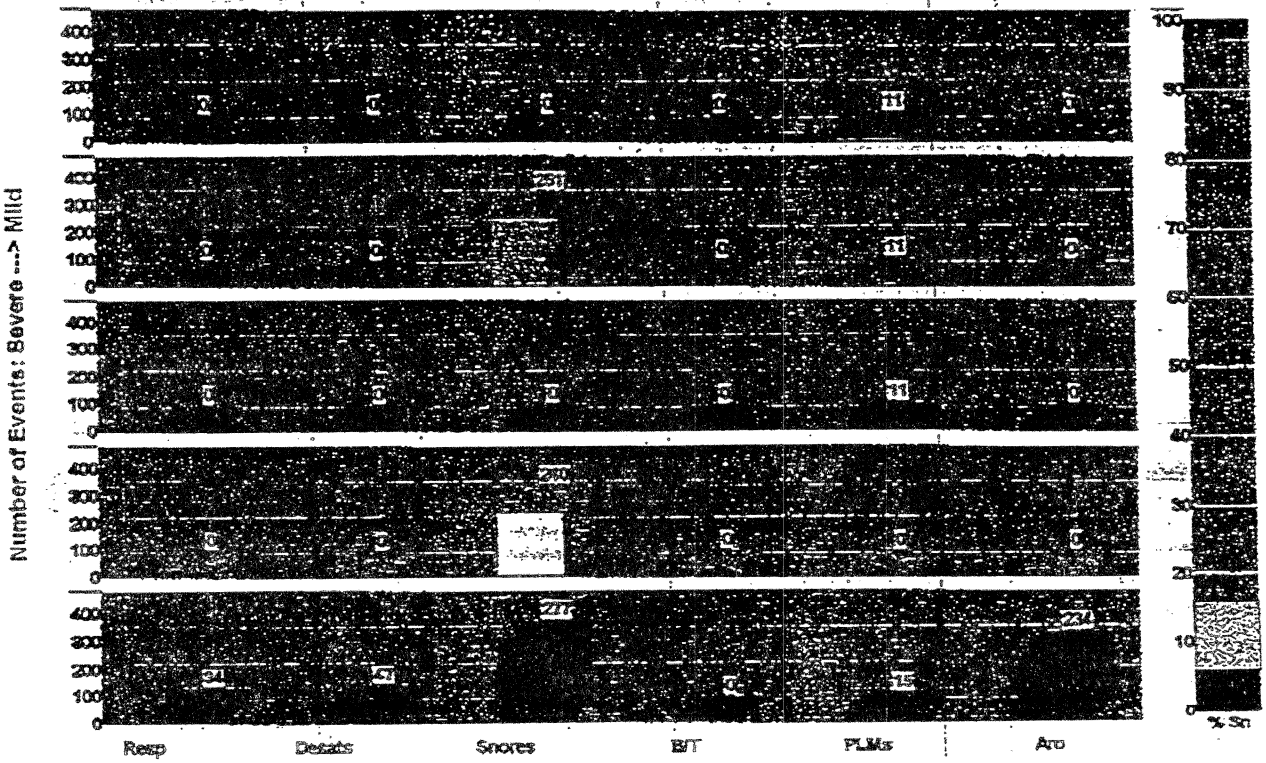
CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 8-82)
Prescribed by GSA/ICMR, FPMR (41 CFR) [illegible]

1-910-697-0076

Boise Sleep Laboratory, Building One

KIMBLE, RONNIE L.
B970028 01/23/97



IMPRESSIONS

SNORES STRONGLY CORRELATE WITH RESP CHANGES AND AROUSALS
SOME DISORDERED BREATHING NOTED NOT MEETING SCORING CRITERIA

Apnea/Hypopnea Associated Desaturation Summary (including possibles)
Number of Respiratory events (number of associated desaturations)

Event duration	Apneas	Hypopneas	Apneas+Hypopneas
0 - 5	0 (0)	0 (0)	0 (0)
5 - 10	0 (0)	0 (0)	0 (0)
10 - 15	13 (10)	4 (3)	17 (13)
15 - 20	8 (6)	1 (1)	9 (7)
> 20	6 (6)	2 (0)	8 (6)
ALL	27 (22)	7 (4)	34 (26)

Sleep Disorders Laboratory
Naval Medical Center
Portsmouth, Virginia 23708

MULTIPLE SLEEP LATENCY TEST TECHNICIAN REPORT

Date: 1-23-97 Tech: BROWN / HODNETT

PATIENT INFO: Name: RIMBLE, RONNIE (Record No. X970029

Nap #1

Lights out 08:07:28 Lights on _____

0800 Pt fell asleep no (yes) Time 08:10:03

REM no yes Time _____

COMMENTS: _____

Nap #2

Lights out 1008 Lights on _____

1000 Pt fell asleep no (yes) Time 1018 (1023)

REM (no) yes Time _____ (1033)

COMMENTS: audible breathing (nasal)

Nap #3

Lights out 1207 Lights on _____

1200 Pt fell asleep no (yes) Time 12[illegible] (12

REM (no) yes Time _____ 125

COMMENTS: audible breathing (nasally) - closed mouthed

Nap #4

Lights out 1407 (1427) Lights on _____

1400 Pt fell asleep no (yes) Time 1426

REM (no) yes Time _____ (1241)

COMMENTS: pt sniffling (nasal drainage)

Nap #5

Lights out _____ Lights on _____

1400 Pt fell asleep no yes Time _____

REM no yes Time _____

COMMENTS: _____

MTF: NMC PORTSMOUTH VA : NAVAL MEDICAL CENTER PORTSMOUT
Personal Data - Privacy Act of 1974 (PL S Automated Version of SF600

ALLERGY NMCP STOCK,MARGARET E 10 Mar 1997 ~~10:00~~ 0830 AM NEW BABA
REF: CMT: cfg
RSN:
APPT TIME:
11½/5 PULSE: 71 RESP: 20 TEMP: 97.5 HT: 72 WT: 175 AGE: 25

He drove here.
He says he cs able to pres
his eprosdes and pu
off the road.

Additional Comments:

I have a sleeping disorder
" They don't know what kind "
" They want me to have Allergy testing "
"I used to do landscaping. If I had bad allergies I'd be dead by no
In the past 4yrs he has uncontrollable hypersomnolence. Falls asleep maybe once a day
Sleeps all night at night. Not aware of restless or uncomfortable sleep. Not a snorer but "deep breather, like I'm fighting to get my breath
Has had 2 sleep studies here.
Recent septoplasty - nasal airway seems clear to him now.
Dr, who did his nose surgery put him on Vancenase for his sinuses.

F/H
(+) asthma mother
(+) "sinus father"

MARGARET E. STOCK
CDR, MC, USN

EXAM ⇒ He appears well.
ENT - somewhat poorer space (+) nostril mid turn Rt = polle.
Neck -
Chest - clear.

Stock
Allergist

Impr: It is extremely easy to determine his atopic status, but I would have to defer the interpretation of the tests vis-a-vis his medical problems.

Patient Education Given _____
Return 1 wk __ 2 wks __ 1 month __ 3 months __ 6 months __ 1 year __ other __

KIMBLE,RONNIE M11
17 Jan 1972 MALE W: (910) 451-5646 H: (910) 697-0076
Spon: KIMBLE,RONNIE CIC:

IBLE,RONNIE M/25 ph# (910) 697-00

.e pec: All --Misc. Results (Replaces SF 557)--

lected	Test	Result	Units	Normal Range	Spec.	Req.HCP
lar97@0957	CAT HAIR	C/I	CLASS	SeeBelow	SERUM	STOCK,M
lar97@0957	DOG DANDE	NEG	CLASS	SeeBelow	SERUM	STOCK,M
lar97@0957	SCOR SYST	SeeBelow			SERUM	STOCK,M
lar97@0957	GRASS MIX	NEG	CLASS	SeeBelow	SERUM	STOCK,M
lar97@0957	HSDUSTMIX	IV H	CLASS	SeeBelow	SERUM	STOCK,M
lar97@0957	MOLD MIX	NEG	CLASS	SeeBelow	SERUM	STOCK,M
lar97@0957	TREE MIX	NEG	CLASS	SeeBelow	SERUM	STOCK,M
lar97@0957	WEED MIX	NEG	CLASS	SeeBelow	SERUM	STOCK,M

.aboratory Loc: NMCP PATHOLOGY LABORATORY

.erpretations: SCOR SYST
'N MRT Scoring System -- 5 Fold

.ASS	Adj Counts	Interpretation
:G	< 501	Negative
'I	501 - 750	Equivocal
	751 - 1600	Positive with increasing amounts of specific IgE antibody.
	1601 - 3600	"
:I	3601 - 8000	"
;	8001 - 18000	"
	18001 - 40000	"
	> 40000	"

:st performed at: Commonwealth Medical Laboratories, Inc.
11150 Main Street, Suite 550
Fairfax, VA 22030

o H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc I=interm

KIMBLE,RONNIE M/25
Rec Loc: LOCATION IN AN
.Unit: qqtrs supbatS 3RDMARDIV
k: CORPORAL OUTPATIENT

Personal Data - Privacy Act of 1974 (PL 93-579)
OUTP IENT CUMULATIVE REPORT Report ID:POUT_0317

MBLE,RONNIE M/25 ph# (910) 697-00

t. Spec: All --Misc. Results (Replaces SF 557)--

llected	Test	Result	Units	Normal Range	Spec.	Req.HCP
Mar97@0957	CAT HAIR	D/I	CLASS	SeeBelow	SERUM	STOCK,M
Mar97@0957	DOG DANDE	NEG	CLASS	SeeBelow	SERUM	STOCK,M
Mar97@0957	SCOR SYST	SeeBelow			SERUM	STOCK,M
Mar97@0957	GRASS MIX	NEG	CLASS	SeeBelow	SERUM	STOCK,M
Mar97@0957	HSDUSTMIX	IV H	CLASS	SeeBelow	SERUM	STOCK,M
Mar97@0957	MOLD MIX	NEG	CLASS	SeeBelow	SERUM	STOCK,M
Mar97@0957	TREE MIX	NEG	CLASS	SeeBelow	SERUM	STOCK,M
Mar97@0957	WEED MIX	NEG	CLASS	SeeBelow	SERUM	STOCK,M

Laboratory Loc: NMCP PATHOLOGY LABORATORY

terpretations: SCOR SYST
/N MRT Scoring System -- 5 Fold

LASS	Adj Counts	Interpretation
EG	< 501	Negative
/I	501 - 750	Equivocal
	751 - 1600	Positive with increasing amounts of specific IgE antibody.
I	1601 - 3600	"
II	3601 - 8000	"
V	8001 - 18000	"
	18001 - 40000	"
	> 40000	"

est performed at: Commonwealth Medical Laboratories, Inc.
11150 Main Street, Suite 550
Fairfax, VA 22030

lo H=hi *=crit []=uncert /A=amend R=resist S=susc MS=mod susc I=interm

KIMBLE,RONNIE M/25
P Rec Loc: LOCATION IN AN
l.Unit: qqtrs supbatS 3RDMARDIV
nk: CORPORAL OUTPATIENT

11150 Main Street, Suite 550
Fairfax, VA 22030

MODIFIED RAST ASSAY

Patient Kibble, RonniePB51

Patient ID	A125	Sample ID	
Cust. ID		Physician	Navy *NAVY
Age		Sex	M
Date Drawn		Time Drawn	
Date Recd.		Time Recd.	

	Allergen	Class	Adj Counts
GX2	Grass Mix.....	Neg	341
MX1	Mold Mix.....	Neg	140
HX2	House Dust Mix.....	IV	10413
E1	Cat Hair.....	0/I	567
E2	Dog Epithelium.....	Neg	197
TX1	Tree Mix.....	Neg	393
WX2	Weed Mix.....	Neg	358

F/K MRT Scoring System — 5 Fold

Class	Adj Counts	Interpretation
Neg	(501	Negative.
0/I	501 - 750	Equivocal.
I	751 - 1500	Positive with
II	1501 - 3500	increasing
III	3501 - 8000	amounts of
	8001 - 18000	specific IgE
	18001 - 40000	antibody.
VI	) 40000	

Assay Documentation

Run ID	031397
Date	Mar 15,1997
Technologist	Brenda

Calibrator and Controls

Total Counts	38861
25 IU/ml Cal.	24999
Neg. Control	125
Pos. Control	19577
Cal. Factor	0.952
Neg. Cutoff	500

11150 Main Street, Suite 550
Fairfax, VA 22030

MODIFIED RAST ASSAY

Patient Kibble, RonniePB51

Patient ID	A125	Sample ID	
Cust. ID		Physician	Navy *NAVY
Age		Sex	M
Date Drawn		Time Drawn	
Date Recd.		Time Recd.	

	Allergen	Class	Adj Counts
GX2	Grass Mix.....	Neg	341
MX1	Mold Mix.....	Neg	140
HX2	House Dust Mix.....	IV	10413
E1	Cat Hair.....	0/I	667
E2	Dog Epithelium.....	Neg	197
TX1	Tree Mix.....	Neg	393
WX2	Weed Mix.....	Neg	358

F/X M2T Scoring System — 5 Fold

Class	Adj Counts	Interpretation
Neg	(501	Negative.
0/I	501 - 750	Equivocal.
I	751 - 1500	Positive with
II	1501 - 3500	increasing
III	3501 - 8000	amounts of
IV	8001 - 18000	specific IgE
	18001 - 40000	antibody.
VI	) 40000	

Assay Documentation

Run ID	031397
Date	Mar 15, 1997
Technologist	Brenda

Calibrator and Controls

Total Counts	39861
25 IU/ml Cal.	24999
Neg. Control	125
Pos. Control	19577
Cal. Factor	0.952
Neg. Cutoff	500

NEUROLOGY CLINIC CZANDER,ERIC W 17 Mar 1997 0930 FU BAKA
REF:
CMT: 14b

BP: 115/64 PULSE: 68 RESP: 16 TEMP: 98.9 HT: 72" WT: 175

ADDITIONAL COMMENTS:

2440 (R) H/O → here for f/u of hypersomnolence. He states there have been no changes. He has been the allergist at for 6 months → no determined cause of hypersomnolence 2° allergies.

Going to bed 21-2200 awakening @ 0630. He is still falling asleep 1/day. Falls easily only 1/2 weeks. Difficulty falling asleep. Running 15-30 mins/ one per week.

Dysphg - ± can / 3-4 days
ETOH - 0

Has had no further episodes of sleeping while driving.

ASS: Hypersomnolence - pt w/ a Polysomnogram / MSLT's which were normal.

Plan: - Medical board
- Stop Tobacco use
- ↑ Exercise

E. W. CZANDER
LT, MC, USNR
68-8097
NEUROLOGIST

KIMBLE,RONNIE LEE
17 Jan 1972 MALE
Spon: KIMBLE,RONNIE LEE
CS:

M11
W:3210
CIC: HBK
Rank: CPL

H:910-697-2887
D:3210

SF600

DEPARTMENT OF THE NAVY
Naval Hospital
P. O. Box 10100
Camp Lejeune, North Carolina 28547-0100

MEMORANDUM

Date: 17 MARCH 1997

From: Patient Administration Department, Medical Board Section
To: Commanding Officer,

Subj: PHYSICAL EVALUATION BOARD

1. CPL RONNIE L. KIMBLE, USMC, is being processed for a Physical Evaluation Board (PEB).

2. The member will be given information regarding the process of the Physical Evaluation Board following a class on FRIDAY, 21 MARCH 1997 at 0700 (CLASS ROOM C)

3. If the member is a "NO SHOW" for the appointment you will be notified.

4. If the member needs to reschedule his/her appointment please contact the medical board section twenty-four (24) hours prior to the scheduled appointment.

5. Point of contact is Mrs. Rhodes at 451-4588.

Sharon Rhodes
Sharon Rhodes
Physical Evaluation Board Counselor

I hereby acknowledge I have been informed that I am being placed on a Physical Evaluation Board (PEB). I understand that I have an appointment scheduled for FRIDAY, 21 MARCH 1997 AT 0700 (CLASS ROOM C) for counseling of the Physical Evaluation Board.

Ronnie L Kimble
Member's Signature

DEPARTMENT OF THE NAVY
Naval Hospital
P. O. Box 10100
Camp Lejeune, North Carolina 28547-0100

MEMORANDUM

Date: 17 MARCH 1997

From: Patient Administration Department, Medical Board Section
To: Commanding Officer,

Subj: PHYSICAL EVALUATION BOARD

1. CPL RONNIE L. KIMBLE, USMC, is being processed for a Physical Evaluation Board (PEB).

2. The member will be given information regarding the process of the Physical Evaluation Board following a class on FRIDAY, 21 MARCH 1997 at 0700 (CLASS ROOM C)

3. If the member is a "NO SHOW" for the appointment you will be notified.

4. If the member needs to reschedule his/her appointment please contact the medical board section twenty-four (24) hours prior to the scheduled appointment.

5. Point of contact is Mrs. Rhodes at 451-4588.

Sharon Rhodes
Sharon Rhodes
Physical Evaluation Board Counselor

I hereby acknowledge I have been informed that I am being placed on a Physical Evaluation Board (PEB). I understand that I have an appointment scheduled for FRIDAY, 21 MARCH 1997 AT 0700 (CLASS ROOM C) for counseling of the Physical Evaluation Board.

Ronnie L Kimble
Member's Signature

DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
P.O. BOX 10100
CAMP LEJEUNE, NORTH CAROLINA 28547-0100

IN REPLY REFER TO:
6100
15A3
21 MAR 97

From: Commanding Officer, Naval Hospital, Camp Lejeune, NC
To: Commanding Officer, I COMPANY, 3/2, 2D MARDIV., CLNC

Subj: MEDICAL BOARD IN THE CASE OF CPL RONNIE L. KIMBLE, USMC,

Ref: (a) MANMED Chapter 18
(b) SECNAVINST 1850.4C

1. The above named member is being processed for a PHYSICAL EVALUATION BOARD.

2. Initial Diagnosis are: HYPERSOMOLENCE

3. Recommended Limitations of Duty are: NO PFT, DRILLING, SQUATTING, DIGGING, FIRING RANGE, PROLONGED STANDING, FORMATION (OVER 10 MINUTES), DRIVING MILITRY VEHICLES, LIFTING WEIGHTS (OVER 10 LBS), GUARD DUTY, KNEELING, JUMPING, CRAWLING.

4. The member is non-deployable. We request the member not be granted leave until the medical board is signed. Member may be granted liberty per discretion of the member's command provided they are in compliance with the limitations. Emergency leave may be granted per command's approval. If granted, please notify the Medical Board Section.

5. We request written notification if member is pending disciplinary action or administrative separation, as these take precedence over a medical board.

6. Member is directed to report to the Medical Board Section to read and sign the medical board dictation on 09 APRIL 1997 at 1300.

7. Member is directed to report to the Medical Board Section to attend the mandatory PEB/DTAP class on 09 APRIL 1997 at 0800.

8. Member is directed to report to his/her BAS or Dispensary to have a physical exam. A copy of the physical exam must forwarded or hand-delivered to the medical board section when completed.

9. Point of contact at this command is Mrs. Rhodes, Medical Boards, at 451-4588.

M. S. CURNOW
By direction

Copy to:
Member
File
Health Record

Subj: MEDICAL BOARD IN THE CASE OF CPL RONNIE L. KIMBLE, USMC,

STATEMENT OF AWARENESS

I hereby acknowledge I have been informed that my medical board is being processed. I have been informed of the following appointments (appointment to read and sign dictation, appointment to attend DTAP). I have been notified that I need to contact my BAS/Dispensary to have a physical exam. I have also been informed of the preliminary lab work requirements prior to a physical exam.

I understand that a copy of the physical exam should be forwarded or hand-delivered to the Medical Board Section after it has been completed. I understand that my medical board cannot be forwarded to the Physical Evaluation Board Office without full documentation to include the physical exam.

I understand until the board is **signed** I am to remain in the vicinity of my command. I further understand in case of emergency, I am to contact the Disability Evaluation System Counselor, at 451-4450 and I am to return to the Naval Hospital when directed. I further understand that if I go on leave I am to notify the Disability Evaluation System Counselor of my leave address and phone number.

Lonnie L Kimble
Member's Signature

Copy to:
Member
File
Health Record
BAS

DATE 21 MAR 97

MC..ANDUM

om: Disability Evaluation System Counselor, Naval Hospital, CLNC
: CPL RONNIE L. KIMBLE, USMC,

bj: DISABILITY TRANSITION ASSISTANCE PROGRAM (D-TAP)

f: (a) SECNAVINST 1850.4C
(b) MILPERSMAN 3620270
(c) MCO P1900.16 Chap 8

Public Law 101-510, extended D-TAP nationwide for all service members 'aiting discharge for disability or who believe they have a disability .alifying them for vocational rehabilitation. Attendance at D-TAP is ndatory unless the service member cannot attend for reasons beyond his or :r control.

You are currently being processed in accordance with references (a) and)) or (c) for determination of Fit for Duty by reason of the submission of medical board reporting a condition(s) which may be considered unfitting)r your continuation of military service.

The next D-TAP program will be held on 09 APRIL 97 beginning at 0800, located at Naval Hospital, Camp Lejeune, NC.

This program will explain the disability procedures as your case is :ocessed and Veterans Administration Rights, Benefits and Vocational ehabilitation to which you may be entitled. Your attendance is mandatory. ailure to attend may result in administrative action being taken. If you annot make the above scheduled date for any reason, your command must)ntact me at least 24 hours prior to the course at 451-4450 to be escheduled.

William T. Gibson
W. T. GIBSON, MSC
DES Counselor

bj: DISABILITY TRANSITION PROGRAM (D-TAP)

CPL RONNIE L. KIMBLE, USMC, 240 47 9667, have been informed that I must attend the D-TAP 1 09 APRIL 97 AT 0800. I understand that I have been scheduled to attend the ext class and it is to my advantage to attend the class. I also understand nat failure to attend may result in administrative action being taken.

Ronnie L. Kimble
(Member's Signature)

:y to:
ile
ember
ESC

HEARING CONSERVATION DATA

ZIP CODE/APO: 28547 0100

DOD COMPONENT: M (A-ARMY, N-NAVY, F-AIR FORCE, M-MARINE CORPS, 1-OTHER DOD ACTIVITY)

SERVICE COMPONENT: R (R-REGULAR, V-RESERVE, G-NATIONAL GUARD, 1-OTHER)

SN: [redacted]

LAST NAME—FIRST NAME—MIDDLE INITIAL: KIMBLE, RONNIE

SEX: M (M-MALE, F-FEMALE)

DATE OF BIRTH: year 72 month 01 day 17

PAY GRADE, UNIF SVCS: E04

GRADE, CIVILIAN:

SERVICE DUTY OCCUPATION CODE: 0311

MAILING ADDRESS OF ASSIGNMENT: 3/2 BN/CAMP LEJEUNE/NC 28542

LOCATION—PLACE OF WORK: I CO. UIC=20361

MAJOR COMMAND: SECONDMARDIV

DUTY PHONE: 910-451-3380

TWA=

AUDIOMETRY

Impulse noise=

PURPOSE: 2 (1—90 DAY, 2—ANNUAL, 3—TERMINATION, 4—OTHER)

AUDIOMETRIC DATA: H1 RE: ANSI S3.6

	LEFT						RIGHT					
	500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
CURRENT AUDIOGRAM DATE (year 97 month 03 day 19)	10	15	10	05	05	35	05	10	05	05	10	25
REFERENCE AUDIOGRAM DATE (year 93 month 04 day 09)	5M	0M	10M	0M	5M	5M	-5M	5M	0M	0M	0M	0M
THRESHOLD SHIFT (+ = Poorer — = Better)		15	00	05	00			05	05	05	10	

2 (1-No Significant threshold shift, 2-Yes ± 20dB or greater)

STS NO: ● Counsel ● Return to duty ● Retest in 12 mo. ● Validated by reviewer ● Orig in health record ● Send copy to registry

STS YES: ● Notify supervisor ● Followup No. 1 after minimum 15 hours noise free

NAME OF EXAMINER (Last, first, MI): STEWART, MARIA, .

TRAINING CERT. NO.: 964702

SSN: 000-00-0020

SERVICE DUTY OCCUPATION CODE: 8499

OFC SYMBOL: 68093

TYPE: 3 (1-Manual, 2-Self-recording (auto), 3-Microprocessor)

MODEL: RA600

MANUFACTURER: PCA

SERIAL NO.: 0976

LAST ELECTROACOUSTIC CALIB DATE: year 96 month 04 day 01

FOLLOWUP NO. 1 — Minimum 15 hours noise free

AUDIOMETRIC DATA: H1 RE: ANSI S3.6

	LEFT						RIGHT					
	500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
CURRENT AUDIOGRAM DATE (year 97 month 03 day 26)	05	05	10	05	10	30	05	10	05	05	05	35
REFERENCE AUDIOGRAM DATE (year 93 month 04 day 09)	5M	0M	10M	0M	5M	5M	-5M	5M	0M	0M	0M	0M
THRESHOLD SHIFT (+ = Poorer — = Better)		05	00	05	05			05	05	05	05	

1 (1-No Significant threshold shift, 2-Yes ± 20dB or greater)

STS NO: ● Counsel ● Return to duty ● Retest in 12 mo. ● Validated by reviewer ● Orig in health record ● Send copy to registry

STS YES: ● Notify Supervisor ● Cleared by medical reviewer before Followup No. 2

NAME OF EXAMINER (Last, first, MI): HIDLEBAUGH, DARREL, e.

TRAINING CERT. NO.: 9708001

SSN: 000-00-0022

SERVICE DUTY OCCUPATION CODE: 8499

OFC SYMBOL: 68093

TYPE: 3 (1-Manual, 2-Self-recording (auto), 3-Microprocessor)

MODEL: RA600

MANUFACTURER: PCA

SERIAL NO.: 0976

LAST ELECTROACOUSTIC CALIB DATE: year 96 month 04 day 01

FOLLOWUP NO. 2 — Minimum 40 hours noise free since Followup No. 1

AUDIOMETRIC DATA: RE: ANSI S3.6

	LEFT						RIGHT					
	500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
CURRENT AUDIOGRAM DATE (year month day)												
REFERENCE AUDIOGRAM DATE (year month day)												
THRESHOLD SHIFT (+ = Poorer — = Better)												

Significant threshold shift ± 20dB or greater: [ ] (1-No 2-Yes)

STS NO: ● Counsel ● Return to duty ● Retest in 12 mo. ● Validated by reviewer ● Orig in health record ● Send copy to registry

STS YES: ● Refer to appro directive ● Requires medical disposition ● Validated by reviewer ● Orig in health record ● Send copy to appro registry

NAME OF EXAMINER (Last, first, MI):

TRAINING CERT. NO.:

SSN:

SERVICE DUTY OCCUPATION CODE:

OFC SYMBOL:

TYPE: (1-Manual, 2-Self-recording (auto), 3-Microprocessor)

MODEL:

MANUFACTURER:

SERIAL NO.:

LAST ELECTROACOUSTIC CALIB DATE: year month day

REVIEWED & VALIDATED BY: STEWART, MARIA

SERVICE DUTY OCCUPATION CODE: 8499

AUTOVON: 484-2767

SSN: 000-00-0020

OFC SYMBOL: 68093

INSTRUCTIONS

(Refer to DOD Component Instructions for Additional Guidance)

PURPOSE: This form is used to record the results of periodic and followup audiometry for individuals routinely exposed to hazardous noise. Before this form is used, a reference audiogram must already be filed in the individual's health record.

GENERAL: Print all information in ink (DO NOT TYPE). Press firmly to ensure dable copies. If a mistake is made, do not attempt to erase or block out error. rt a new form.

1. Zip Code/APO - Enter five digit zip code/APO of installation where audiometric test is conducted.

2. DOD Component - Enter letter in box of major organizational subdivision of DOD to which military or civilian individual is assigned. Enter "1" if DOD component is not listed.

3. Service Component - Enter letter in box corresponding to primary subdivision of separate military service to which military is assigned (e.g., Regular (R) - standing military component of armed forces in peace and war; Reserve (V) - component of ready trained personnel for military service when needed, etc). Enter "1" for all others not listed.

4. SSN - Enter nine digit social security number of individual being tested. If foreign national, enter "FN" in middle two blocks.

5. Last Name, First Name, Middle Initial - Enter surname, given name and middle initial of individual being tested.

6. Sex - Enter "M" if male, "F" if female.

7. Date of Birth - Enter year, month and day individual was born (e.g., if November 20, 1941, enter 41/11/20.

8. Pay Grade, Uniformed Services - For military personnel only, enter military personnel class and pay level serial number as follows:

011 - General of the Army/General of the Air Force/Fleet Admiral
010 - General/Admiral
009 - Lieutenant General/Vice Admiral
008 - Major General/Rear Admiral (Upper Half)
007 - Brigadier General/Rear Admiral (Lower Half)/Commodore
006 - Colonel/Captain (N)
005 - Lieutenant Colonel/Commander
004 - Major/Lieutenant Commander
003 - Captain (A, F, M)/Lieutenant (N)
002 - First Lieutenant/Lieutenant Junior Grade
001 - Second Lieutenant/Ensign

W04 - Chief Warrant Officer, W-4
W03 - Chief Warrant Officer, W-3
W02 - Chief Warrant Officer, W-2
W01 - Warrant Officer, W-1
C00 - Cadet/Midshipman

E09 - Sergeant Major/Chief Master Sergeant/Master Chief Petty Officer
E08 - Master Sergeant (A,M)/Senior Chief Petty Officer/Senior Master Sergeant/First Sergeant (A)
E07 - Sergeant First Class/Gunnery Sergeant/Chief Petty Officer/Master Sergeant (F)/Platoon Sergeant (A)/Specialist-7
E06 - Staff Sergeant/Technical Sergeant/Petty Officer First Class/Specialist-6
E05 - Sergeant (A,M)/Staff Sergeant/Petty Officer Second Class/Specialist-5
E04 - Corporal/Sergeant (F)/Petty Officer Third Class/Specialist-4
E03 - Private First Class (A)/Airman First Class/Lance Corporal/Seaman
E02 - Private (PV1)/Airman/Private First Class (M)/Seaman Apprentice
E01 - Private (PV2)/Private (M)/Airman Basic/Seaman Recruit

9. Grade, Civilian - Enter two letters and two numbers of Federal civilian employee rank (e.g., WG05, GS11, etc). Letter entries will be WG, WL, WS, WN, WD or GS. Number entries will be 01 to 18. Enter "1111" if other (e.g., foreign national, contractor, etc).

10. Service Duty Occupation Code - Enter code to which military members duty occupation is assigned (e.g., MOS, SSI, NEC/Rating, NOBC, or AFSC in which individual is actually working). Enter number code of civilian job series in which civilian member is actually working (e.g., for a carpenter enter "4607").

11. Mailing Address of Assignment - Enter unit, office symbol and zip code/APO of individual's current duty assignment.

12. Location - Place of Work - Enter installation name, and specific location where individual is routinely exposed to hazardous noise including building number (e.g., Corpus Christi, NAS, Bldg 1571, Carpenter Shop).

13. Major Command - Enter authorized abbreviation of military major command to which individual is assigned.

14. Duty Phone - Enter individual's duty phone number.

15. Audiometry

a. Purpose - Enter number in box for reason to complete audiogram

"1" - First periodic test given 90 days after beginning duties in noise-hazardous area or operation.

"2" - Periodic test given at yearly intervals.

"3" - Last test given, regerdless of noise exposure history, before termination of active duty or employment.

"4" - Test at interval for reason not listed above.

b. Current Audiogram Date -Enter year, month, day (see item 7) that audiometric test is given and current threshold levels determined for this individual at six frequencies in each ear. Results are entered in 5 dB increments (e.g., 0,5,10,15, etc). If responses exceed maximum limits of audiometer, enter that limit with plus sign (e.g., "110+").

c. Reference Audiogram Date - Enter year, month, day (see item 7) reference test results were obtained. See DD Form 2215, Reference Audiogram or other appropriate source. Enter threshold levels in 5 dB increments from reference audiogram.

d. Threshold Shift: Enter difference between current and reference audiogram for 1000, 2000, 3000 & 4000 Hz, both ears. Subtract number in reference audiogram row from number in current audiogram row. A current hearing threshold level that is poorer than reference level will show positive threshold shift, e.g., if current audiogram equals "35" and reference audiogram equals "15", then threshold shift is "+20". Conversely, if current audiogram is better than reference, threshold shift will be negative, e.g., if current audiogram is "10" and reference audiogram is "20", then the threshold shift is "—10". If current and reference hearing threshold levels are the same, the entry is "0". For example:

AUDIOMETRIC DATA RE: ANSI S3.6	LEFT					
	500	1000	2000	3000	4000	6000
CURRENT AUDIOGRAM DATE (Year, month, day): 7 8 0 4 1 4	10	10	20	35	30	0
REFERENCE AUDIOGRAM DATE (Year, month, day): 7 5 0 4 2 1	10	20	15	15	25	0
THRESHOLD SHIFT + = Poorer — = Better	/	-10	+5	+20	+5	/

e. Significant Threshold Shift (STS): A threshold shift of 20 dB or more at 1000, 2000, 3000 or 4000 Hz, either ear, is significant. (Threshold shift at 500 and 6000 Hz is not calculated.) Enter "1" if threshold shift is less than 20 dB. Enter "2" if 20 dB or greater (+ or —).

f. STS NO: Outlines procedures required when no significant threshold shift found.

"Counsel" - Individuals should be reminded that excessive noise may cause hearing loss in future if they become lax in their efforts to minimize exposure to intense sound.

"Return to Duty" - no immediate followup required.

"Retest in 12 Months" - Arrange for scheduling annual test, etc.

g. STS YES: Outlines procedures required when a significant threshold shift present:

"Notify Supervisor" - Notify individual's supervisor that significant threshold shift has been found and followup audiogram must be done. "Followup No 1 after Minimum 15 Hours Noise Free" - Schedule individual for the first followup audiogram. They must be instructed to stay in a noise free environment (not to exceed 75 dBA or 120 dBP) for at least 15 hours prior to test. They must be told to avoid environments in which noise levels make it necessary to use raised voice to talk at 1 meter (3 ft) distance. If examinee has obvious ear problem (e.g., earache, draining ear, excessive cerumen buildup), he/she should be examined by physician and followup postponed until after any necessary treatment.

h. Name of Examiner - Enter surname, given name, and middle initial of individual operating audiometer.

i. Training Certificate No. - Enter audiometer technician training certificate number.

j. SSN - Enter examiner's nine digit social security number.

k. Service Duty Occupation Code - Enter examiner's service duty occupation code (see item 10).

l. Office Symbol - Enter complete office symbol where examiner is performing test.

m. Type - Enter number for type of audiometer used (e.g., "1" for manual type, etc).

n. Model - Enter manufacturer's designation of audiometer.

o. Manufacturer - Enter name of company that produced audiometer.

p. Serial Number - Enter manufacturer's serial number of audiometer.

q. Last Electroacoustic Calib Date - Enter year, month, day (see item 7) of last electroacoustic determination of this audiometer's performance specifications.

16. Followup No 1 - If significant threshold shift determined on periodic test, record results of first followup audiogram in this section. Check box to certify "minimum 15 Hours Noise Free" since preceding periodic audiogram (see item 15g).

a. "Current Audiogram", "Reference Audiogram" & "Threshold Shift" rows completed in same format as above. Note: Hearing threshold levels entered in "Reference Audiogram" row are same values as those used in reference row of periodic audiogram.

b. STS NO - If no STS noted, enter "1" in box and follow steps in "STS NO" section.

c. STS YES - If STS remains following this examination (Followup No 1) steps in the "STS Yes" section are followed, i.e., supervisor is notified for the second time, individual is scheduled for Followup No 2 audiogram and individual is instructed to stay in a noise free environment (not to exceed 75 dBA or 120 dBP) for a minimum of 40 hours of auditory rest since Followup No. 1.

d. Enter "same" in any boxes pertaining to examiner or audiometer if this information is unchanged from periodic audiogram. If different, enter the required information according to guidelines for entries on periodic audiogram.

17. Followup No 2 - If significant threshold shift determined on Followup No 1, record results of Followup No 2 in this section. Check box to certify "Minimum 40 Hours Noise Free Since Followup No 1 (see item 15g).

a. "Current Audiogram", "Reference Audiogram" & "Threshold Shift" rows are completed in same format as above. Note: Hearing threshold levels entered in "Reference Audiogram" row are same values as used in reference row of periodic audiogram.

b. STS NO - If no STS noted, enter "1" in box and follow steps in STS No section.

c. STS Yes - If STS remains following this examination (Followup No 2), enter "2" in box and follow steps in "STS Yes" section. Refer to DOD component instructions for appropriate patient disposition.

d. Enter "same" in any box pertaining to examiner or audiometer if this information is unchanged from Followup No 1. If different, enter required information according to guidelines for entries on periodic audiogram.

18. Reviewed and Validated By

a. Enter name (surname, given name, and middle initial) of individual reviewing audiogram (usually local surgeon or designated representative). Review audiogram as noted in "STS" instruction sections above. Indorse with signature after ensuring that all items on original and duplicates are filled out legibly, correctly and completely.

b. Service Duty Occupation Code - see item 10.

c. Autovon - Enter AUTOVON phone number of reviewer.

d. SSN - see item 4.

e. Office Symbol - Enter reviewer's complete office symbol.

DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
P.O. BOX 10100
CAMP LEJEUNE, NORTH CAROLINA 28547-0100

IN REPLY REFER TO
6100
15A3
21 MAR 97

From: Commanding Officer, Naval Hospital, Camp Lejeune, NC
To: Commanding Officer, I COMPANY, 3/2, 2D MARDIV., CLNC

Subj: MEDICAL BOARD IN THE CASE OF CPL RONNIE L. KIMBLE, USMC,

Ref: (a) MANMED Chapter 18
(b) SECNAVINST 1850.4C

1. The above named member is being processed for a PHYSICAL EVALUATION BOARD.

2. Initial Diagnosis are: HYPERSOMOLENCE

3. Recommended Limitations of Duty are: NO PFT, DRILLING, SQUATTING, DIGGING, FIRING RANGE, PROLONGED STANDING, FORMATION (OVER 10 MINUTES), DRIVING MILITRY VEHICLES, LIFTING WEIGHTS (OVER 10 LBS), GUARD DUTY, KNEELING, JUMPING, CRAWLING.

4. The member is non-deployable. We request the member not be granted leave until the medical board is signed. Member may be granted liberty per discretion of the member's command provided they are in compliance with the limitations. Emergency leave may be granted per command's approval. If granted, please notify the Medical Board Section.

5. We request written notification if member is pending disciplinary action or administrative separation, as these take precedence over a medical board.

6. Member is directed to report to the Medical Board Section to read and sign the medical board dictation on 09 APRIL 1997 at 1300.

7. Member is directed to report to the Medical Board Section to attend the mandatory PEB/DTAP class on 09 APRIL 1997 at 0800.

8. Member is directed to report to his/her BAS or Dispensary to have a physical exam. A copy of the physical exam must forwarded or hand-delivered to the medical board section when completed.

9. Point of contact at this command is Mrs. Rhodes, Medical Boards, at 451-4588.

M. S. Curnow

M. S. CURNOW
By direction

Copy to:
Member
File
Health Record

Subj: MEDICAL BOARD IN THE CASE OF CPL RONNIE L. KIMBLE, USMC,

STATEMENT OF AWARENESS

I hereby acknowledge I have been informed that my medical board is being processed. I have been informed of the following appointments (appointment to read and sign dictation, appointment to attend DTAP). I have been notified that I need to contact my BAS/Dispensary to have a physical exam. I have also been informed of the preliminary lab work requirements prior to a physical exam.

I understand that a copy of the physical exam should be forwarded or hand-delivered to the Medical Board Section after it has been completed. I understand that my medical board cannot be forwarded to the Physical Evaluation Board Office without full documentation to include the physical exam.

I understand until the board is **signed** I am to remain in the vicinity of my command. I further understand in case of emergency, I am to contact the Disability Evaluation System Counselor, at 451-4450 and I am to return to the Naval Hospital when directed. I further understand that if I go on leave I am to notify the Disability Evaluation System Counselor of my leave address and phone number.

Ronnie L Kimble
Member's Signature

Copy to:
Member
File
Health Record
BAS

DATE 21 MAR 97

E. RANDUM

rom: Disability Evaluation System Counselor, Naval Hospital, CLNC
o: CPL RONNIE L. KIMBLE, USMC,

ubj: DISABILITY TRANSITION ASSISTANCE PROGRAM (D-TAP)

ef: (a) SECNAVINST 1850.4C
(b) MILPERSMAN 3620270
(c) MCO P1900.16 Chap 8

. Public Law 101-510, extended D-TAP nationwide for all service members waiting discharge for disability or who believe they have a disability ualifying them for vocational rehabilitation. Attendance at D-TAP is andatory unless the service member cannot attend for reasons beyond his or er control.

. You are currently being processed in accordance with references (a) and b) or (c) for determination of Fit for Duty by reason of the submission of medical board reporting a condition(s) which may be considered unfitting or your continuation of military service.

. The next D-TAP program will be held on 09 APRIL 97 beginning at 0800, located at Naval Hospital, Camp Lejeune, NC.

. This program will explain the disability procedures as your case is rocessed and Veterans Administration Rights, Benefits and Vocational ehabilitation to which you may be entitled. Your attendance is mandatory. ailure to attend may result in administrative action being taken. If you annot make the above scheduled date for any reason, your command must ontact me at least 24 hours prior to the course at 451-4450 to be escheduled.

William T. Gibson
W. T. GIBSON, MSC
DES Counselor

ubj: DISABILITY TRANSITION PROGRAM (D-TAP)

, CPL RONNIE L. KIMBLE, USMC, have been informed that I must attend the D-TAP n 09 APRIL 97 AT 0800. I understand that I have been scheduled to atten the ext class and it is to my advantage to attend the class. I also understand hat failure to attend may result in administrative action being taken.

Ronnie L. Kimble
(Member's Signature)

: to:
ile
ember
ESC

FF: NMC PORTSMOUTH VA
Personal Data - Privacy Act of 1974 (PL 5[illegible])
[illegible]: STOCK,MARGARET E
[illegible]:
SN:
APT: JMS:
BP: [illegible]/57 PULSE: 71 RESP: 20 TEMP: 97.5 HT: 72 WT: 175 AGE: 25

DIV: NAVAL MEDICAL CENTER PORTSMOUT
Automated Version of SF600
10 Mar 1997 ~~10:00~~ 0830 AM NEW 8A3A
CMT: cfg

A 18

He drove here.
He says he is able to predic when episodes and pull off the road.

Additional Comments:

I have a sleeping disorder
" They don't know what kind "
" They want me to have Allergy testing "
"I used to do landscaping. If I had had allergies I'd be dead by now"
In the past 4yrs he has uncontrollable hypersomnolence. Falls asleep maybe once a day
Sleeps all night as night. Not aware of restless or uncomfortable sleep. Not a snorer but "deep breather, like I'm fighting to get my breath"
Has had 2 sleep studies here.
Recent septoplasty - nasal airway seems clear to him now.
Dr, who did his nose surgery put him on Vancenase for his sinuses.

FH
(+) asthma mother
(+) "sinus" father

MARGARET E. STOCK
CDR, MC, USN
293-32-9845

EXAM ⇒ He appears well.
ENT - somewhat poorer space (L) nostril mid turn Rt = pale.
Neck -
Chest - clear.

Stock allergist

Impr: It is extremely easy to determine his atopic status, but I would have to defer the interpretation of the tests vis-a-vis his medical problems.
I will fax the results to the ARS. He will provide

Patient Education Given _____
Return 1 wk __ 2 wks __ 1 month __ 3 months __ 6 months __ 1 year __ other __

KIMBLE,RONNIE
17 Jan 1972 MALE
Spon: KIMBLE,RONNIE
CS:
UNIT: qatrs subbatS 3RDMAR
M11
W: (910) 451-5646 H: (910) 697-0076
CIC:
Rank: CPL D: (910) 451-5646
RR: LOCATION IN ANOTHER MTF

SF500

DEPARTMENT OF THE NAVY
Naval Hospital
P. O. Box 10100
Camp Lejeune, North Carolina 28547-0100

MEMORANDUM

Date: 17 MARCH 1997

From: Patient Administration Department, Medical Board Section
To: Commanding Officer,

Subj: PHYSICAL EVALUATION BOARD

1. CPL RONNIE L. KIMBLE, USMC, is being processed for a Physical Evaluation Board (PEB).

2. The member will be given information regarding the process of the Physical Evaluation Board following a class on FRIDAY, 21 MARCH 1997 at 0700 (CLASS ROOM C)

3. If the member is a "NO SHOW" for the appointment you will be notified.

4. If the member needs to reschedule his/her appointment please contact the medical board section twenty-four (24) hours prior to the scheduled appointment.

5. Point of contact is Mrs. Rhodes at 451-4588.

Sharon Rhodes
Sharon Rhodes
Physical Evaluation Board Counselor

I hereby acknowledge I have been informed that I am being placed on a Physical Evaluation Board (PEB). I understand that I have an appointment scheduled for FRIDAY, 21 MARCH 1997 AT 0700 (CLASS ROOM C) for counseling of the Physical Evaluation Board.

Ronnie L Kimble
Member's Signature

DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
P.O. BOX 10100
CAMP LEJEUNE, NORTH CAROLINA 28547-0100

IN REPLY REFER TO:
6100
15A3
21 MAR 97

From: Commanding Officer, Naval Hospital, Camp Lejeune, NC
To: Commanding Officer, I COMPANY, 3/2, 2D MARDIV., CLNC

Subj: MEDICAL BOARD IN THE CASE OF CPL RONNIE L. KIMBLE, USMC,

Ref: (a) MANMED Chapter 18
(b) SECNAVINST 1850.4C

1. The above named member is being processed for a PHYSICAL EVALUATION BOARD.

2. Initial Diagnosis are: HYPERSOMOLENCE

3. Recommended Limitations of Duty are: NO PFT, DRILLING, SQUATTING, DIGGING, FIRING RANGE, PROLONGED STANDING, FORMATION (OVER 10 MINUTES), DRIVING MILITRY VEHICLES, LIFTING WEIGHTS (OVER 10 LBS), GUARD DUTY, KNEELING, JUMPING, CRAWLING.

4. The member is non-deployable. We request the member not be granted leave until the medical board is signed. Member may be granted liberty per discretion of the member's command provided they are in compliance with the limitations. Emergency leave may be granted per command's approval. If granted, please notify the Medical Board Section.

5. We request written notification if member is pending disciplinary action or administrative separation, as these take precedence over a medical board.

6. Member is directed to report to the Medical Board Section to read and sign the medical board dictation on 09 APRIL 1997 at 1300.

7. Member is directed to report to the Medical Board Section to attend the mandatory PEB/DTAP class on 09 APRIL 1997 at 0800.

8. Member is directed to report to his/her BAS or Dispensary to have a physical exam. A copy of the physical exam must forwarded or hand-delivered to the medical board section when completed.

9. Point of contact at this command is Mrs. Rhodes, Medical Boards, at 451-4588.

M. S. Curnow

M. S. CURNOW
By direction

Copy to:
Member
File
Health Record
BAS

DATE 21 MAR 97

ME. RANDUM

From: Disability Evaluation System Counselor, Naval Hospital, CLNC
To: CPL RONNIE L. KIMBLE, USMC,

Subj: DISABILITY TRANSITION ASSISTANCE PROGRAM (D-TAP)

Ref: (a) SECNAVINST 1850.4C
(b) MILPERSMAN 3620270
(c) MCO P1900.16 Chap 8

1. Public Law 101-510, extended D-TAP nationwide for all service members awaiting discharge for disability or who believe they have a disability qualifying them for vocational rehabilitation. Attendance at D-TAP is mandatory unless the service member cannot attend for reasons beyond his or her control.

2. You are currently being processed in accordance with references (a) and (b) or (c) for determination of Fit for Duty by reason of the submission of a medical board reporting a condition(s) which may be considered unfitting for your continuation of military service.

3. The next D-TAP program will be held on 09 APRIL 97 beginning at 0800, located at Naval Hospital, Camp Lejeune, NC.

4. This program will explain the disability procedures as your case is processed and Veterans Administration Rights, Benefits and Vocational Rehabilitation to which you may be entitled. Your attendance is mandatory. Failure to attend may result in administrative action being taken. If you cannot make the above scheduled date for any reason, your command must contact me at least 24 hours prior to the course at 451-4450 to be rescheduled.

William T. Gibson
W. T. GIBSON, MSC
DES Counselor

Subj: DISABILITY TRANSITION PROGRAM (D-TAP)

I, CPL RONNIE L. KIMBLE, USMC, have been informed that I must attend the D-TAP on 09 APRIL 97 AT 0800. I understand that I have been scheduled to attend the next class and it is to my advantage to attend the class. I also understand that failure to attend may result in administrative action being taken.

Ronnie L Kimble
(Member's Signature)

Copy to:
File
Member
DESC

Subj: MEDICAL BOARD IN THE CASE OF CPL RONNIE L. KIMBLE, USMC,

STATEMENT OF AWARENESS

I hereby acknowledge I have been informed that my medical board is being processed. I have been informed of the following appointments (appointment to read and sign dictation, appointment to attend DTAP). I have been notified that I need to contact my BAS/Dispensary to have a physical exam. I have also been informed of the preliminary lab work requirements prior to a physical exam.

I understand that a copy of the physical exam should be forwarded or hand-delivered to the Medical Board Section after it has been completed. I understand that my medical board cannot be forwarded to the Physical Evaluation Board Office without full documentation to include the physical exam.

I understand until the board is signed I am to remain in the vicinity of my command. I further understand in case of emergency, I am to contact the Disability Evaluation System Counselor, at 451-4450 and I am to return to the Naval Hospital when directed. I further understand that if I go on leave I am to notify the Disability Evaluation System Counselor of my leave address and phone number.

Ronnie L Kimble
Member's Signature

Copy to:
Member
File
Health Record
BAS

AUTOMATED MEDICAL BOARD REPORT COVER SHEET INTERNAL MEDICINE OUTPATIENT BO

FROM: NAVAL HOSPITAL,CAMP LEJEUNE,NC NAME: KIMBLE, RONNIE L
TO PEB ARLINGTON, VA DUTY STATION: 3/2, 2ND MARDIV
VIA: MEDICAL BOARD DIVISION SSN: SEX: MALE RACE: C
LENGTH OF SERVICE: 3 YR 11 MON GRADE/RANK SERVICE DOB: 72.01.17
RPTUIC->68093 DUTYUIC->12130 PSDUIC->12130 CPL USMC MTO:
CAUSE OF INJURY: OTHER EXTERNAL CAUSE EAOS: 97.04.06
ENTRANCE PHYSICAL EXAMINATIONS:
ADMITTED TO SICK LIST: NO DATE OF DISPOSTION: N/A LOD REQUIRED: NO
DATE OF BOARD: 18 March 1997 DISCIPLINARY ACTION PENDING: NO

	ICD-9-CM	DIAGNOSIS	EPTE(ORIGIN)
PRIMARY:	7811	HYPERSOMNOLENCE WITH EXCESSICE DAYTIME SLEEPINESS	3
SECOND:			
THIRD:			
FOURTH:			
FIFTH:			
SIXTH:			

A 19

INDICATED DISPOSITION: REFER TO PHYSICAL EVALUATION BOARD
LIMITED DUTY EXPIRES ON: N/A LIMITATIONS ARE:
WITH

BOARD MEMBERS SIGNATURE

SENIOR MEMBER: S. REED, CDR MC USN Sandra L Reed MD

JUNIOR MEMBER: E. CZANDER**, LT MC USNR

ENCLOSURES:

X	SIGNED NAVMED 6100/2	MEMBERS'S REBUTTAL	LOD INVESTIGATI
	SIGNED NAVMED 6100/3 X	COPY OF HEALTH RECORD	CLINICAL RECORD
X	PREVIOUS BOARD	X SF 88, SF 93	X DD FORM 2697

ACTION: MEMBER SENT TO TO AWAIT FINDINGS
APPROVED: YES/NO ADMINISTRATIVE INVOLUNTARY SEPARATION IS/IS NOT PENDING.
DATE CONVENING AUTHORITY SIGNATURE
S.R.MCCLELLAND,BY DIRECTI, CAPT MC USN

MEMO ENDORSEMENT UPON REEVALUATION: MEMBER EXAMINED THIS DATE. THE RESULTS AND FINDINGS ARE: _____

MEMBER COUNSELED THIS DATE OF THE FIND NG OF FIT FOR FULL DUTY:
DATE SIGNATURE GRADE/CORPS/SERVICE

EXAM PHYSICIAN:

MEMBER:

HEAD OF DEPT:

MEMBER TRANSFERRED TO _____
AWAITING FINAL ACTION

NAVAL HOSPITAL, CAMP LEJEUNE, NORTH CAROLINA 28547-0100

154
D/T:03-18/19-97

Subj: KIMBLE, RONNIE L., CPL, , USMC

This 24-year-old, Caucasian male, Corporal, United States Marine Corps, with 03 years and 11 months active duty, was evaluated in the Neurology Clinic, Naval Hospital, Camp Lejeune, North Carolina on 18 March 1997 for HYPERSOMNOLENCE.

Attention is invited to the report of the previous Medical Board dated 15 May 1996 from Naval Hospital, Camp Lejeune, North Carolina with the diagnosis of HYPERSOMNOLENCE, recommending six months limited duty.

The patient is a twenty-four year old right handed male evaluated in the Neurology Clinic for hypersomnolence. The patient states that this has been progressively worsening over many years. He states he falls asleep many times during the day and has occurred once while driving. It also can occur while standing. He knows when he is about to fall asleep. Caffeine has been of no help. He has no trouble falling asleep at night or staying asleep. His wife has noted him sitting up while sleeping and he states he slept walked as a child; no noted sleep walking as an adult. He goes to sleep around 10:00 p.m. and wakes up at 7:00 a.m. He takes 0-1 naps per day. He denies any headaches, no vision changes, no diplopia, no dysarthria, dysphagia, weakness or numbness, no loss of consciousness, head trauma or seizure activity, no enuresis, tongue bite or muscle soreness upon awakening. The patient has been evaluated by a sleep specialist, Dr. DeBeck, and was diagnosed as possibly being a long sleeper. He's had a polysomnogram with multiple sleep latency tests back in 1995 which was determined to be normal. He's also had further work-up including a psychiatric consult which showed no abnormalities, an MRI of the head in May of 1996 which was normal and this was done with gadolinium. He had a Chem-18, CBC, sedimentation rate, Monospot, angiotensin converting enzyme level, RPR, MHA, urinalysis and urine drug screen which were all normal. He was tried on a trial of Zoloft 50 mg PO q day without any evidence of help and he underwent a second polysomnogram multiple sleep latency test on 22 January 1997. The patient had 34 respiratory events averaging about 4 per hour with a minimal oxygen saturation at 89%. Multiple sleep latency tests showed a mean sleep latency of 10.4 minutes and no sleep onset REM over 4 naps. He was diagnosed as having primary snoring and no evidence of significant obstructive sleep apnea, narcolepsy or pathologic sleepiness. He was also seen by an allergist at Portsmouth and there was no determined cause of his hypersomnolence secondary to allergies. He had been evaluated by Ear, Nose and Throat and had a septoplasty done in September of 1996. This did not help him in terms of his sleepiness during the day. The patient also denied any sleep paralysis or hypnagogic and hypnopompic hallucinations. The patient also denied any anhedonia but he did have the stress of his wife having a miscarriage in 1996.

NAVAL HOSPITAL, CAMP LEJEUNE, NORTH CAROLINA 28547-0100

154
D/T:03-18/19-97

Subj: KIMBLE, RONNIE L., CPL, USMC

Past medical history; nonsignificant. Medications; none. Allergies; none. Social history; the patient is married, he has no children, he works in the Base Chaplain Office. He dips about one can every 2 days and rarely drinks. He denies any drug use. Family history; his brother has similar problems. Review of systems is otherwise negative.

Physical exam; the patient is a well-developed, well-nourished white male in no apparent distress with blood pressure of 115/64, pulse of 68, respirations of 16, temperature of 98.9, height of 72 inches and weight of 175 pounds. He is alert and oriented x 3. His attention to months in reverse is normal. Naming, comprehension, repetition and fluency are all normal. Visuospatial skills are normal. Funduscopy exam shows sharp discs bilaterally. Pupils are equally round and reactive to light and accommodation are intact. He has full visual fields. His face is symmetrical. Tongue and palate are midline. He has normal facial sensation, normal opticokinetic nystagmus but he does have breakdown of smooth pursuit. He has 5 out of 5 strength throughout in all four extremities, no pronator drift, normal fine finger movements and finger-to-nose testing. His gait and tandem walking are normal. He has normal vibration and temperature and pinprick sensation. He has 2+ deep tendon reflexes, symmetrically and downgoing plantar responses bilaterally.

Assessment is hypersomnolence with excessive daytime sleepiness. The patient has had two polysomnogram multiple sleep latency tests which did not show any evidence of definite pathology. There is no definite evidence of significant obstructive sleep apnea or narcolepsy. However this has been interfering with his work and he did at one point fall asleep while driving. The plan is to (1) stop tobacco use; (2) increase exercise to at least 3 x per week and (3) to get in contact with the Sleep Disorder Association of America.

FINAL DIAGNOSIS:

HYPERSOMNOLENCE WITH EXCESSIVE DAYTIME SLEEPINESS

It is therefore the opinion of the Medical Board that the above diagnosis is correct. The Board concludes that this condition limits and or deters the patient's ability to satisfactorily fulfill the duties of an active duty member. The Board therefore refers the patient's case to the Physical Evaluation Board for final disposition.

The patient has been informed of the contents of Medical Board's report and does/does not desire to submit a statement in rebuttal.

CAUTION: NOT TO BE USED FOR IDENTIFICATION PURPOSES

THIS IS AN IMPORTANT RECORD. SAFEGUARD IT.

ANY ALTERATIONS IN SHADED AREAS RENDER FORM VOID

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

1. NAME (Last, First, Middle)	2. DEPARTMENT, COMPONENT AND BRANCH	3. SOCIAL SECURITY NO.
KIMBLE Ronnie Lee	USMC-11	

4.a. GRADE, RATE OR RANK	4.b. PAY GRADE	5. DATE OF BIRTH (YYMMDD)	6. RESERVE OBLIG. TERM. DATE
LCpl	E-3	720117	Year 97 Month 06 Day 16

7.a. PLACE OF ENTRY INTO ACTIVE DUTY	7.b. HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known)
Charlotte MEPS Charlotte NC 28202-1626	6318 Liberty Road Julian NC 27283
8.a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND 3dBN 2dMAR 2dMARDIV FMF	8.b. STATION WHERE SEPARATED RUC 12130 Camp Lejeune NC 28542-0096
9. COMMAND TO WHICH TRANSFERRED Marine Corps Reserve Support Command 15303 Andrews Road Kansas City MO 64147-1207 RUC 36005	10. SGLI COVERAGE ☐ None Amount: $ 200,000

11. PRIMARY SPECIALTY (List number, title and years and months in specialty. List additional specialty numbers and titles involving periods of one or more years)

0311: Rifleman: 3yrs5mos

12. RECORD OF SERVICE	Year(s)	Month(s)	Day(s)
a. Date Entered AD This Period	93	04	07
b. Separation Date This Period	97	06	16
c. Net Active Service This Period	04	02	10
d. Total Prior Active Service	00	00	00
e. Total Prior Inactive Service	00	02	11
f. Foreign Service	00	00	00
g. Sea Service	00	06	12
h. Effective Date of Pay Grade	97	06	16

13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (All periods of service)

National Defense Service Medal
Sea Service Deployment Ribbon
Armed Forces Expeditionary Medal
Good Conduct Medal
Certificate of Appreciation (2)
Certificate of Commendation
Letter of Appreciation
Rifle Expert Badge

14. MILITARY EDUCATION (Course title, number of weeks, and month and year completed)

NONE

15.a. MEMBER CONTRIBUTED TO POST-VIETNAM ERA VETERANS EDUCATIONAL ASSISTANCE PROGRAM	Yes	No	15.b. HIGH SCHOOL GRADUATE OR EQUIVALENT	Yes	No	16. DAYS ACCRUED LEAVE PAID
		X		X		SLB 0.0/RLB 17.5

17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION ☒ Yes ☐ No

18. REMARKS

Good Conduct Medal period commences 960407
Subject to active duty recall and or annual screening

While a member of the Marine Corps Reserve, you will keep the Director, MCRSC (Toll free 1-800-255-5082, or if in the State of Kansas call commercial (913) 236-3108; if DSN is available, call 465-3110) informed of any change of address, marital status, number of dependents, civilian employment, or physical standards.

19.a. MAILING ADDRESS AFTER SEPARATION (Include Zip Code)	19.b. NEAREST RELATIVE (Name and address - include Zip Code)
6318 Liberty Road Julian NC 27283	Ronnie L Kimble (F) Same as Block 19a
20. MEMBER REQUESTS COPY 6 BE SENT TO NC DIR. OF VET AFFAIRS ☒ Yes ☐ No	22. OFFICIAL AUTHORIZED TO SIGN (Type name, grade, title and signature) Gary L Thompson GARY L THOMPSON, CWO3, BnPersO
21. SIGNATURE OF MEMBER BEING SEPARATED MARINE NOT AVAILABLE	

DD Form 214, NOV 88 S/N 0102-LF-006-5500 Previous editions are obsolete.

MEMBER 4

CAUTION: NOT TO BE USED FOR IDENTIFICATION PURPOSES

THIS IS AN IMPORTANT RECORD. SAFEGUARD IT.

ANY ALTERATIONS IN SHADED AREAS RENDER FORM VOID

CERTIFICATE OF RELEASE OR DISCHARGE FROM ACTIVE DUTY

1. NAME (Last, First, Middle)	2. DEPARTMENT, COMPONENT AND BRANCH	3. SOCIAL SECURITY NO
KIMBLE Ronnie Lee	USMC-11	

GRADE, RATE OR RANK	4.b. PAY GRADE	5. DATE OF BIRTH (YYMMDD)	6. RESERVE OBLIG. TERM. DATE
LCpl	E-3	720117	Year 97 Month 06 Day 16

7.a. PLACE OF ENTRY INTO ACTIVE DUTY	7.b. HOME OF RECORD AT TIME OF ENTRY (City and state, or complete address if known)
Charlotte MEPS Charlotte NC 28202-1626	6310 Liberty Road Julian NC 27283

8.a. LAST DUTY ASSIGNMENT AND MAJOR COMMAND	8.b. STATION WHERE SEPARATED
3dFSR 2dMAR 2dMARDIV FMF	MCC 12130 Camp Lejeune NC 28542-0096

9. COMMAND TO WHICH TRANSFERRED	10. SGLI COVERAGE
Marine Corps Reserve Support Command 14303 Andrews Road Kansas City MO 64147-1207 MCC 36005	☐ None Amount: $ 200,000

11. PRIMARY SPECIALTY (List number, title and years and months in specialty. List additional specialty numbers and titles involving periods of one or more years.)

0311: Rifleman: 3yrs5mo

12. RECORD OF SERVICE	Year(s)	Month(s)	Day(s)
a. Date Entered AD This Period	93	04	07
b. Separation Date This Period	97	06	16
c. Net Active Service This Period	04	02	10
d. Total Prior Active Service	00	00	00
e. Total Prior Inactive Service	00	02	11
f. Foreign Service	00	00	00
g. Sea Service	00	06	12
h. Effective Date of Pay Grade	97	06	16

13. DECORATIONS, MEDALS, BADGES, CITATIONS AND CAMPAIGN RIBBONS AWARDED OR AUTHORIZED (All periods of service)

National Defense Service Medal
Sea Service Deployment Ribbon
Armed Forces Expeditionary Medal
Good Conduct Medal
Certificate of Appreciation (2)
Certificate of Commendation
Letter of Appreciation
Rifle Expert Badge

14. MILITARY EDUCATION (Course title, number of weeks, and month and year completed)

NONE

15.a. MEMBER CONTRIBUTED TO POST-VIETNAM ERA VETERANS' EDUCATIONAL ASSISTANCE PROGRAM	Yes	No	15.b. HIGH SCHOOL GRADUATE OR EQUIVALENT	Yes	No	16. DAYS ACCRUED LEAVE PAID
		X		X		SLB 0.0/RLB 17.5

17. MEMBER WAS PROVIDED COMPLETE DENTAL EXAMINATION AND ALL APPROPRIATE DENTAL SERVICES AND TREATMENT WITHIN 90 DAYS PRIOR TO SEPARATION [X] Yes [ ] No

18. REMARKS

Good Conduct Medal period commences 960207
Subject to active duty recall and or annual screening

While a member of the Marine Corps Reserve, you will keep the Director, MMSC (Toll free 1-800-255-5082, or if in the State of Kansas call commercial (913) 236-3108; if DSN is available, call 465-3110) informed of any change of address, marital status, number of dependents, civilian employment, or physical standards.

19.a. MAILING ADDRESS AFTER SEPARATION (Include Zip Code)	19.b. NEAREST RELATIVE (Name and address - Include Zip Code)
6310 Liberty Road Julian NC 27283	Ronnie L Kimble (F) Same as Block 19a
20.a. MEMBER REQUESTS COPY 6 BE SENT TO DIR. OF VET AFFAIRS [X] Yes [ ] No	22. OFFICIAL AUTHORIZED TO SIGN (Typed name, grade, title and signature)
21. SIGNATURE OF MEMBER BEING SEPARATED MARINE NOT AVAILABLE	GARY L THOMPSON, GM03, USMC

SPECIAL ADDITIONAL INFORMATION (For use by authorized agencies only)

23. TYPE OF SEPARATION	24. CHARACTER OF SERVICE (Include upgrades)
Discharged	UNDER OTHER THAN HONORABLE CONDITIONS
25. SEPARATION AUTHORITY MARCORSEPMAN par 6210.6 CG 2dMARDIV ltr 1910 SJA/PM of 9 Jun 97	26. SEPARATION CODE GK01
	27. REENTRY CODE RE-4

28. NARRATIVE REASON FOR SEPARATION

Commission of a Serious Offense

29. DATES OF TIME LOST DURING THIS PERIOD	30. MEMBER REQUESTS COPY 4
(77)970401-970616	Initials

DD Form 214, NOV 88 S/N 0102-LF-006-5500 Previous editions are obsolete. MEMBER 4

CHRONOLOGICAL RECORD OF HIV TESTING

NAVMEDCOMINST 6000.

DATE RECORDED	HIV RESULT	VERIFIED BY	COMMAND UIC	DATE DRAWN	ROSTER NUMBER	TEST OR PROCESS MTF
			08321	08 Mar 94		
KIMBLE, R BC: 04412427 UIC: 08321 3/09/94 FILE ROSTER ID: 083219400098 CTRL #: 940315.0149 RTC CODE: HIV-1 ANTIBODY NEGATIVE BY ABBOTT ELISA			08321	20 JAN 95	08321 9501051	
KIMBLE, R BC: 04503452 UIC: 08321 1/20/95 FILE ROSTER ID: 083219501051 CTRL #: 950131.0144 RTC CODE: HIV-1 ANTIBODY NEGATIVE BY ABBOTT ELISA						
28MAR97	NEG	HINSONSON	12130	17MAR97	121307700012	-3 4/N 41

PATIENT IDENTIFICATION

NAME: KIMBLE RONNIE L

SSN: 20[illegible]

COMMAND/UIC: 08321

BRANCH: USMC

SEX: Male

DOB: 17 JAN 72

STATUS: AD

RANK: PFC

NAVMED 6000/2 (7-89)

*U.S. Government Printing Office: 1989-727-001/00089

S/N 0105-LF-007-1500

REFERENCE AUDIOGRAM

ZIP CODE/APO: 2 9 9 0 5 0 0 1

DOD COMPONENT: [M] — A—ARMY, N—NAVY, F—AIR FORCE, M—MARINES, I—OTHER DOD ACTIVITY

SERVICE COMPONENT: [R] — R—REGULAR, V—RESERVE, G—NATIONAL GUARD, I—OTHER

PERSONAL DATA

SSN: [redacted]

LAST NAME—FIRST NAME—MIDDLE INITIAL: KIMBLE, RONNIE L

SEX (M—MALE, F—FEMALE)	DATE OF BIRTH (year month day)	PAY GRADE, UNIFORMED SERVICES	GRADE, CIVILIAN	SERVICE DUTY OCCUPATION CODE
[M]	7 2 0 1 1 7	E 0 1		9900

MAILING ADDRESS OF ASSIGNMENT: PLT 2061 RTR MCRD/PARRIS ISLAND/SC 29905

LOCATION—PLACE OF WORK	MAJOR COMMAND	DUTY PHONE
COMPANY F	MCRD PISC	— —

AUDIOMETRY

[1]
1. REFERENCE ESTABLISHED PRIOR TO INITIAL DUTY IN HAZARDOUS NOISE AREAS
2. REFERENCE ESTABLISHED FOLLOWING EXPOSURE IN NOISE DUTIES
3. REFERENCE RE-ESTABLISHED AFTER FOLLOWUP PROGRAM

HEARING THRESHOLD LEVELS OF TEST FREQUENCIES RE: ANSI S3.6

LEFT EAR						RIGHT EAR					
500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
5	0	10	0	5	5	-5	5	0	0	0	0

DATE OF AUDIOGRAM (year month day)	DAY OF WEEK (1-SUN 2-MON 3-TUES 4-WED 5-THURS 6-FRI 7-SAT)	MIL-TIME-DAY	HOURS SINCE LAST NOISE EXPOSURE	ENT PROBLEM AT TIME OF TEST (1—NO 2—YES 3—UNKNOWN)
9 3 0 4 0 9	[6]		24	[1]

EXAMINER

LAST NAME—FIRST NAME—MIDDLE INITIAL	TRAINING CERT. NO.	SSN	SERVICE DUTY OCCUPATION CODE	OFFICE SYMBOL
Simmons Manny	924401R		640	32583

AUDIOMETER

TYPE (1-MANUAL 2-SELF-RECORDING (automatic) 3-MICROPROCESSOR)	MODEL	MANUFACTURER	SERIAL NUMBER	LAST ELECTROACOUSTIC CALIB DATE (year month day)
[3]	RA600	TREMETRICS	1277	9 2 1 1 0 4

PERSONAL HEARING PROTECTION

TYPE USED (1-SINGLE FLANGE (V51R), 2-TRIPLE FLANGE, 3-HAND FORMED EARPLUGS, 4-EAR CANAL CAPS, 5-NOISE MUFFS, 6-OTHER)	EARPLUGS ISSUED (1-NO 2-YES 3-PREVIOUSLY ISSUED)	SIZE EARPLUGS (R L) (1-XS 2-S 3-M 4-L 5-XL)	DOUBLE PROTECTION USED (1-NO 2-YES)	GLASSES WORN (including goggles) (1-NO 2-YES)	FREQUENCY GLASSES WORN (1-ALWAYS 2-SELDOM 3-N/A)
[3]	[1]	R L	[1]	[1]	[3]

REMARKS

CONTENTS REVIEWED AND VALIDATED BY

NAME OF REVIEWER (Signature)	SERVICE DUTY OCCUPATION CODE	AUTOVON	SSN	OFFICE SYMBOL
J. C. Holley	640	832-2528		32583

DD FORM 1 Sep 79 2215

HEARING CONSERVATION DATA

ZIP CODE/APO: 28547 0100

DOD COMPONENT: M (A-ARMY, N-NAVY, F-AIR FORCE, M-MARINE CORPS, 1-CTHER DOD ACTIVITY)

SERVICE COMPONENT: R (R-REGULAR, V-RESERVE, G-NATIONAL GUARD, 1-OTHER)

SSN: [redacted]7

LAST NAME—FIRST NAME—MIDDLE INITIAL: KIMBLE, RONNIE

SEX: M (M-MALE, F-FEMALE)

DATE OF BIRTH: year 72 month 01 day 17

PAY GRADE, UNIF SVCS: E04

GRADE, CIVILIAN:

SERVICE DUTY OCCUPATION CODE: 0311

MAILING ADDRESS OF ASSIGNMENT: 3/2 BN/CAMP LEJEUNE/NC 28542

LOCATION—PLACE OF WORK: I CO. UIC=20361

MAJOR COMMAND: SECONDMARDIV .

DUTY PHONE: 910-451-3380

TWA=

AUDIOMETRY

Impulse noise=

PURPOSE: 2 (1—90 DAY, 2—ANNUAL, 3—TERMINATION, 4—OTHER)

AUDIOMETRIC DATA RE: ANSI S3.6

	LEFT						RIGHT					
	500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
CURRENT AUDIOGRAM DATE: year 97 month 03 day 19	10	15	10	05	05	35	05	10	05	05	10	25
REFERENCE AUDIOGRAM DATE: year 93 month 04 day 09	5M	0M	10M	0M	5M	5M	-5M	5M	0M	0M	0M	0M
THRESHOLD SHIFT (+ = Poorer, — = Better)		15	00	05	00			05	05	05	10	

2 (1-No Significant threshold shift, 2-Yes ± 20dB or greater)

STS NO: ● Counsel ● Return to duty ● Retest in 12 mo. ● Validated by reviewer ● Orig in health record ● Send copy to registry

STS YES: ● Notify supervisor ● Followup No. 1 after minimum 15 hours noise free

NAME OF EXAMINER (Last, first, MI): STEWART, MARIA, .

TRAINING CERT. NO: 964702

SSN: 000-00-0020

SERVICE DUTY OCCUPATION CODE: 8499

OFC SYMBOL: 68093

TYPE: 3 (1-Manual, 2-Self-recording (auto), 3-Microprocessor)

MODEL: RA600

MANUFACTURER: PCA

SERIAL NO.: 0976

LAST ELECTROACOUSTIC CALIB DATE: year 96 month 04 day 01

FOLLOWUP NO. 1 — Minimum 15 hours noise free

AUDIOMETRIC DATA RE: ANSI S3.6

	LEFT						RIGHT					
	500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
H1												
CURRENT AUDIOGRAM DATE: year 97 month 03 day 26	05	05	10	05	10	30	05	10	05	05	05	35
REFERENCE AUDIOGRAM DATE: year 93 month 04 day 09	5M	0M	10M	0M	5M	5M	-5M	5M	0M	0M	0M	0M
THRESHOLD SHIFT (+ = Poorer, — = Better)		05	00	05	05			05	05	05	05	

1 (1-No Significant threshold shift, 2-Yes ± 20dB or greater)

STS NO: ● Counsel ● Return to duty ● Retest in 12 mo. ● Validated by reviewer ● Orig in health record ● Send copy to registry

STS YES: ● Notify Supervisor ● Cleared by medical reviewer before Followup No. 2

NAME OF EXAMINER (Last, first, MI): HIDLEBAUGH, DARREL, e.

TRAINING CERT. NO: 9708001

SSN: 000-00-0022

SERVICE DUTY OCCUPATION CODE: 8499

OFC SYMBOL: 68093

TYPE: 3 (1-Manual, 2-Self-recording (auto), 3-Microprocessor)

MODEL: RA600

MANUFACTURER: PCA

SERIAL NO.: 0976

LAST ELECTROACOUSTIC CALIB DATE: year 96 month 04 day 01

FOLLOWUP NO. 2 — Minimum 40 hours noise free since Followup No. 1

AUDIOMETRIC DATA RE: ANSI S3.6

	LEFT						RIGHT					
	500	1000	2000	3000	4000	6000	500	1000	2000	3000	4000	6000
CURRENT AUDIOGRAM DATE: year month day												
REFERENCE AUDIOGRAM DATE: year month day												
THRESHOLD SHIFT (+ = Poorer, — = Better)												

Significant threshold shift ± 20dB or greater: [ ] 1-No 2-Yes

STS NO: ● Counsel ● Return to duty ● Retest in 12 mo. ● Validated by reviewer ● Orig in health record ● Send copy to registry

STS YES: ● Refer to appro directive ● Requires medical disposition ● Validated by reviewer ● Orig in health record ● Send copy to appro registry

NAME OF EXAMINER (Last, first, MI):

TRAINING CERT. NO:

SSN:

SERVICE DUTY OCCUPATION CODE:

OFC SYMBOL:

TYPE: [ ] (1-Manual, 2-Self-recording (auto), 3-Microprocessor)

MODEL:

MANUFACTURER:

SERIAL NO.:

LAST ELECTROACOUSTIC CALIB DATE: year month day

REVIEWED & VALIDATED BY: STEWART, MARIA

SERVICE DUTY OCCUPATION CODE: 8499

AUTOVON: 484-2767

SSN: 000-00-0020

OFC SYMBOL: 68093

DD Form 2216 /N 0102-LF-005-8900

N 7540-00-634-4176

ALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*

26 MEU 3/2 BLT I CO.

20Sep94

ASBESTOS MEDICAL SURVEILLANCE PROGRAM QUESTIONAIRE

Breathing asbestos dust may be hazardous to your health. All personnel who have been, or who are significantly exposed to asbestos are to be included in an Asbestos Medical Surveillance Program (AMSP). While present engineering and environmental controls and personnel protective equipment prevent personnel from being exposed to hazardous levels of asbestos dust, continued periodic medical surveillance is required to assure the continued adequacy of control measures and/or detect early asbestos related changes. Personnel in selected jobs are being surveyed to determine if they should be included in the Asbestos Medical Surveillance Program.

1. During your career, have you been exposed to asbestos dust during rip-out operations, or other asbestos dust operations or worked with asbestos, or asbestos products?

A. Prior to your military/civil service career? YES (NO) UNCERTAIN

B. During your military/civil servive career? YES (NO) UNCERTAIN

2. Total exposure to asbestos in years: ○

3. Years' in rating/job:

4. Brief description of how you were exposed and when exposure was incurred:

SIGNATURE: Ronnie L Kimble

Work phone number:

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT:	3/2 BAS		
PATIENT'S NAME *(Last, First, Middle Initial)*	Kimble, Ronnie L.		SEX male
RELATIONSHIP TO SPONSOR	N/A	STATUS Active Duty	RANK/GRADE LCPL
SPONSOR'S NAME	N/A	ORGANIZATION	R.CO 3/2
DEPART./SERVICE	DOD/USMC	SSN/IDENTIFICATION NO. 20/	DATE OF BIRTH 17JAN72

Standard Form 600
General Services Administration and
Interagency Committee on Medical Records
FPR 101 11 800 8
October 1975

HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

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

BRANCH CLINIC
NAVAL HOSPITAL BEAUFORT

MCRD PARRIS ISLAND, S. C. 29905

DATE

12 APR 1993

SCREENING PHYSICAL EXAMINATION CONDUCTED THIS DATE AND FOUND TO BE PHYSICALLY FIT TO UNDERGO MILITARY TRAINING. SCREENED BY: K. COLBY P.A

K.R. Montgomery

VIEWED FILM ON TESTICULAR SELF EXAM/BREAST EXAM.

MONTGOMERY, K.R.
LT/USN/AD

RECRUIT SCREENING, BLOOD DRAWN THIS DATE AND BLOOD SCREENING TESTS (LABORATORY TESTS) CONDUCTED WITH THE FOLLOWING RESULTS:

DATE

BLOOD TYPE AND RH FACTOR
Opos

GLUCOSE 6-PHOSPHATE DEHYDREOGENASE CELL TEST - G6PD TEST

(✓) NORMAL AMOUNT OF ENZYME PRESENT

( ) ABNORMAL/DEFICIENT AMOUNT OF ENZYME

SICKLE CELL HEMOGLOBIN SCREENING TEST

(✓) NEGATIVE FOR SICKLE CELL TRAIT

( ) POSITIVE FOR SICKLE CELL TRAIT
( ) POSITIVE FOR SICKLE CELL DISEASE

SENIOR, R.J.

CDR, MC, USNR

R.J. Senior

SIGNATURE

SECURITY NUMBER	SEX	RACE	DATE OF BIRTH	ORGANIZATION OR UNIT	PHONE
[redacted]	M	C	17 JAN 72	2061	

NAME	SERVICE NO.	RANK	COMP OR BRANCH	SERVICE DEPT. OR AGENCY
KIMBLE RONNIE L		PVT	USMC	DEPT. OF DEFENSE

File as top page on left side of folder.

Summary of Care

(This form is subject to the Privacy Act of 1974)

No.	Significant Health Problem	Date
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		

Medical Alert *(SBE Prophylaxis, allergies, other)*
NKA
Alcohol:
Tobacco:

Medications	Start	Stop

Exceptional Family Member Program

	Hospitalization/Surgery	Date
1.	Septoplasty	2/97
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.	**Advance Directive Provided:**	
11.	**Advance Directive Returned:**	

Health Maintenance	Date of Last Test *(Pencil entry)*
Prostate Exam	
RPR	
G6PD / GPAB	Normal 12 Dec 96
Stool GUAIAC	
Mammogram	
Chest X-Ray	
ECG	
Birth Control Method	
PAP Smear	
Sickle Cell Trait	Normal 12 Dec 96
HIV Screen	Neg
Other	Chol 203 12 Dec 96

(Continue significant health problems, medications, hospitalizations/surgery on reverse)

Space for Mechanical Imprint

Patient's Name:	Rank/Grade:	Sex:
[redacted]		[redacted]
SSN/Identification Number:	Status:	Date of Birth:
[redacted]	Active Duty	17 JAN 72
Branch of Service:	Organization:	

Patient Name: RONNIE KIMBLE
Test Date: 01/23/97

Staging Summary:

Recording start time :	21:40:23	Recording end time :	05:51:47
Analysis start time :	21:40:23	Analysis end time :	05:51:23
Total number of epochs :	982	Epoch size (sec) :	30
Total recording time (hr) :	8.2	Total sleep time (hr) :	7.7
Number of Awakenings :	16	Total wake time (hr) :	0.5
Sleep Efficiency (%):	94.4	Sleep Maintenance Effic(%):	97.8
Sleep onset latency (min) :	17.5	Stage REM latency (min) :	154.0

Oximetry Summary:

Total number of desaturations	47
Desaturation Index (/hr)	6
Basal O2 during sleep	95.9

Heart Rate Summary:

Basal heart rate during sleep (bpm)	61.9
Slowest heart rate (bpm)	45.5
Fastest heart rate (bpm)	128.6
Number of Bradycardic events	0
Number of Tachycardic events	0

Respiratory Summary:

	Total #	Min time	Max time	Mean	Total hrs
Apneas+Hypopneas	34	10	25	16	0.1
Apneas	27	10	25	16	0.1
Hypopneas	7	11	25	16	0.0

	REM	Non-REM	Sleep
Apneas	4	23	27
Hypopneas	4	3	7
Apneas+Hypopneas	8	26	34
% time in Apnea+Hypopnea	2	2	2
Apnea Index (/hr)	2	4	3
Apnea Arousal Index (/hr)	2	3	3

PLMs and Arousal Summary:

	Number of Movements	Index/hr
Sleep	14	1.8
Wake	0	0.0
Respiratory event related movements	3	

	Arousals	Possible Arousals
Number	234	0
Index (/hr)	30.3	0.0

MEDICAL RECORD — CONSULTATION SHEET

REQUEST

FROM: (Requesting physician or activity) Camp Lejeune - Neurology

DATE OF REQUEST 20 NOV 96

REASON FOR REQUEST (Complaints and findings)

Eyo male with excessive daytime sleepiness, snoring w/ episodes of uncontrollable sleep 1-2/ day, even while driving. Wife denies episodes of sleep paralysis, hallucinations, cataplexy, sleep paralysis. Has had inconclusive PSG/MSLT 9/96 - 6.95 no improvement

PROVISIONAL DIAGNOSIS

R/O Narcolepsy, Obstructive Sleep Apnea

PHYSICIAN'S SIGNATURE — APPROVED — PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL — ☒ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

E.W. CZANDER
LT, MC, USNR
668-8097
NEUROLOGIST

CONSULTATION REPORT

PATIENT EXAMINED ☐ YES ☐ NO

11/26/96 left message at work for Patient to call.

1 auto accident - falling asleep

appt Wednesday Jan 22 @ 2100.

(Continue on reverse side)

SIGNATURE AND TITLE — DATE

Jod 910-451-4633

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 facility)

KIMBLE, Ronnie
20
17 Jan 72
AD/USMC/ECHL

W: 910 451-3240

H: 910 677-2082 non-published

5646

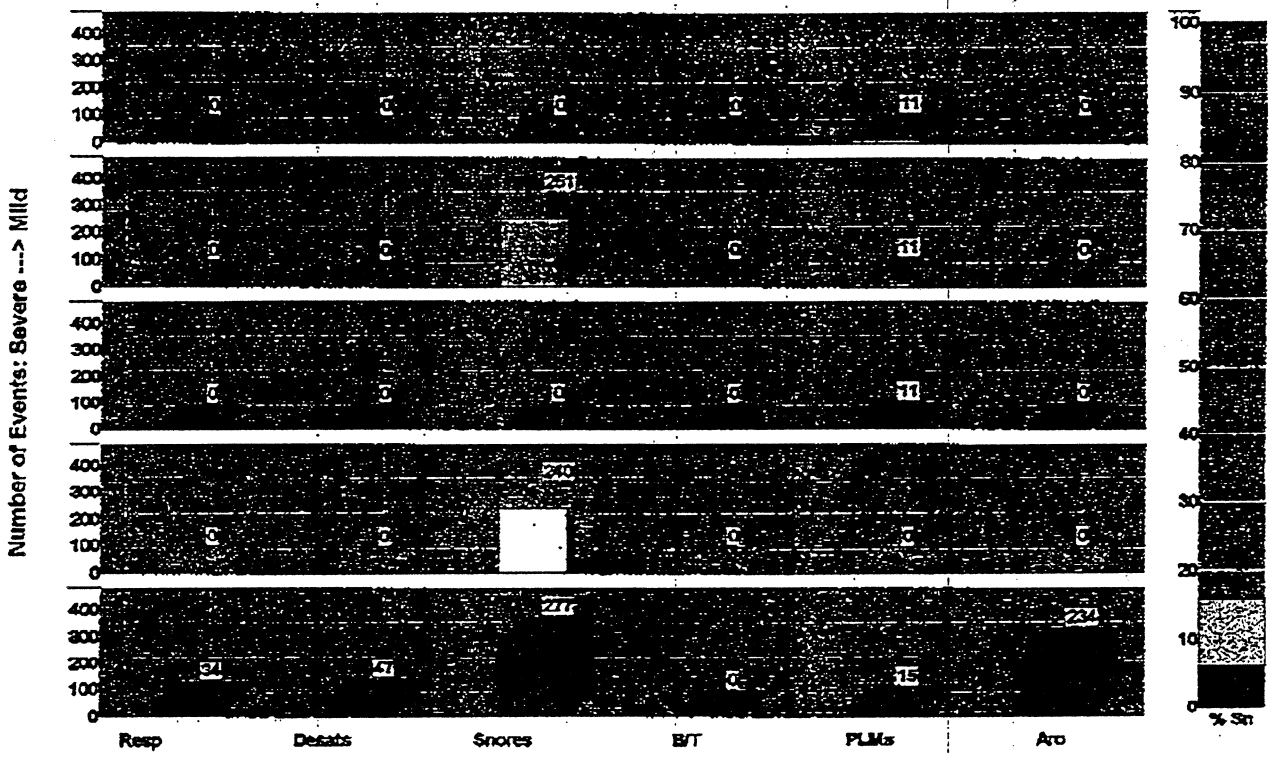
CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 6-82)
Prescribed by GSA/ICMR, FPMR (41 CFR) 101-11.4

1-910-697-0076

Boise Sleep Laboratory, Building One

KIMBLE, RONNIE L.
B970028 01/23/97



IMPRESSIONS

SNORES STRONGLY CORRELATE WITH RESP CHANGES AND AROUSALS
SOME DISORDERED BREATHING NOTED NOT MEETING SCORING CRITERIA

Apnea/Hypopnea Associated Desaturation Summary (including possibles)
Number of Respiratory events (number of associated desaturations)

Event duration	Apneas	Hypopneas	Apneas+Hypopneas
0 - 5	0 (0)	0 (0)	0 (0)
5 - 10	0 (0)	0 (0)	0 (0)
10 - 15	13 (10)	4 (3)	17 (13)
15 - 20	8 (6)	1 (1)	9 (7)
> 20	6 (6)	2 (0)	8 (6)
ALL	27 (22)	7 (4)	34 (26)

Sleep Disorders Laboratory
Naval Medical Center
Portsmouth, Virginia 23708

MULTIPLE SLEEP LATENCY TEST TECHNICIAN REPORT

Date: 1-23-97 Tech: BROWN / HODNETT

PATIENT INFO: Name: RIMBLE, RONNIE /Record No. X970029

Nap #1

0800

Lights out 08:07:28 Lights on _____

Pt fell asleep no (yes) Time 08:10:03

REM no yes Time _____

COMMENTS: _____

Nap #2

1000

Lights out 1008 Lights on _____

Pt fell asleep no (yes) Time 1018 (1023)

REM (no) yes Time _____ (1033)

COMMENTS: audible breathing (nasal)

Nap #3

1200

Lights out 1207 Lights on _____

Pt fell asleep no (yes) Time 12-18 (22)

REM (no) yes Time _____ (25)

COMMENTS: audible breathing (nasal) - closed mouth

Nap #4

1400

Lights out 1407 (1427) Lights on _____

Pt fell asleep no (yes) Time 1426

REM (no) yes Time _____ (1241)

COMMENTS: pt sniffling (nasal drainage)

Nap #5

1400

Lights out _____ Lights on _____

Pt fell asleep no yes Time _____

REM no yes Time _____

COMMENTS: _____

...EUROLOGY CLINIC CZANDER,ERIC W 17 Mar 1997 0730 Pa...
... CMT: 14D
...DN:

...P: 115/64 PULSE: 68 RESP: 16 TEMP: 98.9 HT: 72" WT: 175

ADDITIONAL COMMENTS:

24 yo (R) HO → here for flu & hypersomnolence
He states there have been no changes.
He has seen the allergist at ... Patsmouth - no determined cause of hypersomnolence 2° allergies.
Going to bed 21-2200, awakens @ 0630. He is still falling asleep 1/day. Falls easily only 1/2 weeks difficulty falling asleep. Running 15-30 mins/ one per week.

Dyping - ÷ can / 3-4 days
Eto H-P

Has had no further episodes of sleeping while driving.

ASS: Hypersomnolence - pt w/ ↓ Polysomnogram / MSLT's which were normal

Man: - Medical board
- Stop Tobacco use
- ↑ Exercise

E. W. CZANDER
LT, MC, USNR
68-8097
NEUROLOGIST

KIMBLE,RONNIE LEE M11
17 Jan 1972 MALE W:3210 H:910-697-2587
Spon: KIMBLE,RONNIE LEE CIC: HBK
CS: Rank: CPL D:3210
...F800 Unit: A COMPANY HOSPTBN RR: BLDG 15 ... FILI

TF: NMC PORTSMOUTH VA
Personal Data - Privacy Act of 1974 (PL 5[illegible])
DIV: NAVAL MEDICAL CENTER PORTSMOUT
Automated Version of SF600

[illegible] STOCK,MARGARET E
EF:
10 Mar 1997 ~~10:00~~ 0830 AM NEW BASA
CMT: cfg

Appt TIME:
BP: 112/[illegible] PULSE: 71 RESP: 20 TEMP: 97.5 HT: 72 WT: 175 AGE: 25

Additional Comments:

He drove here.
He says he is able to presc his epipodes and pull off the road.

I have a sleeping disorder"
"They don't know what kind"
"They want me to have Allergy testing"
"I used to do landscaping. If I had bad allergies I'd be dead by now"
In the past 4yrs he has uncontrollable hypersomnolence. Falls asleep maybe once a day
Sleeps all night as night. Not aware of restless or uncomfortable sleep. Not a snorer but "deep breather, like I'm fighting to get my breath"
Has had 2 sleep studies here.
Recent septoplasty - nasal airway seems clear to him now.
Dr, who did his nose surgery put him on Vancenase for his Sinuses.

FH
⊕ asthma mother
⊕ "sinus father"

MARGARET E. STOCK
CDR, MC, USN

EXAM ⇒ He appears well.
ENT - somewhat poorer space ⊕ nostril mid turn Rt = pale.
Neck ⊖
Chest - Clear.

Stroke
Allergist

Impr: It is extremely easy to determine his atopic status, but I would have to defer the interpretation of the tests vis-a-vis his medical problems.
I will fax the results of the tests. He will provide

Patient Education Given _____
Return 1 wk __ 2 wks __ 1 month __ 3 months __ 6 months __ 1 year __ other __

KIMBLE,RONNIE
17 Jan 1972 MALE
Spon: KIMBLE,RONNIE
CS:
UNIT: gatrs supbatS 3RDMAR
M11
W: (910) 451-5646 H: (910) 697-0076
CIC:
Rank: CPL D: (910) 451-5646
RR: LOCATION IN ANOTHER MTF

BOICE SLEEP DISORDERS LABORATORY
BLDG ONE, SUITE 101
NAVAL MEDICAL CENTER, PORTSMOUTH
PORTSMOUTH, VA 23708-2197

FACSIMILE TRANSMISSION

Please deliver the following pages :

TO: Dr. W. Beck
OF: Neurology - Camp Lejeune

FROM: Iris Price
NUMBER OF PAGES (INCLUDING THE COVER SHEET): 4

Our fax number is (804) 398-7792. Please call (804)398-7781 if there are any problems with the transmission.

Thank you,
The Boice Sleep Lab Staff

MESSAGES:

SLEEP DISORDERS LABORATORY
NAVAL MEDICAL CENTER
PORTSMOUTH, VIRGINIA 23708-5100
(804) 398-7781

POLYSOMNOGRAPHY REPORT

Date: 31 July 95

Patient: KIMBLE, Ronnie
SSN:
Date of Study: 21 Jun 95

Referring Physician: Dr. DeBeck
Clinic: NEUROLOGY-Camp Lejeune
Ref: A950248 & X950250

Chief Complaint: "Daytime drowsiness."

Reason for Referral: Rule out Narcolepsy, Myoclonus.

Pre-study Data: The 23 year old man describes a history of excessive daytime sleepiness which he feels is independent of total sleep time. PLM's are suggested from history. No secondary symptoms of Narcolepsy. He has no significant medical problems listed. Medications: Sudafed.

Height: 72 inches **Weight:** 168 pounds

Psychometrics: The Beck Depression Inventory was normal.

Polysomnography Data: Overnight polysomnography was performed with EEG, EOG, EMG, EKG, respiratory effort, respiratory airflow, and pulse oximetry leads attached in standard fashion.

a. Sleep Quality. The subject went to bed at 2200 and arose at 0630, sleeping for 474 minutes out of 511 minutes in bed for a sleep efficiency of 93%. Sleep architecture was normal. Subjective assessment of sleep quality was "better than usual."

b. The technician noted the following: No snoring, hypopnea or Myoclonus. Some body movement was seen during slow-wave sleep, suggesting night terrors or sleep-walking.

c. Respiratory Events. There were no abnormal respiratory events. There were no events associated with oxygen desaturations below 90%. No unusual cardiac events.

d. A trial on nasal CPAP was not done.

e. Periodic leg movements. There were no PLM'S noted.

f. Multiple Sleep Latency Test (MSLT). An MSLT was performed the morning after his polysomnogram. This was normal. Over 5 naps, the mean sleep latency was 12.4 minutes (normal is greater than 10 minutes) with one REM sleep onset (normal is one or less).

Patient: KIMBLE, Ronnie
SSN:
Date of Study: 21 Jun 95
Ref: A950248 & X950250

Impression:

1. Normal overnight polysomnogram.
2. No evidence of Pathologic Sleepiness or multiple REM sleep onsets on his MSLT.

Recommend:

1. Review sleep hygiene (handout).
2. Try to increase allotted sleep time by 1-2 hours per night.
3. Follow up with Neurology at Camp Lejeune.

These findings were sent to the referring physician on 8/3/95

Andrew K. Vaaler, LCDR, MC, USNR

Sleep Hygiene Guidelines

Time in Bed
A person should stay in bed for as long as sleep is needed but no longer. Most patients with insomnia tend to stay in bed too long; the result is shallow and fragmented sleep with many awakenings. Some behavioral treatments (see page 20) severely curtail the time allowed in bed.[26]

Sleep-Wake Rhythm
Each day the internal oscillators that control the human circadian cycle must be synchronized with one another and "reset" to the rotation of the planet. For young persons, whose clocks are typically much slower than 24 hours, the most effective means of accomplishing these goals is to establish a regular wake-up time. In many elderly persons, with their often shorter than 24-hour clocks, a regular, somewhat delayed sleep-onset time is indicated to stretch the periodicity to 24 hours. The best way to maintain circadian cycling is to remain active and be exposed to bright light during the day, even after a night of poor sleep.[27]

Trying to Sleep
The more one tries to sleep, the less one is able to do so. Relaxation and sleep are promoted by quiet activities, such as reading, watching television, or listening to music. Investigators disagree about whether such activities should be done in bed or away from the bedroom. Whether a patient should engage in reading or TV-watching in bed depends on whether that individual finds the activity stimulating or soporific.

Exercise or a Hot Bath
Regular exercise in late afternoon or early evening seems to promote sleep,[28] but the effects may evolve slowly (over weeks). Intermittent strenuous exercise has little effect on sleep.[29] Exercise initially increases body temperature, but a rebound cooling 5 to 6 hours later seems to help sleep. Spending 20 minutes in a tub of hot water an hour or two before going to bed may have a similar effect.[30]

Napping
Individuals must determine for themselves whether a nap helps them. Some patients with insomnia "pay" for each daytime nap with more sleeplessness during the following night, whereas others are considerably refreshed by a daytime nap and seem to fall asleep more easily during the subsequent night.

Bedroom Environment
Both extreme heat and extreme cold can disturb sleep. In nearly all studies, a quiet environment is more soporific than a noisy one; in fact, even after subjects had seemingly habituated to an intermittent noise (eg, living near an airport), an EEG revealed partial arousal whenever the noise occurred.[31] When unavoidable, intermittent noises can be masked by background white noise, for example, from a fan or from an FM radio tuned between two stations. An illuminated bedroom clock can significantly contribute to anxiety when patients are unable to sleep.

Eating
A light bedtime snack, such as a glass of warm milk or cheese and crackers, can promote sleep.[32] Some researchers think digestive hormones have a sedative effect.[33] Others believe that the tryptophan in the snack might be involved.

@1435

Date: 20-Sep-96Day: Friday SDS: X SDA: ROUT: Scheduled: X Emergency:
Hospital ID#: 150652 SSN: Age: 24
Name(Last, First): KIMBLE, RONNIE
AA: AEBA: ABAA: ACAA: ACBA: ABEA: ABGA: X ABKA: ABFA: AADA:
Preop DX: NSD/NASAL DEFORMITY
OP DX: SAA
OP Procedures: SEPTORHINOPLASTY

# of Procedures: 1
Surgeon: KEYSER Assistant:
Anesthesia Technique Used: MAC WITH LOCAL
Anesthetist: SMITH Assistant:
RN: JONES RN Relief:
Technician 1st Assistant: HUNT
Technicians: CARTER Scrub Tech:
Patient Pick Up Time: 07:00
Anesthesia Start Time: 07:30
Surgery Start Time: 07:45
Surgery Stop Time: 10:40
Anesthesia Stop Time: 10:55
Total Room Time: 205 Total Surgery Time: 175 Total Patient Care Time: 235

Sponge: Needle: Count: RN Signature: JONES
Correct: X2: X3: Aborted: Discrepancy:
Items Involved: Surgeon Notified: X-ray Taken: MVR:
Pathology Tissue to Lab N: X Y: (Specimen):

b Specimens:

Drains None: X Foley/Size: Hemovac: Jackson/Pratt: Other:
Wound Class: 2
X-rays (N): X Portable: Imaging: CSR: 36323 Flash Sets:
Excessive Personnel N: X Y: Steris: Individual Inst:
Total Tourniquet Time(Minutes):
Room No: 4

MC/AD: X	RET:	DEP/AD:	DEP/RET:
N/AD:	RET:	DEP/AD:	DEP/RET:
A/AD:	RET:	DEP/AD:	DEP/RET:
AF/AD:	RET:	DEP/AD:	DEP/RET:
CG/AD:	RET:	DEP/AD:	DEP/RET:
CIV HUM:	OTHER:		

Cesarean:Male: Female:
APGAR 1 min: APGAR 5 min: Pediatrician:
ID#:
Drugs Given:
Additional Remarks:

Implants:

JRGERY DATA COLLECTION WORKSHEET NHCLNC 6150/34 (3-94)

OUTPATIENT RECORD COPY

513-110

NSN 7540-00-634-4127

MEDICAL RECORD | CONSULTATION SHEET

REQUEST

TO: ENT

FROM: (Requesting physician or activity) [illegible]

DATE OF REQUEST: 960416

REASON FOR REQUEST (Complaints and findings)

THIS 24 Y/O ♂ HAS PROBLEM BREATHING THRU (R) NOSTRIL PLEASE EVALUATE.

PROVISIONAL DIAGNOSIS: NARROW (R) NOSTRIL

DOCTOR'S SIGNATURE: G. T. BJORNSSON CAPT, MC, USNR [signature]

APPROVED

PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL

☒ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO

PATIENT EXAMINED ☐ YES ☐ NO

~~31 May 96~~ ~~0915~~ ~~10 Jul 96~~ ~~1015/CALC~~

DATE: 13 Dec 96
APPT. TIME: 0851
TIME ARRIVED: 1015
PROVIDER: KNUTSON
ENT CLINIC NRMC/CLNC

Hx 24 y/o WM c (R) nasal trauma, dyspnea. Hx nasal trauma; Hx intermittent ~~[illegible]~~ nasal congestion,

PMHx hypersomnolence syndrome? W/up neurology

PE WD, WN, WM
NOSE - NSD c ~~[illegible]~~ caudal septal shift (R)
OC/OP - mucosa clear

IMP: NSD c (R) nasal dyspnea

PLAN: - Will await final result of sleep eval

(Continue on reverse side)

SIGNATURE AND TITLE: - F/u c neurology w/u. - will need septoplasty [signature] TKM 4907 22235

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 facility)

KIMBLE, RONNIE L

20/.

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 8-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

U.S. GOVERNMENT PRINTING OFFICE 1995-398-543

Hg: NKDA
Meds: ∅
11/9/70
51
18
- 96.9

5.24 y/o in for referral to infertility Dept

Wife beginning eval for infertility F 1 year of unsuccessful attempts to become pregnant. Her doctor request he get a sperm count as a first step.

A. infertility work up.

P. Order sperm count.

K.C. NANNEY PA-C
GS-11

atient/Responsible other:
nstructed on:

erbalizes an understanding of instructions given
s No
eaching standards given to patient: Yes No
rovider

KIMBLE,RONNIE LEE M11
17 Jan 1972 MALE W:321U
Soon: KIMBLE,RONNIE LEE CIC:

513-110

NSN 7540-00-634-4127

MEDICAL RECORD | CONSULTATION SHEET

REQUEST

FROM: (Requesting physician or activity) BAS 3/2

DATE OF REQUEST 7 Apr 95

neurology, Seymour Johnson AFB

REASON FOR REQUEST (Complaints and findings)

SUM TAD TO your Area Due To Family ~~Area~~ problems. Sx Suggestive of Narcolepsy or Absence Seizures. requires w/u prior to return to duty.

PROVISIONAL DIAGNOSIS

Narcolepsy vs. Absence SZ.

DOCTOR'S SIGNATURE

APPROVED

PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL

☒ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO

PATIENT EXAMINED ☐ YES ☐ NO

(Continue 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 facility)*

Kimble Ronnie
AD USMC cpl
ωf
3(2Ico 3968

DoB: 17 Jan 72
NKDA
male

home # 3126
work # 3468

CONSULTATION SHEET

Medical Record

STANDARD FORM 513 (REV. 8-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

NSN 7540-00-634-4127

513-110

MEDICAL RECORD | **CONSULTATION SHEET**

REQUEST

TO: Neuro

FROM: (Requesting physician or activity) OPC

DATE OF REQUEST: 4/3/95

REASON FOR REQUEST (Complaints and findings): 23 yo (M) c lifelong an exhaustion, daytime fatigue (poss. c/w OSA) but also - fall asleep while standing! (+) MVA 2° falling asleep while driving @ 19 yo. pt 6', 175# & nl pharyngeal anatomy.

PROVISIONAL DIAGNOSIS: ? narcolepsy, obs. apnea sy. +2181

DOCTOR'S SIGNATURE: [signature]

APPROVED: K. A. BONACQUISTI LCDR, MC, USNR/OTO-HNS

PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL | ☑ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT — Recieved: 03APR95 HR Sherman

RECORD REVIEWED: ☐ YES ☐ NO PATIENT EXAMINED: ☐ YES ☐ NO

Pt c LO time of 2300 & Wake at 0515 (pt not late to work) uses 3 alarms when wife not with him). SL short. Wakes 08 or 09 on weekends. Trying has fallen asleep in class

1330 20 Apr 95

Pt gives 5 yr+ Hx of some tendency to daytime sleepiness & he's unaware of any change, he thinks this is independent of TST at night. When he naps in the day he doesn't recall dreaming. If driving (trips) he will stop briefly. Pt has PMH of falling asleep x1 driving 4 years ago. No Hx sleep paralysis, H. halluc, and no Hx of cataplexy. Pt snores when sleeps on back, also pt has Hx of kicking wife in sleep; occ sitting up for which he has no recall (incl. engaged in conversation).

Pt has occ tension HA & 4 syncopal episodes not related to sleep. PMH of febrile SZ as child. No other significant neuro sx. occ sl. hand tremor (esp after working long day).

EXAM - alert c normal station, gait, speech. CN - OK

motor - trace tremor (R) hand on extension. RH pt.

sen/cerebellar OK. Reflexes symmetrical

Imp 1) Excessive daytime sleepiness c possible periodic limb movements. Doubt narcolepsy

2) R/O positional apnea

(Continue on reverse side)

SIGNATURE AND TITLE | DATE

IDENTIFICATION NO. | ORGANIZATION | REGISTER NO. | WARD NO.

Disp 1) Schedule for MSLT after PSG (both at PNH)

2) Advised re: measures & will return in 2 weeks. May allow pt to drive c caution once [illegible]

U.S.GPO:1994-362-955

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

Kimble Ronnie L 17 JAN 72

USMC/AD/LCPL

3/2 100 3rd plt

EW PL 3968

H 3736

DE BECK, T.W., NEUROLOGIST
CDR, MC, USNR
217-34-0988
NAVHOSP CAMP LEJEUNE

[signature]

CONSULTATION SHEET
Medical Record
STANDARD FORM 513 (REV. 8-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

NSN 7540-00-634-4127

MEDICAL RECORD | CONSULTATION SHEET

REQUEST

TO: ENT

FROM: (Requesting physician or activity) 3/2

DATE OF REQUEST: 14 Feb 95

REASON FOR REQUEST (Complaints and findings)

Daytime drowsiness, wakes up during night (wife sometimes wakes him due to snoring). Chronic ↓ nasal passage air flow. Fam. Hx of airway related sleep apnea in father + brother. Please eval for sleep apnea.

PROVISIONAL DIAGNOSIS

Sleep apnea due to airway anatomy.

DOCTOR'S SIGNATURE: JAMES M. MICK LT, MC, USNR 2AA [illegible]

APPROVED

PLACE OF CONSULTATION: ☐ BEDSIDE ☐ ON CALL

☑ ROUTINE ☐ TODAY ☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NO

PATIENT EXAMINED ☐ YES ☐ NO 23 y/o

TE: 03 APR 95
T. TIME: 0930
ME ARRIVED: 0905
Bonacquisti
T CLINIC /CLNC

3 Apr 95 0930 Dr B.

[illegible] sleeps 4-8° (<8° x2/wk)
⊕ AM exhaustion
⊕ daytime hypersomnolence
⊕ falls asleep driving to/from work - pt has totalled a truck running off the road - 3 y ago
⊖ ⊕ AM HAs
⊕ loud snorer.
* Pt has fallen asleep while marching 4/93 - neuro © [illegible] but not done.
Sx (except for snoring) have been present his whole life.

PMH - Ø
PSH Ø
Rx Ø
NKA

SH - [illegible]
ETOH, 2 glasses wine Q 2 months.

ROS - wt 175#
ht 6'0"

focal PE - [illegible]
NR [illegible]
[illegible] nl soft palate, tonsils 1+ - 2+ [illegible]; Class I.
[illegible] nl [illegible]

(Continue on reverse side)

A/P ① snoring ? OSA
② Hx above suggests narcolepsy, absence [illegible] etc. need to r/o before [illegible] OSA

P/ ① pt advised not to drive [illegible]
② © Neuro [illegible]
will probably need sleep study P →

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 facility)

Kimble Ronnie L.
20/
USMC/AD/Lcpl
3/2 I Co. 3rd plt

ph: 3968
Male
DOB: 17 Jan 72

wk# 3948/2136
~~[illegible]~~

HEALTH RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE /TIME | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (SIGN EACH ENTRY)

:7JUN94/1845 | USS AUSTIN LPD-4

Malaria Chemophophylaxis Questionaire

1) Have you ever been in a malaria endemic area? Y (N)
2) Have you ever been on chemoprophylaxis before? Y (N)
3) Did you ever have any side effects from the antimalarial? Y (N)
4) Do you have Sickle Cell Trait or are you G6PD deficient? Y (N)
5) Do you have a nervous condition or psychiatric problems? Y (N)

Chemoprophylaxis initiated this date: ENTERED Somalia operation area

Agent: ~~LARIAM~~ Mefloquine

Dosage: 250mg

Departure date: 27JUN94

Terminal prophylaxis initiated on: 25 Jul 94
PT Did not go ASHORE

Agent: N/A

Dosage: N/A

Terminate: N/A

In accordance with current Navy Medical Department Guide to Malaria Prevention and Control and NEPMU Guidelines, you have been placed on the Malaria Prophylaxis Program.

The side affects have been described to me and I understand the procedures of the program.

X Ronnie L Kimble
Patient signature

ATIENT'S IDENTIFICATION (USE THIS SPACE FOR MECHANICAL MPRINT)

PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)	SEX
X Kimble, Ronnie L.	MALE

YEAR OF BIRTH	RELATIONSHIP TO SPONSOR	COMPONENT/STATUS	DEPART/SERVICE
X 1/17/72	N/A	AD Active Duty	DOD/USN

SPONSOR'S NAME	RANK/GRADE
N/A	X LCpl

SSN/IDENTIFICATION NO	ORGANIZATION
29	BLT 3/2 / CO,

SN 7540-00-634-4176

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
21 June 94 T - 98.6 72 6 meds 20 P 102 NKDA 56	BAS 3d Battalion, 2d Marines, 2d MarDiv, FMF, 26 MEU, LPD-4 USS Austin
	MESS-PHYSICAL INTERVIEW FOR MESS COOK/DUTY
YES/NO	1. Have you ever been: a. Treated for any STD within the last 30 days or present being evaluated for possible STD exposure (Yes-explain)
YES/NO	b. Treated for diarrhea within the past two weeks?
YES/NO	c. Treated for intestinal parisites within the last six months?
YES/NO	d. Exposed or treated for hepititis?
YES/NO	e. Treated for flu, cold, or any URI within the last 30 days?
YES/NO	f. Exposed to or treated for tuberculosis? Last PPD: 23 Feb 94 Results 2 mm
YES/NO	g. Treated for severe acne/rash? Any open lesions in hand, face, neck, arms?
YES/NO	h. Exposed to any other communicable diseases?
needs ϕ HEPG NKA	2. Member is qualified for mess duty. Joe Kenneth Gaines Jr (HM signature) Joe Kenneth Gaines Jr (HM print name) 251 37 6406 (HM SSN) K.K. Butler 170-58-0743 HM USN
	3. Or member is temporarily disqualfied for mess cook/duty and can be reevaluated in 30 days. (HM signature) (HM printed name) (HM SSN) (Over)

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT: ▶ 3/2 BAS USS Austin LPD 4			SEX
PATIENT'S NAME *(Last, First, Middle initial)* Kimble, Bonnie L.			Male
RELATIONSHIP TO SPONSOR N A	STATUS Active Duty		RANK/GRADE LCPL
SPONSOR'S NAME N K		ORGANIZATION INDIA BLT 3/2	
DEPART./SERVICE DOD/USMC	SSN/IDENTIFICATION NO. 20/240-47-9667		DATE OF BIRTH 17 Jan 72

13 Sep 1993 0913 TXRM BHAP

CAMP GEIGER - SIC MICHELLI,MICHAEL CMT: DNA

REF:

SEE RINGWORM, ATHLETE'S FOOT, RASH ON BUTTOCKS

BP: 124/74 PULSE: 72 RESP: 16 TEMP: 99.2 HT: WT:

ADDITIONAL COMMENTS:

PATIENT/RESPONSIBLE OTHER: [redacted]

INSTRUCTED ON _____

AND VERBALIZES UNDERSTANDING. COPY OF TEACHING STANDARD GIVEN TO PATIENT. YES ____ NO ____

PROVIDER _____ DATE _____

ALLERGIC TO: NKDA

MEDS: Ø

S - 21 YO ♂ in S/C for c/o possible ringworm, athlete's and rash on buttocks. Pt. denies any history of skin disease. Pt. states he has had a history of ringworm on buttocks, arms, & back. Pt. state he was taking Lotrimin cream.

O - WD, WN, WM, NAD, NAD
- Ⓑ scaly spots on buttocks, right hand.
- erythemic border on right wrist
- ~~Tinea pedis~~ & erythema ~~to~~ of blistered foot.
- small open blister to blistered foot under toes
- whitespot to right side of face.

A - Tinea pedis
- Tinea Corporis

P - Ⓑ Oral Monostat derm BID X 3 wks 1 refill
Ⓔ instructed pt. on personal hygiene in/out field
3) instructed pt. how to apply meds & to return if symptoms occur.

ELECTRONICALLY PA

Sajid M. Fakhruddin
HA Sajid M. Fakhruddin

NSN 7540-00-634-4178

HEALTH RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE | SYMPTOMS, ~~DIAGNOSIS~~, TREATMENT TREATING ORGANIZATION *(Sign each entry)*

DATE: 10 Feb 97

APPT. TIME: 1330

TIME ARRIVED: 1325

PROVIDER: Keyser

ENT CLINIC NRMC/CLNC

Pt eval by Neurology for somnolence. Ablel by sleep lab to have ENT F/U. Report by phone today of study 3 wks ago => AI = 4.

Notes congestion.

Nose - septum ↓, NL mucosa
- clear slight
- mucus well held.

A - 1) chronic rhinitis
2) Hypersomnolence - NO OSA

P - Vancenase 2-3 puffs/day
F/U 3-4 mos

J.S. KEYSER
LCDR MC USNR
OTOLARYNGOLOGY

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT: 5 mos S/P

PATIENT'S NAME *(Last, First, Middle Initial)*: Kimble, Ronnie L.

SEX: M

RELATIONSHIP TO SPONSOR: Self

STATUS: AD

RANK/GRADE: LCPL

SPONSOR'S NAME: n/a

ORGANIZATION: 3D BN 2nd Mar

DEPART./SERVICE: USMC

SSN/IDENTIFICATION NO.:

DATE OF BIRTH:

PATIENT VERBALIZES UNDERSTANDING OF INSTRUCTIONS, SIGNATURE: Ronnie L Kimble

NSN 7540-00-634-4176

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

16 Jan 97

HADNOT POINT BRANCH MEDICAL CLINIC, NAVAL HOSPITAL, CAMP LEJEUNE, NC 28547-0100

HEALTH RECORD VERIFICATION PERFORMED IN ACCORDANCE WITH NAVMED P-117.

Age of patient: NOBC/MOS: Occasion: Check-in Check-out PE (Annual)

(N) Y PRP (Personnel Reliability Program)

Y NAVMED 6150/20, Summary of Care, complete and current.

(N) Y G6PD ABNORMAL (deficient). 'X' in 'Sensitivities' Box on jacket front.
Documentation of participation in educational program present/absent.

(N) Y SCT POSITIVE. Documentation of participation in educational program present/absent.

(NKDA) Y Allergy. 'X' in 'Allergies' Box on jacket front. Documented on SF 601, NAVMED 6150/20, and separate SF 600 annotated with 'Special-hypersensitivity.' Medical Warning Tag issued/ordered.

(Y) SF 601, Immunization Record. Deficiencies circled below.
; Tetanus ; (Typhoid) 1 2 (3) ; Yellow Fever ; Polio ; (MMR) 1 (2) ; (HBV) 1 (2) 3 ; Influenza ; (PPD) ;

N (Y) DNA Collection documented on SF 601.

(N) Y Tuberculin Reactor (PPD Converter). NAVMED 6224/1, TB Contact/Tuberculin Reactor Follow-up:
'X' in 'Sensitivities' Box on jacket front.

(Y) NAVMED 6000/2, Chronological Record of HIV Testing. HIV within last 12 months:

N (Y) SF 88, Record of Medical Examination. (enter last date below)
Entry: 17JAN93 (Entry - age 49) Q5: (age 50-59) Q2: (age 60)) Q1:

~~N Y Female Annual PAP: Mammogram - 35, 40, 43, 46, 49: (age 50)) Q1:~~

(N) Y Corrective lenses. Exam within last 24 months: Glasses: 0 1 2 Contacts: GMIs:

~~N Y Over age 40 Tonometry within last 24 months:~~

N (Y) DD 2215, Reference Audiogram. Audiogram within last 60 months:

(Y) Asbestos Medical Surveillance Questionnaire, patient signature present/absent.

(Y) NAVMED 6150/4, Abstract of Service and Medical History.

Y DD 2005, Privacy Act Statement - Health Care Records, patient signature present/absent.

(Y) Forms in proper order.

(Y) 4-part record with serviceable jacket.

(Y) Inside jacket front leaf completed (in pencil).

(Y) Current year of verification blackened on jacket front.

Y Advance Directives information provided.

DEFICIENCIES NOTED: H.v, Age Exam, Privacy Act, Typ (B), PPD, HepB2-3, HepA1-2, MMR

Record Screened by: [signature] HM2 Greaves

PATIENT ACKNOWLEDGMENT

I have been instructed on the importance of immediately correcting any deficiency. I have been informed that military treatment records and their contents are the property of the Federal Government and the practice of patients maintaining custody of health care treatment records is prohibited. I understand I may charge the record out from file for periods not to exceed five (5) workdays.

DATE: SIGNATURE OF PATIENT:

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT: HADNOT POINT BRANCH MEDICAL CLINIC, BLDG 15

PATIENT'S NAME (Last, First, Middle initial)		SEX
Kimble Ronnie L		Male
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SELF	ACTIVE DUTY	E-4
SPONSOR'S NAME		ORGANIZATION
SAME AS ABOVE		MCB Adm
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH
DOD/USMC	2011	17 Jan 73

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (Rev. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

NSN 7540-00-634-4178

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
DATE: 18 Nov 96	
APPT. TIME: 1435	
TIME ANSWERED: 1415	
PROVIDER: Kayser	
ENT CLINIC NAMC/CLINIC	FU Septorhinoplasty
	Pleased w/ rs-lt
	Breathing better
	PE- Good symmetry
	Septum ⊥
	A- Doing well
	P- Photos taken
	F/U 6 mos

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT: 2 MOB postal

PATIENT'S NAME *(Last, First, Middle initial)*: Kimble, Bonnie

SEX: M

RELATIONSHIP TO SPONSOR: self

STATUS: AP

RANK/GRADE: LCPL

SPONSOR'S NAME: NA

ORGANIZATION:

DEPART./SERVICE: USMC

SSN/IDENTIFICATION NO.:

DATE OF BIRTH:

N 7540-00-634-4176 600-108

HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

...: 12 Sep 96

...PT. TIME: 0730 WI

...ME ARRIVED: 0805

...OVIDER: Keyser

...LINIC NP...

Pre-op septoplasty - pt
c/o (R) nasal dyspnea.

PE- dorsal bony + cartilaginous dev to
(R), bowed cartilage.
(R) caudal cartilage dev to (R)
large (R) inf turb.
mild dorsal hump
NLA 90° NFA 135°
tip narrow but dev to (L)
skin mod.

A/P. - pt to consider septorhinoplasty
will change surgery to 9/20 c
new proc -

[signature]
J.S. KEYSER
LCDR MC USNR
OTOLARYNGOLOGY

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT:		
PATIENT'S NAME *(Last, First, Middle initial)* Kimble, Ronnie		SEX Male
RELATIONSHIP TO SPONSOR	STATUS AD	RANK/GRADE LCPL
SPONSOR'S NAME	ORGANIZATION MCB	
DEPART./SERVICE USMC	SSN/IDENTIFICATION NO.	DATE OF BIRTH 17Jan72

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

600-108

NSN 7540-00-634-4176

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

DATE: 8/6/96
TIME: 0815
ARRIVED: 0815
DR: George
NRMC/

Hx) here for f/u NSD, and recent w/u by neurology regarding hypersomnolence syndrome. Patient now on Zoloft.

Px: NOSE - mucosa healthy, NSD c̄ (R) caudal septal show.

Imp: NSD
PLAN: will need septoplasty

[signature]

H# 910-697-2687
PAGER 1-800-412-6666
W# 451-3210

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT:			
PATIENT'S NAME *(Last, First, Middle initial)*: Kimble, Bonnie Lee			SEX: M
RELATIONSHIP TO SPONSOR: Self	STATUS: AD		RANK/GRADE: LCPL
SPONSOR'S NAME: —		ORGANIZATION: 3D BN 2nd Mar	
DEPART./SERVICE: USMC	SSN/IDENTIFICATION NO.		DATE OF BIRTH: 17 Jan 72

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

NAVHOSP ... NC 28542-5008

600-108

NSN 7540-00-634-4176

HEALTH RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
01 Apr 96	S: 24 y/o male to clinic for fever, sore throat,
Alg: NKDA	sinus pressure. —— HN3 Clipser
Meds: Advil	Pt complaining of sinus pressure and pain c fever and
B/P 110/70	sore throat since last Thursday. Pt denies any other
P - 80	sxs at this time.
R - 16	O - Ears - nl ext canals, TMs c nl landmarks
T - 100.4	Nose - mucosa clear
	Sinus - percussed mild tenderness to max sinuses
	Throat - mod erythema to posterior pharyngeal wall,
	c mild post nasal drip, no exudate noted
	No lymphadenopathy noted. Neck - supple full ROM
	Lungs - clear to A&P Bilat, no rales, rhonchi, wheezes
	A - 1. Sinusitis
	2. Pharyngitis vs Strep
	P 1. Septra DS #20 i tab p.o. BID F10
	2. Tylenol 325 mg #50 ii tabs p.o. Q4h prn
	3. Sudafed 60 mg #21 i tab p.o. tid F7
	4. Force fluids
	5. SIQ 24 hrs, pt to restrict unit area.
	6. RTC to clinic as needed if worse or again.
	7. Throat Culture
	R.G. Meyer HM IDC
	R. A. MEYER HM IDC

BRANCH MEDICAL CLINIC, BLDG 15
NAVHOSP CAMP LEJ. NC 28542-5008

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

•Patient/Responsible other:
•Instructed on: Rx plan & follow up
...rbalizes an understanding of instructions given
(Yes) No
•Teaching standards given to patient: Yes (No)
•Provider

RECORDS MAINTAINED AT: ▶

PATIENT'S NAME *(Last, First, Middle initial)*: Kemble, Ronnie L

SEX: Male

RELATIONSHIP TO SPONSOR:

STATUS: AD

RANK/GRADE: Lcpl / E-3

SPONSOR'S NAME:

ORGANIZATION: Base Chaplains

DEPART./SERVICE: DOD/USMC

SSN/IDENTIFICATION NO.:

DATE OF BIRTH: 72 Jan 17

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

NSN 7540-00-634-4178

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
~~6 JUL 1995~~ 7 JUL 1995	To Blood tests for Hypo Glycemia — Jayk Jonson
BP- 129/68	S: Hasn't had blood drawn yet
P- 62	Lungs Clear
R- 18	P: Labs ordered:
T- 96.6	Chem 7 - OK
NKDA	CBC OK
Omeds	TFT pending
	RTC p lab results.
	S. L. WOODRUFF
	CDR, USNR, ANP

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

Patient/Responsible other:
Instructed on:

alizes an understanding of instructions given
es No
eaching standards given to patient: Yes No
rovider

RECORDS MAINTAINED AT: BRANCH MEDICAL CLINIC, BLDG 15 NAVHOSP CAMLEJ NC 28542-5006

PATIENT'S NAME *(Last, First, Middle, Initial)*: Kimble, Ronnie L

SEX: Male

RELATIONSHIP TO SPONSOR

STATUS: Active Duty

RANK/GRADE: ~~E-5~~ E-6

SPONSOR'S NAME

ORGANIZATION: HQSPTBN A&O

DEPART./SERVICE: USMC

SSN/IDENTIFICATION NO.: [illegible]

DATE OF BIRTH: 1-17-72

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

NSN 7540-00-634-4176

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
16 Jul 95	Pt in for CBC and Glucose test
All: NKDA	request —— [illegible signature]
Meds: Ø	Request consult for sleep disorder, seen
BP 131/66	at Portsmouth, Va. Jun '95 [illegible signature]
P 66	S: [illegible]
T 99.3	sleep disorder ~ [illegible]
R 20	c/o excessive sleepiness [illegible]
	Has episodes lightheadedness ~ occasion-
FH - DM -	ally feels better ō intake sugar.
	O: [illegible] NAD, VS [illegible], looks well, A+O.
	HENT: no nodes, supple, [illegible] NT,
	ears, nose, pharynx nl, thyroid WNL.
	lungs CTA Cor S1-S2, RRR, no m
	Abd - BS⊕, soft, NT, [illegible]/ing nodes.
	DTR's ankles 2+/=.
	A: Sleepiness
	Lightheadedness - ? cause
	P: Appt made c Dr DeBeck, IM clinic
	1300 27 July
	CBC, TFT, SMA7
	RTC 2 days - r labs.
	S.L. Woodruff
	S. L. WOODRUFF CDR, USNR, ANP

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

•Patient/Responsible other:
•Instructed on: Above
•Verbalizes an understanding of instructions given: Yes No
•Teaching standards given to patient: Yes No
•Provider [illegible initials]

RECORDS MAINTAINED AT: BRANCH MEDICAL CLINIC, BLDG 15, NAVHOSP, CAMLEJ, NC 28542-5008

PATIENT'S NAME (Last, First, Middle initial): Kimble, Ronnie

SEX: Male

RELATIONSHIP TO SPONSOR: ——

STATUS: Active Duty

RANK/GRADE: Lcpl

SPONSOR'S NAME: ——

ORGANIZATION: A Co. MCBHQSF

DEPART./SERVICE: DOD/USMC

SSN/IDENTIFICATION NO.:

DATE OF BIRTH: 17 Jan 72

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

NSN 7540-00-634-4178

CHRONOLOGICAL RECORD OF MEDICAL CARE

HEALTH RECORD

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
4 JUL 1995	HADNOT POINT BRANCH MEDICAL CLINIC, NAVAL HOSPITAL, CAMP LEJEUNE, NC 28547-0100

HEALTH RECORD VERIFICATION PERFORMED IN ACCORDANCE WITH NAVMED P-117.

Age of patient: 23 NOBC/MOS: Occasion: (Check-in) Check-out PE Annual

(N) Y PRP (Personnel Reliability Program)

YES NAVMED 6150/20, Problem Summary. G6PD, SCT, and ABO test results entered/absent/ordered.

(N) Y G6PD ABNORMAL (deficient). "X" after "Sensitivities" in "Alert" Box on jacket front.
Documentation of participation in educational program present/absent.

(N) Y SCT POSITIVE. Documentation of participation in educational program present/absent.

(N) Y Allergy documented. Medical Warning Tag issued/ordered. "X" after "Allergies"
in "Alert" Box on jacket front. (circle if none) (NKDA)

YES SF 601, Immunization Record. Deficiencies circled below.
| Tetanus | Typhoid 1 2 B | Yellow Fever | Polio | MMR 1 2 | HBV 1 2 3 | Influenza | PPD |

(N) Y PPD Converter. NAVMED 6224/1, TB Contact/Tuberculin Reactor Follow-up:

YES NAVMED 6000/2, Chronological Record of HIV Testing. HIV within last 12 months: 20JAN95

N (Y) SF 88, Record of Medical Examination. (enter last date below)
Entry: 27JAN93 (Entry-49)Q5: (50-59)Q2: (60>)Q1:

(N) Y Female. Annual PAP: Mammogram - 35,40,43,46,49: (50>)Q1:

(N) Y Corrective lenses. Exam within last 24 months:

(N) Y Over age 40. Tonometry within last 24 months:

N (Y) DD 2215, Reference Audiogram. Audiogram within last 60 months: 09APR93

YES Asbestos Medical Surveillance Questionnaire, patient signature present/absent.

YES NAVMED 6150/4, Abstract of Service and Medical History.

YES DD 2005, Privacy Act Statement - Health Care Records, patient signature present/absent.

YES OPNAV 5211/9, Record Of Disclosure - Privacy Act of 1974.

YES Forms in proper order.

YES Jacket serviceable.

YES Inside jacket front leaf completed (in pencil).

YES Current year of verification blackened on jacket front.

DEFICIENCIES NOTED: NONE NOTED. PAS TO SNM

LATE ENTRY: HEP B #2

Record Screened by: C. L. Langford

MEMBER ACKNOWLEDGMENT

I have been instructed on the importance of immediately correcting any deficiency. I have been informed that military treatment records and their contents are the property of the Federal Government and the practice of patients maintaining custody of health care treatment records is prohibited. I understand I may charge the record out from file for periods not to exceed five (5) workdays.

Date: 950714 Signature of Service Member: Ronnie L. Kimble

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT: HADNOT POINT BRANCH MEDICAL CLINIC, BLDG 15

PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
KIMBLE, RONNIE L.		M
RELATIONSHIP TO SPONSOR	**STATUS**	**RANK/GRADE**
SELF	ACTIVE DUTY	LCPL
SPONSOR'S NAME	**ORGANIZATION**	
SAME AS ABOVE	HQ&SPT BN MCB CLNC	
DEPART./SERVICE	**SSN/IDENTIFICATION NO.**	**DATE OF BIRTH**
DOD/USMC		17JAN72

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

600-108

540-00-634-4178

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (*Sign each entry*)
950504	Pt returns today and is scheduled for his sleep studies in Portsmouth June 21st & 22nd. Pt sleepiness ↑ at duty. Pt states his brother has similar SX (age 25).
	Dx [illegible]
	RTC after sleep studies. Driving restrictions at this point hard to defend in that his SX are of years duration & now he is more alert to the problem & working on his sleep hygiene. Pt's light sensitivity is of interest. Dona light, AM light & sleep transition SX
	T.W. DeBeck [signature] T.W. DEBECK CDR MC USNR 0988

PATIENT'S IDENTIFICATION (*Use this space for Mechanical Imprint*)

Kimble, Ronnie

RECORDS MAINTAINED AT: 312 SAS

PATIENT'S NAME (*Last, First, Middle initial*): Kimble Ronnie L.

SEX: male

RELATIONSHIP TO SPONSOR: —

STATUS: Active Duty

RANK/GRADE: Lcpl E3

SPONSOR'S NAME: —

ORGANIZATION: 3/2 I co

DEPART./SERVICE: DoD USMC

SSN/IDENTIFICATION NO.: 20

DATE OF BIRTH: 17 Jan 72

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

600-108

NSN 7540-00-634-4176

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
1 April 94 ~~1300~~	S) 22yo ♂ for Mess PE PH Denies UCT's, GI Disturbances, Eye infection, Nail biting O Hx of heat Related injuries Last PPD 13FEB94 Dental Class O) Ø Skin infection, has open wound on his right index finger. Ø wounds or lessions on hands/face A) Mess PE Fail 2° finger wound P) unfit For Mess duty Hm3 Haney, D.A JONDAVID POLLOCK LT MC USNR

NVD
FURTH
EVAL
NFE

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT:	3/2 BLT India USS Austin LPD4
PATIENT'S NAME *(Last, First, Middle Initial)*	Kimble, Bonnie L
SEX	male
RELATIONSHIP TO SPONSOR	S
STATUS	~~AD~~ Actv DEP
RANK/GRADE	PFC
SPONSOR'S NAME	P A
ORGANIZATION	India
DEPART./SERVICE	POD/USMC
SSN/IDENTIFICATION NO.	- -
DATE OF BIRTH	17 JAN 72

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

NSN 7540-00-634-4178

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
2-MAY 93	P.I BMC meds: ∅ ALL: ∅
T 98.9	S) 21y/o ♂ c PAIN to (R) SHIN & KNEE. PAIN
R 18	IN KNEE HAS been SINCE PT ARRIVED AT
P 68	PI (R) SHIN PAIN SINCE 3 DAY AGO. PT
BP 98/62	STATES he hit his ~~KNEE~~ SHIN ON LOCKER...
training day:	Continue to c/o Bilat knee pain
rd phase	Mainly infrapatellar when sitting, Indocin
	and running.
	Obj: normal Tenderness over
	patellar Tendon. Full ROM
	No effusion. No crepitus.
	Ap: Patellar Tendonitis - mild.
	plan: Indocin 25 mg tid c food
	: Ret prn.
	[signature] - C

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS MAINTAINED AT: MCRD

PATIENT'S NAME (Last, First, Middle initial)	SEX
Gamble Ronnie L	MALE
RELATIONSHIP TO SPONSOR: N	STATUS Active: URT duty
RANK/GRADE: PVT	
SPONSOR'S NAME: N	ORGANIZATION: PLT 2061
DEPART./SERVICE: USMC	SSN/IDENTIFICATION NO.
DATE OF BIRTH: 17 JAN 72	

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

NSN 7540-00-634-4176

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
20APR93	BMC, MCRD, PARRIS ISLAND, SC ALLERGIES: ~~RECRUIT SICK CALL~~ ~~MEDS:~~ Ø
TEMP: 99.2	TYLENOL, SUDAFED AFRIN
~~PULS:~~ 68	21 4/0 ♂ C F/U SORE THROAT, also C c/o
~~RESP:~~ 16	PAIN TO (R) KNEE x 2 DAYS
B/P: 118/72	Second day Hx of Sore throat
	No Cough.
	~~c/o~~ hx of episode of intermittent pain
	(R) knee while running.
	Alert male NAD
	TArat - postnasal + ~~lat~~ wall erythema.
	NO exudate.
	Nodes - unremarkable
	Resp - clear bilat.
	Cardio - Reg NL
	(R) knee - min Tenderness over patellar
	Tendon.
	Dx: Pharyngitis
	: Tendonitis (R) knee
	plan: T.C.
	: Pen V-K 250mg TID -
	: Motrin 800mg PRN.
	: Rest prn.

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT: MCRD

PATIENT'S NAME *(Last, First, Middle initial)*: KIMBLE, RONNIE L

SEX: Male

RELATIONSHIP TO SPONSOR: N/A

STATUS: URT Active Duty

RANK/GRADE: PVT

SPONSOR'S NAME: N/A

ORGANIZATION: PLT# 2061

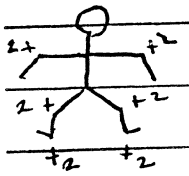
DEPART. SERVICE: DOD/USMC

SSN/IDENTIFICATION NO.

DATE OF BIRTH: 17 JAN 72

NSN 7540-00-634-4176

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
FEB 14 1995	3rd Battalion, 2nd Marines 2nd Marine Division, FMF Camp Lejeune, NC 28542 SLEEPING PROBLEMS
T: 98.2 P: 58 R: 16 B/P: 110/68 ALLERG: NKDA MEDS: Ø TIN: 0815	S: 23 year old wm to s/c ō c/o uncontrollable sleeping problem. Hx: Pt states "had this problem all of my life". documentation in health record from Sep 93. Pt states "sleeping attack happens when not doing anything / when marching or standing Pt falls asleep just for a few minutes then regaining consciousness now knowing what happened. Pt states only time ever having physical trauma was a car wreck 2 years ago.
	O: Pt Alert and responsive to surroundings normal gait. ⊖ masses or edema head, ⊖ sinus pressure, Eyes PEARL, 12 CN intact ⊖ nystagmus 20/20 uncorrected bilat., ⊖ problems c hearing ⊕ wet/clear bilat. lungs CTA bilat, Heart/HRR pulse equal, strong bilat in extremities. NVI, full ROM in all extremities. ⊕ alignment of spine.
	A: Normal exam / ~~r/o~~ ~~sleep apnea~~ sleep apnea
	P: ~~recommend neuro consult~~ 1. refer to MO.
	Little Jon AD/USN/E4 515 76 0892
	JAMES M. MICK LT, MC, USNR

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT: 3/2 BAS

PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
KIMBLE, RONNIE		MALE
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
-NA-	ACTIVE	LCPL
SPONSOR'S NAME		ORGANIZATION
-NA-		3/2 I CO.
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH
USMC/[illegible]		17JAN72

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	To BG
14 Feb 95	Lifelong Hx of daytime sleepiness.
(CONT)	Sleeps 6-8 hrs per night. Falls asleep
	9-11 pm every night no trouble falling
	asleep. Difficulty waking up [illegible]
	wakes 1-2 times during night but
	falls to sleep instantly. Wife reports
	excessive snoring [illegible]
	from Hx of [illegible] [illegible]
	to sleep apnea.
	Sleepiness during day is [illegible]
	he is inactive. Will fall asleep in
	many situations and if awaken will
	fall asleep again promptly. No Hx
	of [illegible] & suggestive of seizures.
	O/ [illegible]
	↓ Air flow through [illegible] passages
	[illegible]
	Neuro grossly normal
	A/ Daytime drowsiness prob.
	Sleep apnea
	P/ ENT consult for eval of
	airway.
	[signature] JAMES M. MICK LT, MC, USNR 2AA

*U.S. Government Printing Office: 1994 — 300-892/10075

600-108

7540-00-634-4176

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
7 AUG 94	BCT 3/2 I CO. SICK CALL c̄ c/o (L) foot pain x1 day
T:	S: 22 YR ♂ c̄ c/o (L) foot pain x1 day. PT states while
P:	riding in back of 5 ton it hit a bump in the
R:	rode & box c̄ another Marine sitting on went up
BP: 120/84	in the air & came back down on his foot.
ALLEG: Ø	NO HX of foot pain before. PT states foot pain
MEDS: Ø	2½ on scale of 1-5. PT states pain increase
	c̄ pressure to (L) foot unable to bear wt on foot
	O: (−) signs of redness or edema to (L)
	foot. (+) cap refill. ROM to (L) foot limited in
	movement. (+) Tenderness c̄ palpation mid dorsum foot c̄ palpa (−) Deformity palpated
	A: contusion r/o plantar fasciitis
	P: (1) Refer to MSSG 26
	(2) X-RAY (AP LAT (L) foot) appear (negative) [signature]
	(3) ICE 2 TWICE A DAY
	(4) NO Running or jumping x4 days
	(5) F/U Thurs. c̄ Corpsman or sooner if condition
	worsen.
	(6) Morfin 800mg i TAB every 8 hrs. Take c̄
	Food or milk [signature] Pedicke, Corpsman
	[signatures] Pollock ... Surgeon

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS MAINTAINED AT:	
PATIENT'S NAME (Last, First, Middle initial): KIMBLE, Ronnie L	SEX: MALE
RELATIONSHIP TO SPONSOR: N/A	STATUS: Active Duty	RANK/GRADE: LCPL/E-3
SPONSOR'S NAME:	ORGANIZATION: BCT 3/2 I CO
DEPART./SERVICE: DoD/USMC	SSN/IDENTIFICATION NO.:	DATE OF BIRTH: 17 JAN 72

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
15SEP94	HEALTH RECORD VERIFIED THIS DATE IN ACCORDANCE WITH MMD CH 16-3 Hm³ K.G. Rosh

NO FURTHER ENTRIES

NSN 7540-00-634-4178

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
MAR 0 8 1994	3/2 BAS 1300 BP
T:	ROUTINE BP TAKEN AT 1300 WNL.
R:	DERRICK ROUSE
P:	5838071-7
B/P: 112/70	
ALLERG:	
MEDS:	
09 MAR 94	3/2 BAS
	Pt. reports for A.M. portion of 3 day
	B/P check:
	Sitting 116/70 Avg: 118/66
	Standing 120/68
	Supine 118/58
	Rodney K Majors
	MAJORS, RODNEY K
	HM3 USN
	3/2 BAS
	PT REPORTS FOR P.M. PORTION OF 3day
	B/P CHECK.
	SITTING 112/62 AVG: 111/59
	SUPINE 108/56
	STANDING 114/60
	[signature]
	HN/HD/USN

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT:	3/2 BAS
PATIENT'S NAME *(Last, First, Middle Initial)*	KIMBLE, Ronnie L.
SEX	MALE
RELATIONSHIP TO SPONSOR	NA
STATUS	AD Active Duty
RANK/GRADE	PFC
SPONSOR'S NAME	NA
ORGANIZATION	3/2 INDIA
DEPART./SERVICE	USMC
SSN/IDENTIFICATION NO.	[redacted]
DATE OF BIRTH	17 Jan 72

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
10 MAR 91	36 BAS 1300 BP SITTING: 114/70 SUPINE: 104/58 STANDING: 102/76 DR: 110/ AUG: 110/ DERRICK E. ROUSE
10 APR 91	36 BAS 0900 BP SITTING: 118/78 SUPINE: 110/70 STANDING: 102/76 DERRICK E. ROUSE
	NO FURTHER ENTRY

*U.S. Government Printing Office: 1993 — 342-199/50262

NSN 7540-00-634-4176 600-108

HEALTH RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
2 Mar 94	3/2 BAS
T: 99.1 site oral	Pt PASSED out while standing. Pt stated he can't
P: 68, 74 site scand	remember when he woke up, just that everyone talking
R: 14, 14	and he was being helped at the floor.
B/P: 138/94, 146/90 site scand	S. ⊖ drinking last night. Pt states happened 2 times before
ALLERG: NKDA	in boot camp, high school. Vision started to blur. then
MEDS: ~~NONE~~	just passed out. States lately been under great stress on
	personal matters. Before passing out Pt was stress almost
	point of crying. NSTOD ON PPROPRANOLOL
	O. H. ⊖ ~~pain pressure~~ ⊖ masses ⊖ ecchymosis
	E. full ROM, PEERLA, convergence good. -
	E. ⊖ pain tympanic membrain clear no discharge
	& ears
	N. ~~clear~~ ⊕ alignment septum mucus membrain
	pink moist slight drainage.
	T. tons's ⊖ abnormalities mucous membranes moist pink
	2-12 cranial nerves INTACT ~~normal~~, heart - normal rythm
	pulses ⊕ x 4 extremities ~~ext~~ full sensation x 4 extremities ~~ext~~ lungs clear
	to auscultate all lobes ABD ⊕ bowel sounds x 4 quads
	Pt A&Ox3 motor reflex intact bilateral sensory system
	↑↓ extremities symmetrical accessories intact. Skin dry pink.
	A. Stress related reeding
	P. Relax continue to discuss personal problems.

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT: 3/2 BAS

PATIENT'S NAME *(Last, First, Middle Initial)*		SEX
Kinkle Ronnie L.		M/Male
RELATIONSHIP TO SPONSOR: N/A	STATUS: AD Active Duty	RANK/GRADE: PFC
SPONSOR'S NAME: N/A		ORGANIZATION: 3/2 Inf Co
DEPART./SERVICE: USMC	SSN/IDENTIFICATION NO.	DATE OF BIRTH: 17 Jun 72

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	B/P check BID x 3 days. return [illegible]
	f/u.
	[signature]
	JAMES A. REESE HM1 USN [illegible] 160897
07 MAR 94	3/2 BAS
T: 99.4	S: Pt c/o (R) ear pain x 1 day. Pt states
P: 68	everything sounds muffled. Ø pain upon palpation.
R: 16	Pt also stated it was sore when he slept on ~~the~~
B/P: 132/60	his (R) side. Pt states he feels a little dizzy
ALLERG: NKDA	O: Observed Redness & dark coloring behind
MEDS: None	tympanic membrane c̄ Otoscope. Ø drainage
	Noted. (L) Ear appeared normal c̄ Ø
	discoloration or drainage.
	A. R/O Otitus Media.
	P. Amoxicillin 250 mg 1 tab ~~x 4 days~~ 4 x a day Number 40
	Drixoral 1 tab BID Number 10 c̄ plenty of H_2O
	Light duty x 10 days while on antibiotics
	Follow up 72 hrs.
	[signature] HN
	Aaron J McEntire
	HN / AD / USN
MAR 08 1994	3/2 BAS SICKCALL Routine Vital signs
T: 97.8	WNL. [signature] HN
P: 76	DERRICK [illegible]
R: 14	
B/P: 120/78	
ALLERG: NKDA	
MEDS: NEG	

*U.S. Government Printing Office: 1993 — 342-199/60006

STANDARD FORM 600 BACK (REV. 5-84)

NSN 7540-00-634-4178 600-108

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
03DEC93	21 Y/O c/o COUGHING, SNEEZING, SINUS CONGESTION, HA, MUCOUS DISCHARGE,
T: 98.3	NOSE BLEED, PAIN IN SINUS CAVITIES. TAKING OTC FOR CONDITION
P: 72	S. N: (-) SWELLING OF LYMPH NODES, SKIN WARM & DRY TO TOUCH. (-)
R: 18	DEFORMITIES NOTED, (+) SINUS TAP
B/P: 102/60	E: BOTH TM DULL GRAY, SLIGHT LOSS OF HEARING, (-) PERFORATIONS,
ALLERG: Ø	E: REDNESS IN CONJUNCTIVA, (+) SWELLING CONJUNCTIVA, (+) LACRIMATION,
MEDS: Ø	PERLA
	N: (+) SEPTUM DEVIATION, (+) MUCOUS DISCHARGE, (+) REDDNESS IN BOTH
	NOSTRILS, (+) INFLAMMATION
	T: (-) UVUELLA DEVIATION, (-) TONSILLARY SWELLING, COBBLESTONE EFFECT
	INDICATIVE OF POST NASAL DRIP
	L: LS CLEAR IN ALL LOBES, Ø WHEEZING, (-) RALES.
	ABD: BS X4 ACTIVE,
	A: URI
	P: 1. SUDAFED 60MG 1 TAB PO QID X 5 DAYS
	2 HUMIBID LA 1 TAB PO BID X 5 DAYS
	3. PUSH FLUIDS
	4 F/U 8 DEC 93 IN AM.
	FRANKLIN GILFERT
	JAMES K. KEESE HM1 USN
	[illegible] MD USN LT MC USNR

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT: BAS 3/2

PATIENT'S NAME *(Last, First, Middle Initial)*	SEX
KIMBLE RONNIE L	MALE
RELATIONSHIP TO SPONSOR: A	STATUS: USMC/AD active	RANK/GRADE: PFC
SPONSOR'S NAME: [illegible]	ORGANIZATION: 3/2 INDIA
DEPART./SERVICE: USMC	SSN/IDENTIFICATION NO.	DATE OF BIRTH: 17JAN72

CHRONOLOGICAL RECORD OF MEDICAL CARE — STANDARD FORM 600 (REV. 5-84) Prescribed by GSA and ICMR

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

Health Record Verified This Date
8 Dec 93 In Accordance With
MMD Chapter 16-3

HM P. Kelly

31 JAN 94
T: 98.6
P: 76
R: 16
B/P: 114/76
ALLERG: ∅
MEDS: ∅

3/2 BAS

✓ PAIN IN HIPS

1000 S: 22 y/o ♂ C/O BILATERAL HIP PAIN. PT STATES PAIN STARTED APPROX 9 MONTHS AGO & PROGRESSIVELY GOT WORSE. PT STATES THAT IT IS A BURNING SENSATION. PT STATES PAIN IS A 7 ON A SCALE OF 1-10 (10 BEING WORST EVER FELT). PT ALSO STATES THAT PAIN IS USUALLY BROUGHT ON DURING HUMPS.

O: ⊖ DEFORMITIES NOTED. ⊖ EDEMA. STRENGTH WNL. ROM GOOD. DISTAL PULSES ⊖ BI-LAT. CAP. REFILL GOOD NEURO ✓'S WNL. (SHARP/DULL). TENDERNESS NOTED BEGINNING AROUND GROIN MUSCLES THEN TO PROX TO GREATER TROCHANTER. ⊖ LAXITY NOTED IN EITHER SIDE.

A: R/O POSSIBLE FX / CONNECTIVE TISSUE DISORDER

P: X-RAY. RETURN TO BAS.

HM3 John E. Rollins
HM3 JOHN E ROLLINS

31 JAN 94
1419

O: X-RAYS - ⊖ FX ⊖ CONNECTIVE TISSUE PROBLEM.

A: TENDONITIS.

P: INDOCIN TAKE 1 CAP PO TID x 7 DAYS. (25mg.)
F/U C PLATOON HM PRN.

HM3 John E. Rollins

JAMES M. MICK
LT, MC, USNR
2AA 286-72-2704

JAMES R. REESE
HM1 USN

NSN 7540-00-634-4176

600-108

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION *(Sign each entry)*
OCT 1 5 1993	Health Record Verified This Date ____ In Accordance With MMD Chapter 16-3 — 091564069 HN WILKINS/HN [signature]
27 Oct 93 T: 97.4 P: 72 R: 16 B/P: 102/60 ALLERG: NKDA MEDS: T-3	3/2 BAS Pt here for follow up on (L) Ankle & Pt c/o congestion in Am & coughing. Pt twisted ankle aprox 1wk prior and was given LD x 5days. injury was an inversion. O) (+) edema. (+) ecchymosis. Full Range of Motion. (+) strength. edema and ecchymosis was noted encompasing lateral maleolus. (L) ankle. Point tenderness to anterior aspect of lateral maleolus (L) ankle. Neuro + Vascular intact. X-rays prove neg (-) for Fx (L) ankle. A) 2nd ° Ankle sprain (L) foot. P) 1) LD x 5days 2) RICE Therapy 3) ~~Motrin 800~~ Aspirin 325mg II Q4-6h x 5days. 4) F/U 1 NOV 93 OR PRN. Boston, Joseph D. HM3/USN/20 579051829 Reviewed 28 OCT 93 [signature] JAMES [illegible] REESE HM1 USN [signature] JAMES M. MICK LT. MC. USNR [signature]

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT: 3/2 BAS

PATIENT'S NAME *(Last, First, Middle initial)*		SEX
KIMBLE RONNIE L		Male
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
N/A	Active Duty ~~AD~~	PFC
SPONSOR'S NAME		ORGANIZATION
N/A		3/2 INDIA
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH
USMC	[illegible]	17 JAN 72

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
FIRMR (41 CFR) 201-45.505

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

16 NOV 93

3/2 BAS

T: 98
P: 80
R: 16
B/P: 130/58
ALLERG: Ø
MEDS: Ø

S: (L) ANKLE SWELLING, "KEEPS GIVING OUT ON ME" x 2 WKS AGO. PT HURT ANKLE RUNNING. PT. ORIGINALLY Dx c̄ a sprain. PT STATES Ø RELIEF in LAST 2 WEEKS. PT STATES WHEN ANKLE IS MOVED MEDIALLY or Foot inward PAIN and a giving out feeling. PT HAS been WEARING personal ankle brace.

O: (L) ankle R.O.M. is limited slightly when moving medially. neuro: MOTOR AND MOTION / STRENGTH ARE INTACT. COLOR appears to be normal when compared to both ankles. swelling to (L) ankle appears to be just lateral of achiles tendon upon palpation of this sight PT STATED pain.

A: FIRST DEGREE SPRAIN OF (L) ANKLE

P: 1. ASPIRIN 325mg Q 4 hours x 7 DAYS. 2: CRUTCHES x 5 DAYS. 3: LIGHT DUTY x 5 DAYS. 4. F/U c̄ line corpsmen

JAMES K. REESE HM1 USN

HN ... RESLER ... USN/AD

JAMES M. MICK
LT, MC, USNR
2AA

3/2 BAS

23 NOV 93

T: 99.3
P: 84
R: 18
B/P: 112/64
ALLERG: Ø
MEDS: ASA Q4H

(S) 21 y/o NKA returns on follow up on (L) ankle. States pain when walking also popping when stretching. Swelling noted on lateral ankle. Ø redness, pain c̄ palpation. Pt. states pain has decreased a little.

(O) FPROM 5/5 motor neuro intact good pedal pulses ~~pen pain~~. (+) slight edema to lateral side of ankle Ø ecchymosis

(A) First degree (L) ankle sprain Resolving

(P) 1) Return to duty c̄ instructions how to avoid hurting ankle again.
2) Continue meds as prescribed.

JAMES M. MICK
LT, MC, USNR
2A

HM1 J. K. REESE

HN KNIPPLEUAUGH EMT-B

*U.S. Government Printing Office: 1992 — 342-199/50195

CAMP GEIGER · SIC

RES. POSS FLU

CMT: 184

1930

92/64 PULSE: 100 RESP: 16 TEMP: (101.9) HT: —— WT: ——

ADDITIONAL COMMENTS: TEMP RE-TAKEN @ 1124 = 101.6

ALLERGIC TO: NKDA

MEDS - Ø

PATIENT/RESPONSIBLE OTHER: INSTRUCTED ON Flu c S/C in A.M. AND VERBALIZES UNDERSTANDING. COPY OF [illegible] TEACHING STANDARD GIVEN TO PATIENT. YES ____ NO ____

PROVIDER [signature] DATE 23 SEPT [illegible]

NSU-CM-11

KENDRICK [illegible]

2 Tylenol tabs [illegible] given. @2030 —— [signature]

S/ 21 y/o ♂ in S/C c c/o H/A, S/T, F/C, general malaise, x this a.m. pt states "I feel cold yet [illegible] is hot, and my [illegible] aches a little, and my throat [illegible]" Ø N/V, Ø diarrhea, ⊖ tick bites, ⊕ tobacco use, smoker x 5 yrs, ⊕ smokeless user x 5 yrs. Ø Hx of heart disease / asthma / illnesses

O/ WD / WN WM, NAD, c ↑ temp / pulse, other VSS

E/ PERRLA [illegible]

E/ TM's + canals clear bilat. s bulging ⊖ nodes

N/ ⊕ Bogginess, turbinates c mild edema + erythema to nasal pass. Ø sinus lobe tenderness

T/ Ø pustules Ø exudate c +1/3 cryptic tonsils, c mild erythema to oral / pharynx, neck) soft / supple s stiffness F.R.O.M., ⊕ shotty post. cervical nodes ⊕ pinpoint tenderness to mandibular arch area

(over)

23 SEPT 93 (cont) C/lungs = CRAX

HEART = RRR s m/R

TEMP RCVD @1251 = 100.1

A/ Strep throat

VITALS: B/P 110/60 P-72

B/P 124/70 P-80

P/ ① TX – pending

② PENVK 250 mg i tab p.o QID x 10 days #40

③ Tylenol 325mg i to ii tabs q 4-6 hrs, prn

④ Removed #2 ticks from shoulders b/LAT

⑤ push fluids

⑥ SIQ x 24 hrs.

⑦ Cont c meds u.d.

⑧ Tx & plan discussed c pt.

JOHN E. LEWIS JR.
HM3 USN

M.S. Kendrick

KENDRICK MARY S.

LT-MC-USN

Pag 402
0381

NAVAL HOSPITAL, CAMP LEJEUNE — DIVISION: CAMP GEIGER, BR

Personal Data - Privacy Act of 1974 (PL 93-579) — Automated Version of SF600

Printed: 01 Sep 1998@0712

CAMP GEIGER [illegible] MCCONNELL, JAMES A [illegible]

REF: UNIT: [illegible]

RSN: SLEEPING DISORDER

BP: 100/72 PULSE: 84 RESP: 12 TEMP: 97.4 HT: —— WT: ——

ADDITIONAL COMMENTS: (POC Sgt. Schroeder)

ALLERGIC TO: NKDA
MEDS: Ø

MOS: 0311

PATIENT/RESPONSIBLE OTHER: INSTRUCTED ON See below
AND VERBALIZES UNDERSTANDING. COPY OF TEACHING STANDARD GIVEN TO PATIENT. YES ____ NO ____
PROVIDER ____ DATE ____

S/ 21 y/o wm presents for c/o
(1) insomnia
(2) ~~sleeping difficulty~~ daytime sleeping

states no difficulty sleeping at night and claims adequate hours of sleep, however state he easily falls asleep during daytime hours - states can occur while sitting, standing, etc. - never actually falls down (per patient)
Ø known Hx narcolepsy or sleep apnea; denies depression or past psych Hx; ⊕ Hx febrile seizures as infant, but none since then; Ø Hx head trauma c̄ LOC; Ø Hx cardiopulmonary disease
Fam Hx ⊖ for thyroid + cardiovascular disease;
difficulty has occurred as long as the pt can remember; denies dissatisfaction c̄ usmc

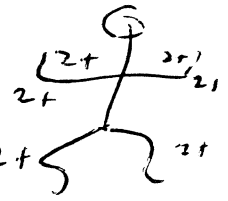
O/ A+O x4 in NAD

PERRLA EOMI Ø nystagmus fundi nl
TM's clear
mouth/throat - clear
neck - supple Ø LAD or thyromegaly
lungs - CTA
ht - reg rate; nl S_1, S_2 Ø S_3 S_4 or ⊖
abd - benign
skin - several raised, minimally erythematous patches on neck and abdomen
ext. Ø C/C/E

meds - rare ASA
ETOH - rare
tobacco - chews 3-4 cans per week
caffeine - rare

↓ cont

Neuro - CN II - XII intact
motor 5/5
sensory intact
FTN normal



A/ ① daytime hypersomnolence - r/o etiology
② narcolepsy

P/ ① will contact Sgt Schroeder (msg left) to get his input with the problem.
② Lotrisone cream Apply bid.
③ will F/u c pt after conversation c Sgt Schroeder

09 Sep 93
conversation c Sgt Schroeder states pt falls asleep briefly during P.T. (bent over position), classes, in formation standing; never falls over or falls to ground.

10 Sep 93 - discussed c Dr. Yeskes - recommended consider absence seizures, consider sleep disorder (apnea) - recommend Neuro consult to consider EEG, sleep studies - consider speaking c parents to assess sleeping pattern / any problem as youngster - rec - labs to include TFT's, CBC, SMA 18, U/A
spoke c CPT Smith to have P.T. humble report to clinic next week.

J. McDonell MD
J. A. [illegible]
LT [illegible]

NSN 7540-00-634-4176 600-108

HEALTH RECORD — **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
9 APR 93	RANCH MEDICAL CLINIC ~~MARINE CORPS RECRUIT DEPOT~~ PARRIS ISLAND, S.C. 29905
T 98.6	
P 80	S) 21 y/o MALE WITH COMPLAINTS OF SORE THROAT
R 16	AND SINUS PROBLEM X 3 DAYS.
B/P 110/60	Pt has no hx of tonsilectomy. (+) Hx of strep throat. (+) hx of sinus problems.
RO	O) WN WD VS noted NAD A/O X3. UPON exam of pt found;
	H) (-) TTP of frontal or maxillary sinuses
	E) canals clear; TMs visible and reflective
	E) (+) perrla (-) injective conjuctiva (+) symmetry
	N) Nasal passages c purulent drainage. (+) MILD ERYTHEMA.
	T) (+) erythema (-) tonsilar edema (-) pustule (-) exudate.
	Lungs: CTA
	A) Sinus Congestion - pharyngitis
	P) Consulted c HM1 McCutcheon
	(2) Tylenol 325mg TT PO Q4-6hRS.
	(3) Sudafed 30mg TT PO TID #18
	(4) Afrin* 2 sprays each nare
	*not to exceed three days.

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT: Muir

PATIENT'S NAME *(Last, First, Middle initial)*	SEX
KIMBLE Rowie L	Male
RELATIONSHIP TO SPONSOR: N/A	STATUS: Active URT Duty
RANK/GRADE: PVT	
SPONSOR'S NAME: N/A	ORGANIZATION: 2061
DEPART./SERVICE: USMC	SSN/IDENTIFICATION NO. [illegible]
DATE OF BIRTH: JAN 77	

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

(5) Cepacol lozenges PRN
(6) Sore Throat Spray PRN
(7) FID RTN prn if s/s ↑ →
(8) Pt understands Dx and Tx. —
J. Freeman
J. FREEMAN

J.E. Member HM1
J.E. Member HM

HA USN/AD

NO
Further
Entry

12/6/78 PULSE: 71 RESP: 16 TEMP: 98.7 HT: 72" WT: 182

ADDITIONAL COMMENTS: NKDA

24yo (R)HO here for f/u of hypersomnolence. Pt underwent Septoplasty ~~one~~ 2 months ago. He can breath better but he hasn't shown any improvement in terms of his sleepiness. Goes to bed 22-2300 - awakes 0700. ~~Hobbs is up~~ Appetite has been sporadic. No sleep paralysis. Has had ? of hypnapompic hallucinations. Taking 1-2 naps/day. He believes he will fall asleep if he doesn't do anything. Anhedonia. Recently wife had miscarriage.

ASS: ? Hypersomnolence w/o ? hypnapopic hallucination
- Wife has noticed apneas
- ? epworth in part
- ? narcolepsy

Plan: (1) Repeat Poly/MSLT
(2) Return after study

E. W. CZANDER
LT, MC, USNR
68-8087
NEUROLOGIST

KIMBLE,RONNIE LEE
17 Jan 1972 MALE
Soon: KIMBLE,RONNIE LEE

M11
W:3210
CIC: HBK
Rank: LCP

H:910-697-2687

D:3210

MEDICAL RECORD — OPERATION REPORT (SF 516)

DATE OF SURGERY: 20 SEPTEMBER 1996

PREOPERATIVE DIAGNOSIS:
[illegible]

[illegible]

PROCEDURE
SEPTORHINOPLASTY AND TURBINATE CRUSH AND CAUTERY.

COMPLICATIONS
NONE.

ESTIMATED BLOOD LOSS:
MINIMAL.

FLUIDS.
600 CCs.

INDICATIONS:
This is a 24-year-old male who has a nasal septal deformity with deviation of his septum and nasal dorsum to the right with right nasal dyspnea.

PROCEDURE:
Consent was obtained. The patient was taken to the operating room where he underwent monitored anesthesia care. The nose was topically anesthetized with 4% cocaine. The nose was then locally injected with a 50/50 mixture of 2% lidocaine with 1:100,000 epinephrine and 0.5% Marcaine with 1:100,000 epinephrine. The patient was then prepped and draped in the standard fashion. Inverted gull wing incision was made, and the skin incision carried upwards. Marginal incisions were extended laterally. The dissection was carried up along the medial and alar cartilages. The septum was

Signature of Surgeon:

DATE:
09/21/96

J.S. KEYSER
LCDR MC USNR

PATIENT IDENTIFICATION:

REGISTER NO.:
150652

WARD NO.:
3A

KIMBLE, RONNIE L., ME3 AD

HQSPTBN MCB

NAVAL HOSPITAL, CAMP LEJEUNE, NC 28547-0100
dm 09/24/96

... bony dorsum. Next the septal angle was identified and a mucoperichondrial flap was elevated on the left side identifying the septum. There was a high right septal deviation to a rightward ... the caudal septum with protrusion of the caudal septum out ... right nostril. The mucosa on the caudal portion of the right ... septum was elevated to better visualize the septum. The most ... portion was excised and the septum mobilized out of the tip ... by scalpel. Next the bony dorsum was ... and ... elevated and the portion of the rightward deviated nasal bone was ... making horizontal cuts in the bony septum. The caudal septum was then packed to a more midline position by placing 6-0 nylon suture through the inferior caudal portion and securing it to periosteum on the left nasal sill. The upper lateral cartilages were then released preserving the inner mucosal attachment. This allowed further straightening of the septum. The bony dorsum was gently rasped and then medial osteotomies were performed to correct the bony deviation. Attention was then turned to the tip which showed asymmetry of the dome. The left alar cartilage had a concaved deformity to it. A cartilaginous strut was placed between the medial crus and secured with a 4-0 chromic suture. A 6-0 clear nylon suture was placed just anterior and posterior to the dome to provide better tip definition and symmetry. Next a portion of the harvested septal cartilage was placed to fill the left alar concavity defect. This was secured with 4-0 chromic. The columellar incision was then reapproximated with 5-0 Vicryl. The incision was closed with 6-0 Prolene. Next the inferior turbinates were lateralized. The right inferior turbinate was cauterized with a bipolar cautery. Next lateral osteotomies with a curved osteotome were performed. The right osteotomy was incomplete and a 3 mm straight chisel was used to postage stamp and complete the osteotomy. The nasal pyramid was straightened. Next, bilateral Telfa packs coated with Bacitracin ointment were placed. The nose was taped in a standard fashion followed by a splint. The patient tolerated the procedure well and was transferred to the recovery room for postoperative monitoring.

Signature of Surgeon:

DATE.
09/21/96

J.S. KEYSER
LCDR MC USNR

PATIENT IDENTIFICATION:

REGISTER NO..
150652

WARD NO.:
3A

KIMBLE, RONNIE L., ME3 AD

HQSPTBN MCB

NAVAL HOSPITAL, CAMP LEJEUNE, NC 28547-0100
dm 09/24/96

112/68 71 16 98.3 72" 181

NKDA

24 yo (R) HH o→ here for f/u of hypersomnolence
Pt states he has noticed no change except that it's worse during the heat. Wondered if Allergies can do this. No rash, - has nasal blockage → no draining. trouble breathing, sneezing. Wife has noticed apnea during sleep.

PE: WDWNWM NAD
Alert, fluent speech
No sinus tenderness or pain on head shaking.
Gait nl

ASS: Hypersomnolence - has normal MRI, labs (Chem 18, CBC, ESR, Mono, ACE, RPR, MHA, U/A, UDrug Screen).
Also normal Polysom/MSLT 6/95.
- will try Zoloft as trial to help 50mg QD & ↑ in 2 weeks to 100 (can go up to 200mg)
- possible improvement after Septoplasty to be done in the next 2 months - next month
- f/u 6-8wks

E G[illegible]

E. W. CZANDER
LT. MC, USNR
NEUROLOGIST

KIMBLE, RONNIE LEE
17 Jan 1972 MALE
MII
W:3210 H:910-677-2687

99/63 73 20 97.6° 72" 178#

NKA

24yo Ⓡ H ♂ → here for f/u of hypersomnolence. Seen by Psychology → no abnormals. Pt states he has noticed no Δ over past 6 weeks but notes that his hypersomnolence is actually greater than previously thought but no worse. He devates plasma 2x per week over past 3 months. MRI of head normal. Wife has noticed episodes of apnea during sleep.

ASS ① Hypersomnolence - pt w/o change has been years. Will try Zoloft if labs normal labs. May try Zoloft if labs normal

② pt to get septoplasty w/i next 2 wks.

Plan: ① Chem 18, CBC, ESR, Monospot, ACE, RPR U/A, UDS

② RTC

E. W. CZANDER
LT, MC, USNR
NEUROLOGIST

KIMBLE, RONNIE LEE
17 Jan 1972 MALE
Spon: KIMBLE, RONNIE LEE
CG:

MIL
W:3210
CIC:
Rank: LCP

H:910-697-2687

D:3210

Printed: 15 May 199[illegible]

[illegible] CLINIC CZANDER, ERIC W 15 May [illegible]

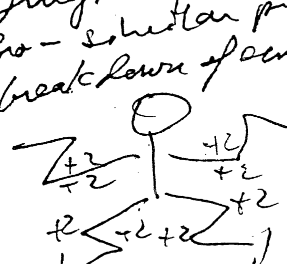
CMT: 144

BP: 124/36 PULSE: 67 RESP: 16 TEMP: 98.7 HT: 72" WT: 131

24 y/o Ⓡ H O♂ w/ long hx of falling asleep many times during day which he believes has occurred thru out his life. He believes, if anything, that this has progressively worsened over many years. He falls ~~asleep~~ like sleeping while driving, standing. He knows when he's going to fall asleep. Caffeine no help. No trouble falling asleep ~~but~~ or staying asleep. His wife has noticed him ~~sitting~~ sitting up while sleeping - slept walk as child. No naked sleep walking as adult. ~~Wife~~ can't remember if wife has noticed apnea during sleep. Goes to sleep ~10PM → 7AM Naps 0-1/day. No H/A's. No vision Δ's, diplopia, No dysarthria, dysphagia, weakness, numbness, tongue bites, No LOC, head trauma, sz activity, enuresis. muscle soreness upon awakening. polysomnogram last year → nl & MSLT

PMHx - ∅
Meds: ∅ All: ∅
SHx: Married, kids, Base Chaplain
TOB - dip
EtOH - Rel 1 can/2 days; the
Drugs - ∅ Fam problems

PE: WDWNWMNAD
A&OX3, attn: nos, language nl, nam/comp/rep/fluent
vis spat nl
Fundi: sharp discs, PERRLA, EOMI, full fields
FHx: Bro - similar problems
Face symm, tongue/pal mid, nl sens nl OKN's, breakdown of smooth pursuit
5/5 strength ⊖ drift nl FTN, FTN
gait/tandem nl
nl Vib, T, PP



SS: Hypersomnolence - pt w/ Hx not fully compat. ble w/ normal exam & w/ nl polysomnogram.
narcolepsy

Plan: ① ψ consult & discuss considering Zoloft, SSRI
② Breathe-right trial ③ MRI head w/ gado ④ Ltd Duty Board ⑤ F/U 8 wks

E Czander

E. W. CZANDER
LT, MC, USN
NEUROLOGIST

KIMBLE, RONNIE LEE
17 Jan 1973 MALE

CMT: 19A

DIFFICULTY BREATHING WHILE LYING DOWN DUE TO NOSE INJURY 1 YR AGO

98/56 PULSE: 60 RESP: 18 TEMP: 969 HT: WT:

==

ADDITIONAL COMMENTS: S. This pat. claims that his nose is not functioning right

Alg - NKDA

Meds - ∅

states that he cannot breathe properly since ⓡ tonsil. Has repeated sinus problem but probably not sinusitis. No 8 ? mo respiratory infections

O. NAD

VS as seen.

Sinuses: No tenderness.

Throat: WNL.

Nose: No acute inflammation in nose. Ⓡ nostril narrow.

Neck: No glands.

Chest: Lungs: CTA. Heart: Reg.

A. Narrow Ⓡ nostril.

Sleeping problem.

P. D Referred back to ENT (as by request.

② Appointment ē Neurologist.

•Patient/Responsible other:

•Instructed on: Dx + Plans

•Verbalizes an understanding of instructions given

Yes No

•Teaching standards given to patient: Yes No

•Provider

G. T. BJORNSSON
CAPT MC USNR

==

KIMBLE,RONNIE LEE
17 Jan 1972 MALE

W:3210

H:910-697-2687

O:3210

1/6/94 80 20 98.8 72" 176 lbs

Pt's PSG/MSLT done & interpreted as normal (S.O) interest pt had S. efficiency 93% c 8½ mTIB. and c MSL of 12.4 there was 1 SOREM (which may not stated).

Will focus on sleep hygiene. Pt may be a long sleeper. RTC late Oct.

TW DeBeck MD

951026 Pt doing OK. Still has difficulty c waking up but may be going back to office until but I'm not sure that will work as he is a long sleeper.

DEP RTC 6 weeks

TW DeBeck MD

951121 Pt given note recommending he continue in present assignment.

RTC Feb 96

TW DeBeck MD

KIMBLE, RONNIE LEE M:1
17 Jan 1972 MALE W:3210 H:7
Spon: KIMBLE, RONNIE LEE CIC:

DE BECK, T.W., NEUROLOGIST
CDR, MC, USNR
NAVHOSP CAMP LEJEUNE

Ronnie has had MSLT/PSG. called PNH and results not yet done.

Sleep situation unchanged. no close calls on drive from greensboro to cc each sun evening. He states he knows when to stop.

Will see next week or whenever results are in hand.

TWdeRoeck MD.

KIMBLE,RONNIE LEE M11
17 Jan 1972 MALE W:3210 H:910-697-2687
SS#: KIMBLE,RONNIE LEE CIC:

Standard Form 88
Revised 10/75
General Services Administration
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-43.505

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
Kimble Ronnie Lee	CIVILIAN	

4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)
6031 Monnett Rd. Julian NC 27283

5. PURPOSE OF EXAMINATION: (ENLISTMENT) COMMISSION; ARMY NAVY AIR FORCE (MARINE CORPS); COAST GUARD RESERVE NATIONAL GUARD

6. DATE OF EXAMINATION: 27 JAN 93

7. SEX	8. RACE: (WHITE) (BLACK) (AMERICAN INDIAN) (ASIAN) (OTHER/UNKNOWN)	9. TOTAL YEARS GOVERNMENT SERVICE: MILITARY None / CIVILIAN None	10. AGENCY	11. ORGANIZATION UNIT
Male				

12. DATE OF BIRTH	AGE	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
17 Jan 72	(21)	Alamance Co. NC.	Ronnie L. Kimble (Father) Same AS 4

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS: CHARLOTTE MEPS 401 WEST TRADE STREET CHARLOTTE, NC 28202-1626

16. OTHER INFORMATION: NONE

17. RATING OR SPECIALTY

TIME IN THIS CAPACITY (Total) | LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column; enter "NE" if not evaluated.)	ABNORMAL
✓	18. HEAD, FACE, NECK AND SCALP	
✓	19. NOSE	
✓	20. SINUSES	
✓	21. MOUTH AND THROAT	
✓	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)	
✓	23. DRUMS (Perforation)	
✓	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
✓	25. OPHTHALMOSCOPIC	
✓	26. PUPILS (Equality and reaction)	
✓	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
✓	28. LUNGS AND CHEST (Include breasts)	
✓	29. HEART (Thrust, size, rhythm, sounds)	
✓	30. VASCULAR SYSTEM (Varicosities, etc.)	
✓	31. ABDOMEN AND VISCERA (Include hernia)	
✓	32. ANUS AND RECTUM (Hemorrhoids, fistulae) Prostate, if indicated)	
✓	33. ENDOCRINE SYSTEM	
✓	34. G-U SYSTEM	
✓	35. UPPER EXTREMITIES (Strength, range of motion)	
✓	36. FEET	
✓	37. LOWER EXTREMITIES (Except feet)(Strength, range of motion)	
✓	38. SPINE, OTHER MUSCULOSKELETAL	
✓	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
✓	40. SKIN, LYMPHATICS	
✓	41. NEUROLOGIC (Equilibrium tests under item 72)	
✓	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

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

36 FEET
NORMAL ARCH
PER CAVUS
MILD
MODERATE
SEVERE
ASYMPTOMATIC
SYMPTOMATIC
PES PLANUS
(39) Burn scar (L) forearm
(42) knee + (L) thigh scar
scar (R) chest
supraclavicular nipple (L) chest
27 JAN 1993

ITEM 50. OTHER TESTS	[redacted] PLACE SECOND SPECIMEN ID LABEL HERE			
	FIRST TEST		SECOND TEST	
	RESULTS	CODE	RESULTS	CODE
HIV	neg	5B		
DRUGS	2	2		
ALCOHOL	2 2	2		

(Continue in item 73)

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

RIGHT									LEFT							
1	2	3	4	5	6	7	8		9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25		24	23	22	21	20	19	18	17

Restorable teeth: 0 over 1 2 3 / 32 31 30
Non-restorable teeth: / over 1 2 3 / 32 31 30
Missing teeth: x over 1 2 3 / 32 31 30
Replaced by dentures: x x x over 1 2 3 / 32 31 30
Fixed partial dentures: (x) over 1 2 3 / 32 31 30 and (x) over 11 15

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES
ACCEPTABLE
NOT ACCEPTABLE
(DENTAL EXAMINATION NOT DONE BY DENTAL OFFICER)

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY
B. ALBUMIN-REAGENT STRIP NEGATIVE
C. SUGAR-REAGENT STRIP NEGATIVE
D. MICROSCOPIC

46. CHEST X-RAY (Place, date, film number and result)
PLACE AS IN ITEM 15: FILM NO .....
DATE ..... RESULT .....

47. SEROLOGY (Specify test used and result)
RPR N/R

48. EKG

49. BLOOD TYPE AND RH FACTOR

50. OTHER TESTS neg Elisa
URINE HCG: _____

20

NAME: Kimble, Ronnie Lee | **MEASUREMENTS AND OTHER FINDINGS** | **SSN:** | USMC

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD:	56. TEMPERATURE / HIV AB CODE:
69¾	166	Brown	Brown	☐ SLENDER ☑ MEDIUM ☐ HEAVY ☐ OBESE	5B

57. BLOOD PRESSURE (Arm at heart level)

A. SITTING		B. RECUMBENT		C. STANDING (3 min.)	
SYS.	124	SYS.		SYS.	
DIAS.	80	DIAS.		DIAS.	

58. PULSE (Arm at heart level)

A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.
64				

59. DISTANT VISION		60. REFRACTION			61. NEAR VISION		
RIGHT 20/ 15	CORR. TO 20/	BY	S	CX	20/15	CORR. TO	BY
LEFT 20/ 15	CORR. TO 20/	BY	S.	CX	20/15	CORR. TO	BY

62. HETEROPHORIA (Specify distance)

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

ACCOMMODATION — RIGHT LEFT

64. COLOR VISION (Test used and result) PIP PASS 2X /14

65. DEPTH PERCEPTION (Test used and score) AFVT

UNCORRECTED

CORRECTED

66. FIELD OF VISION

67. NIGHT VISION (Test used and score)

68. RED LENS TEST

69. INTRAOCULAR TENSION

HEARING

RIGHT WV /15 SV /15

LEFT WV /15SV /15

71. AUDIOMETER ANSI-69

	250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192
RIGHT	●	0	10	0	0	0	10	●
LEFT		0	0	0	0	0	15	

72. PSYCHOLOGICAL AND PSYCHOMOTOR FOR MEPS USE ONLY

WK	ST	DATE	INITIAL
1	P	27 JAN 1993	[signature]
5	P	930129	AS
7	P	18 FEB 1993	[initials]
7	P	22 FEB 1993	[initials]

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

ITEM 64:

RED/GREEN (ARMY ONLY) 123-222

PHYSICAL INSPECTION DATE	HT	WT	RPR	HCG	QUAL	DISQ	SIGNATURE
18 FEB 1993	69¾	168			✓		[signature]
22 FEB 1993	70	171			✓		[signature]
07 APR 1993	70	171			✓		[signature]

18 FEB 1993 Aspirin taken for not frequent headache [initials]

FOR MEPS USE ONLY			
WK	ST	DATE	INIT
6	P	07 APR 1993	[initials]

(Use additional sheets if necessary)

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

THIS EXAMINATION HAS BEEN ADMINISTRATIVELY REVIEWED FOR COMPLETENESS AND ACCURACY

[signature] MSG 27 JAN 1993

SIGNATURE GRADE DATE

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

76. A. PHYSICAL PROFILE

P	U	L	H	E	S
1	1	1	1	1	1

X

B. PHYSICAL CATEGORY 0

A	B	C	E

77. EXAMINEE (Check)

A.☐ IS QUALIFIED FOR SERVICE AS IN ITEM 5

B.☐ IS NOT QUALIFIED FOR

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

79. TYPED OR PRINTED NAME OF PHYSICIAN: DR.EDWIN GONZALEZ — SIGNATURE [signature]

TYPED OR PRINTED NAME OF PHYSICIAN: CMO — SIGNATURE [signature]

81. TYPED OR PRINTED NAME OF DENTIST OF PHYSICIAN (Indicate which): DR.EDWIN GONZALEZ CMO — SIGNATURE [signature]

82. TYPED OR PRINTED NAME OF REVIEWING OFFI[...] OR APPROVING AUTHORITY: [...]R.EDWIN GONZALEZ CMO — SIGNATURE [signature]

NUMBER OF ATTACHED SHEETS 1

STANDARD FORM 93
REV. OCTOBER 1974
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-[illegible]

Approved
Office of Management and Budget No. 29-R01

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.
Kimble, Ronnie Lee	20 [illegible]
3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE)	**4. POSITION** (Title, grade, component)
6031 Monnett Rd Julian NC 27283	CIVILIAN
5. PURPOSE OF EXAMINATION ~~ENLISTMENT~~ COMMISSION; ARMY NAVY AIR FORCE (MARINE CORPS); COAST GUARD RESERVE NATIONAL GUARD	**6. DATE OF EXAMINATION** 27 JAN 73
7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS CHARLOTTE MEPS 401 WEST TRADE STREET CHARLOTTE, NC 28202-1626	

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

PRESENT HEALTH: Good

CURRENT MEDICATIONS: None

ALLERGIES (INCLUDING TO INSECT BITES/STINGS AND TO COMMON FOODS): 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 RK 27 JAN 73
	✓	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 diseases		✓		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 or goiter		✓		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				
	✓		Heart trouble or murmur		✓		Painful or "trick" shoulder or elbow				
	✓		High or low blood pressure		✓		Recurrent back pain				

12. FEMALES ONLY: HAVE YOU EVER

			Been treated for a female disorder
			Had a change in menstrual pattern
DATE OF LMP			
DATE OF LMP			

13. WHAT IS YOUR USUAL OCCUPATION?

Cut steel

14. ARE YOU (Check one)

☑ Right handed ☐ Left handed

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.)*

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
Ronnie Lee Kimble	Ronnie Kimble

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.)*

(0) Medically Unfit

APPLICANT DENIES SERIOUS MEDICAL HISTORY

QUESTIONING REVEALS	YES	NO	DETAILS
MARIJUANA USE		✓	
OTHER DRUG ABUSE		✓	
ALCOHOL ABUSE		✓	RLK.
HOMOSEXUALITY		✓	

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS
[redacted] GONZ[redacted]Z CMO	27 JAN 1983	[redacted]	

TRACT OF SERVICE AND
DICAL HISTORY, NAVMED 61
CRD PI OVERPRINT (REV. 11-8

SHIP OR STATION	DIAGNOSIS, DIAGNOSIS NUMBER AND REMARKS	DATE FROM	DATE TO
BRANCH CLINIC NAVAL HOSPITAL BEAUFORT	RECRUIT TRAINING		
MCRD PARRIS ISLAND, S.C. 29905		6 APR 1993	2 JUL 199
F CO. MCT 34-93 CAMP GEIGER BRANCH CLINIC CAMP LEJEUNE NC 28542-5008			
	Dunis	7 JUL 1993	6 AUG 199
3rd Battalion, 2nd Marines 2nd Marine Division, FMF Camp Lejeune, NC 28542	BRAVO Co Duty INDIA E	8/3/93	10/5/93
3rd Battalion, 2nd Marines 2nd Marine Division, FMF Camp Lejeune, NC 28542	India (DUTY)	6 OCT 93	
A6 HQ&SPT BN MCB CLNC	F.A.P.	14 JUL 1995	12 MAR 1997

20

SOCIAL SECURITY NUMBER	SEX	RACE	DATE OF BIRTH	ORGANIZATION OR UNIT	PHONE
	F	C			

NAME	SERVICE NO.	RANK	COMP OR BRANCH	SERVICE DEPT. OR AGENCY
		PVT	USMC	DEPT. OF DEFENSE

Standard Form 600
Promulgated Nov. 1952
By Bureau of the Budget
Circular A-32

MCRD PI OVERPRINT (8-88)

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 * 2-3 DAYS	RESULT * 7-10 DAYS	STATION	PHYSICIAN'S NAME
1		WYETH		MAJ		MCRD, PISC	
2							
3							
4							
5							
6							

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
1	22 NOV 93	0.5cc		[illegible]	7				
2	8 MAR 94	0.5cc		[illegible]	8				
3					9				
4					10				
5					11				
6					12				

TETANUS TOXOID AND DIPHTHERIA

	DATE	DOSE	UNTOWARD REACTION	PHYSICIAN'S NAME		DATE	DOSE	UNTOWARD REACTION	PHYSICIAN'S NAME
1	05 MAY 1993	0.5cc		R. J. Senior, CDR, MC, USNR	4				
2	22 NOV 93	0.5cc		[illegible]	5				
3					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
1					4			[illegible]	
2					5				
3					6				

CHOLERA VACCINE

	DATE	ORIGIN	BATCH NO.	PHYSICIAN'S NAME		DATE	ORIGIN	BATCH NO.	PHYSICIAN'S NAME
1					7				
2					8				
3					9				
4					10				
5					11				
6					12				

YELLOW FEVER VACCINE

	DATE	ORIGIN	BATCH NO.	STATION	PHYSICIAN'S NAME
1	29 JUN 1993	CONNAUGHT	3B41037	MCRD, PISC	R.J. SENIOR, CDR, MC, USNR
2					
3					

SOCIAL SECURITY NUMBER	SEX	RACE	DATE OF BIRTH	ORGANIZATION OR UNIT	PHONE
[illegible]	M	C	17 JAN 72	[illegible]	

NAME	SERVICE NO.	RANK	COMP OR BRANCH	SERVICE DEPT. OR AGENCY
[illegible]		PVT	USMC	DEPT. OF DEFENSE

IMMUNIZATION RECORD
Standard Form 601
MCRD PI OVERPRINT (REV. 11-89)

OTHER IMMUNIZATIONS

	DATE	TYPE	DOSE	REACTION	REMARKS	PHYSICIAN'S NAME
1						
2	12 APR 1993	ADENOVIRUS 2 TABS ORAL VAC. TYPE IV & VII				R. SENIOR CDR,MC,USNR
3	12 APR 1993	MENINGOCOCCAL 0.5cc				R. SENIOR CDR,MC,USNR
4	05 MAY 1993	INFLUENZA TRIVALENT 0.5cc				R. J. Senior, CDR, MC, USNR
5	12 APR 1993	MEASLES/MUMPS/RUBELL VAC. 0.5ml				R. SENIOR CDR,MC,USNR
6	12 APR 1993	ORAL TRIVALENT POLIO VIRUS TYPE I, II, III				R. SENIOR CDR,MC,USNR
7	12 APR 1993	BICILLIN 1.2 MIL. UNITS I. M.				
8	22NOV93	FLU	0.5cc			
9	17MAY94	ZOSTA	1cc			
10	31MAY95	HEP B #1	1cc			
11	22NOV95	FLU	.5cc			
12	13NOV96	FLU	0.5CC			
13						
14						
15						

SENSITIVITY TESTS (*Tuberculin, Etc.*)

	DATE	TYPE	DOSE	ROUTE	RESULTS	PHYSICIAN'S NAME
1	12 APR 1993	TUBERCULIN P.P.D.	5TU	ID	Zero mm	R. J. Senior, CDR, MC, USNR
2	23FEB94	PPD	5TU	ID	Zero mm	
3	28JAN95	PPD	5TU	ID	Zero mm	HM3 Polly
4						
5						
6						
7						
8						
9						
10	12 APR 1993	HIV	NA		HIV NEGATIVE	R. J. Senior, CDR, MC, USNR

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

	DATE	AGENT	TYPE OF REACTION	SEVERITY	PHYSICIAN'S NAME
1					
2					
3					
4					
5					

BLOOD TYPING

	DATE	TYPE (*International*)	RH FACTOR	PHYSICIAN'S NAME
1	12APR93	O	POS	Transcribed from Official Record
2				
3				

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

NKA

DNA Specimen drawn & duplicate registry card filed in the Medical Record.