MEDICAL RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE — AUTHORIZED FOR LOCAL REPRODUCTION

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
JULY 02	③ c/o drsg Δ q wd care.
	④ pt brought to clinic to clean + repack
	Ⓑ mandibular I&D. old iodoform remove
	& drainage noted. wd cleaned c NS +
	about 1in of iodoform was repacked in wd.
	facial hair was removed. wd covered c
	2x2 + secured c tape.
	Ⓐ ① wd care
	② drsg Δ
	③ cleaned wd -
	repacked wd -
	cont drsg Δ's daily.
10 sug 02	⑤ 23 y/o ♂ presents to clinic c c/o dysuria c kidney &
135	Bilateral pain. states (via translator) testicles "don't feel
83	normal" to palpation, swelling of testicles switches back
70	& forth between Ⓑ & Ⓓ. This episode has been going on
(18)	for 2 weeks.
	⑨ UNWD, PMH - dysuria x 4 years, dx. 4 years ago said
	Pt had "a lot of salts" in urine and gave meds to
	reduce salts. Ø FMH of prostate cancer. Pt
	states "Sometimes I urinate a lot, Sometimes I feel like
	I have to go, but I can't." Pt admits drinking
	only 3-4 8oz cups H2O daily.

(b)(3):10 USC §130b,(b)(6)

HOSPITAL OR MEDICAL FACILITY — STATUS — DEPART./SERVICE — RECORDS MAINTAINED AT

SPONSOR'S NAME — SSN/ID NO. — RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.) — REGISTER NO. — WARD NO.

OVER →

D, Ø693

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/IDMR
FIRMR (41 CFR) 201-8.205-1 USAPPC V1.00

(Cont) Upon testicular exam, (L) TTP, (L) testicle normal in shape, size, epididymis intact, (R) testicle considerably smaller than (L), but normal in shape, epididymis intact. ∅ c/o ↓ Abd pain.

(A) Testicular pain of unknown origin c̄ dysuria & poss kidney stone(s).

(P) (1) Lab: UA C/C → send to lab

(2) ↑ fluids.

(3) F/U 11 July 02 @ clinic

(4) returns to cell

(b)(3):10 USC §130b,(b)(6)

[redacted]

AUTHORIZED FOR LOCAL REPRODUCTION

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

DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7/6/02	pt was brought to clinic for dsg Δ c
	wound care. Pt hypertensive. NAD
T 99.5	aware - BP √ again 7/7/02 c wd
P 99	care & dsg Δ. Old packing removed
BP 158/103	from pt (R) & jaw. Iodoform about
Normal 152/102	1½ in in length c noted greenish/yellow
	"goopy" purlent drainage. Abt 1½ in
	of Iodoform was replaced & NS cleaning
	of wd. Covered c Steri-Strip 2x2 &
	secured c tape. Pt dtl procedure
	well & was medicated c 1 tylenol #3
	PO for pain. F/u 7/7/02 for wd care
	& dsg Δ.
07JUL02	PT REFUSED PSC-Δ TX

(b)(3):10 USC §130b,(b)(6)

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	
PATIENT'S IDENTIFICATION (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)		REGISTER NO.	WARD NO.

D, 4093

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1 USAPPC V1.00

GTMO JMG 126

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
5Jul02 1708	Corpsman Note. (S) "I feel some anxiety." (+) self-control. (-) SI s̄ plan "It is against my religion." (-) HI / (+) AVH of voices and the ceiling coming down. ↓ Sleep (broken) due to nightmares. ↓ appetite, but forces himself to eat. Reported ↓ concentration. (O) Broad affect. (+) eye contact. Calm, cooperative. Thought process linear & goal directed. Speech spontaneous c̄ RRR/V. ~~Thought~~ Cand. (b)(3):10 USC Condition unchanged. Continue present tx plan. F/U 7/6/02. RN notified of (-) SI. (b)(3):10 USC §130b,(b)(6)
06Jul02	
T 99.5°F	
P 99	
R	
B/P 158/103	
manual 152/102	

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.	WARD NO.

DSTF 000693
888 000693

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5-99)
Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

509-114

GTMO JMG 127

DATE	NOTES

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

MINOR SURGERY PROCEDURE FORM

DATE: 05 JUL 02

VITALS: BP 113/100 P 83 R 27 T 98.9

ALLERGIES: NKDA

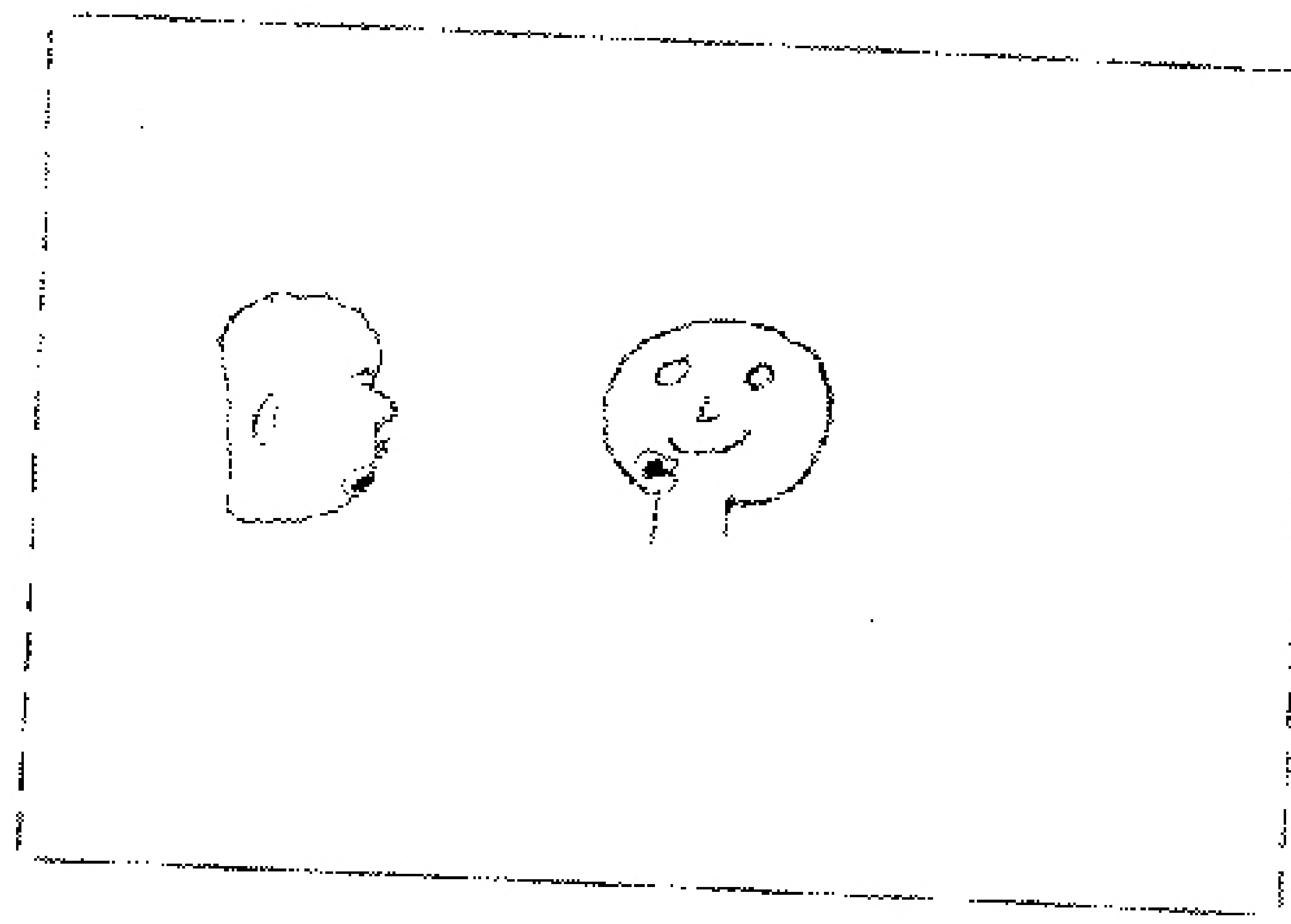
MEDICINES: ______

INFORMED CONSENT SIGNED: (✓)

SKIN PREP: ALCOHOL ( ) BETADINE (✓) OTHER ______

ANESTHESIA: XYLOCAINE 1% (✓) 1 ccs
XYLOCAINE 1% w/epi ( ) ___ccs
XYLOCAINE 2% ( ) ___ccs
XYLOCAINE 2% w/epi ( ) ___ccs

DIAGRAM SITE: (R) jaw



PROCEDURE: SHAVE REMOVAL ( )
PUNCH BIOPSY ( )
ELLIPSE EXCISION ( )
OTHER (✓ straight incision 3 cm

INSTRUMENT: BLADE: #10 (✓ #11 ( ) #15 ( )
PUNCH: ( ) size: ______
CURETTE: ( ) size: ______

HEMOSTASIS: ALUM CHLORIDE ( ) ELECTROCOAG ( )
MONSELS ( ) OTHER (✓ pressure

CLOSURE: Ø NYLON ( ) ___.0 VICRYL ( ) ___.0 PROLINE ( ) ___.0 CHROMIC( ) ___.0

SUTURES: Ø NUMBER ______ TYPE ______

DRESSING: STERILE NONSTICK (✓ PRESSURE (✓ Iodoform 4"
BANDAID ( ) BACITRACIN ( )

SPECIMEN TO PATHOLOGY: IN FORMALIN ( ) NO SPECIMEN (✓

PREOP DIAGNOSIS: E&C

POST OP DIAGNOSIS: E&C

PATH F/U: none

COMPLICATIONS: NONE (✓ OTHER ( ) ______
PATENT CONDITION AT DISCHARGE: Improved (✓ Unchanged ( )
RETURN TO CLINIC: 24H (✓ 48 ( ) Other______
SUTURE REMOVAL ( ) DATE/TIME ______
COMMENTS:
1) Dicloxacillin 250 mg ↑ PO QID x 10 days – 1st dose now
2) Motrin 800 mg ↑ PO TID PRN pain x 10 days
3) RTC for daily dsg Δ, Iodoform 1/4" left @ ..., Telfa, 4x4, tape
4) F/U s/s infection / fever
5) Return to CBH

(b)(3):10 USC §130b,(b)(6)

MEDICAL OFFICER SIGNATURE AND STAMP

NAME: D, ... 000093
DOB:
SPONSOR:
FMP/SSN: 888 000093
W:
RANK:
PATCAT:
R:
UNIT:

GTMO JMG 129

GTMO JMG 130

522-113

NSN 7540-00-634-41

MEDICAL RECORD | REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

I & D of cyst

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be A small incision will be made over cyst site and fluid will be drained
(Description of operation or procedure in layman's language)

which is to be performed by or under the direction of Dr. [illegible]

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: none
(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES
(Appropriate items in Parts A and B must be completed before signing)

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient [redacted] (b)(3):10 USC §130b,(b)(6)
expected results, as described above.

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby [redacted] (b)(3):10 USC §130b,(b)(6) ned.

[redacted] operating team)

(Signature of Patient)

05 Jul 02
(Date and Time)

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, ______ sponsor/guardian of ______ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)

(Signature of Sponsor/Legal Guardian)

(Date and Time)

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

REGISTER NO.

WARD NO.

0, 2 7 F 00 0 6 9 ? [handwriting partly illegible]

§ 3 6 00 0 6 9 3 [handwriting partly illegible]

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Medical Record

STANDARD FORM 522 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

U.S. Government Printing Office: 1993 — 342-198/20198

GTMO JMG 131

GTMO JMG 132