PRELIMINARY AUTOPSY REPORT

Name: N/A
SSAN: NA
Date of Birth: Unknown
Date of Death: BTB 19 May 2004
Date of Autopsy: 1 June 2004
Date of Report: 1 June 2004

Autopsy No.: ME04-387
AFIP No.: Pending
Rank: Civ
Place of Death: Abu Ghraib Prison
Place of Autopsy: BLAP Morgue

Circumstances of Death: This male died while in US custody at Abu Ghraib prison. There is a verbal report only of pain.

Authorization for Autopsy: Office of the Armed Forces Medical Examiner, IAW 10 USC 1471

Identification: By family members only, DNA sample obtained

CAUSE OF DEATH: Peritonitis of undetermined etiology

MANNER OF DEATH: Natural

These findings are preliminary, and subject to modification pending further investigation and laboratory testing.
PRELIMINARY AUTOPSY DIAGNOSES:

I. Peritonitis
   A. 3 liters of cloudy brown liquid with feculent material and fibrinous adhesions
   B. Dense peri-splenic adhesions
   C. No perforations or injuries of the stomach, small bowel, or colon identified at autopsy

II. Pulmonary edema and congestion (right lung 1000 grams, left lung 750 grams)

III. Healing 3/8 inch abrasion of the right shin

IV. Tooth number 8 absent due to decay (used by family members as identification)

V. No significant trauma

VI. Toxicology and histology pending
AUTOPSY EXAMINATION REPORT

Name: [Redacted]
SSAN: NA
Date of Birth: Unknown
Date of Death: BTB 19 May 2004
Date of Autopsy: 1 June 2004
Date of Report: 8 Jul 2004

Autopsy No.: ME04-387
AFIP No.: 292645
Rank: Civ
Place of Death: Abu Ghraib Prison
Place of Autopsy: BLAP Morgue

Circumstances of Death: This male died while in US custody at Abu Ghraib prison.

Authorization for Autopsy: Office of the Armed Forces Medical Examiner, IAW 10 USC 1471

Identification: By family members only, DNA sample obtained

CAUSE OF DEATH: Peritonitis

MANNER OF DEATH: Natural
FINAL AUTOPSY DIAGNOSES:

I. Peritonitis
   A. 3 liters of cloudy brown liquid with feculent material and fibrinous adhesions in the peritoneal cavity
   B. Dense peri-splenic adhesions
   C. No perforations or injuries of the stomach, small bowel, or colon identified at autopsy
   D. Neutrophilic and histiocytic inflammation of the serosa (microscopic)

II. Pulmonary edema and congestion (right lung 1000 grams, left lung 750 grams)
    A. Moderate anthracosis (microscopic)

III. Chronic thyroiditis (microscopic)

IV. Healing 3/8 inch abrasion of the right shin

V. Tooth number 8 absent due to decay (used by family members as identification)

VI. No significant trauma

VII. Toxicology (blood clot)
    A. Meperidine 0.46 mg/L
    B. Promethazine 0.23 mg/L
    C. Diphenhydramine 0.37 mg/L
    D. No ethanol (bile) or illicit substances
EXTERNAL EXAMINATION
The body is that of a thin, 74 inches in length, 160 pounds (estimated), Caucasian male with an estimated age of 40 years.

Lividity is posterior, purple, and fixed. Rigor is absent.

The scalp is covered with black hair in a normal distribution. There is a beard and mustache. The irides are brown and the pupils are round and equal in diameter. The external auditory canals are unremarkable. The ears are unremarkable. The nares are patent and the lips are atraumatic. The nose and maxillae are palpably stable. The teeth appear natural and in poor repair. Tooth # 8 is missing.

The neck is straight, and the trachea is midline and mobile. The chest is symmetric. The abdomen is flat. The genitalia are those of a normal adult male. The testes are descended and free of masses. Pubic hair is present in a normal distribution. The buttocks and anus are unremarkable.

The upper and lower extremities are symmetric and without clubbing or edema.

There is early decomposition consisting of vascular marbling and skin slippage.

CLOTHING AND PERSONAL EFFECTS
The body is received nude at the time of autopsy.

MEDICAL INTERVENTION
There are no attached medical devices at the time of autopsy.

RADIOGRAPHS
No radiopaque foreign objects or displaced fractures are identified.

EVIDENCE OF INJURY
On the anterior right shin is a 3/8 inch red abrasion.

INTERNAL EXAMINATION

HEAD:
The galeal and subgaleal soft tissues of the scalp are free of injury. The calvarium is intact, as is the dura mater beneath it. Clear cerebrospinal fluid surrounds the 1350 gm brain, which has unremarkable gyri and sulci. Coronal sections demonstrate sharp demarcation between white and grey matter, without hemorrhage or contusive injury.
The ventricles are of normal size. The basal ganglia, brainstem, cerebellum, and arterial systems are free of injury or other abnormalities. There are no skull fractures. The atlanto-occipital joint is stable.
NECK:
The anterior strap muscles of the neck are homogenous and red-brown, without hemorrhage. The thyroid cartilage and hyoid are intact. The larynx is lined by intact white mucosa. The thyroid is symmetric and red-brown, without cystic or nodular change. The tongue is free of bite marks, hemorrhage, or other injuries.

The cervical spine is intact and there is no paraspinous muscular hemorrhage.

BODY CAVITIES:
The peritoneal cavity contains approximately 3 liters of cloudy brown liquid and feculent material. The left pleural cavity contains approximately 400 ml of cloudy brown liquid and has dense fibrous adhesions. The ribs, sternum, and vertebral bodies are visibly and palpably intact. The organs occupy their usual anatomic positions.

RESPIRATORY SYSTEM:
The right and left lungs weigh 1000 and 750 gm, respectively. The external surfaces are smooth and deep red-purple. The pulmonary parenchyma is diffusely congested and edematous. No mass lesions or areas of consolidation are present.

CARDIOVASCULAR SYSTEM:
The 300 gm heart is contained in an intact pericardial sac. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution, with a right-dominant pattern. Cross sections of the vessels show no significant atherosclerosis. The myocardium is homogenous, red-brown, and firm. The valve leaflets are thin and mobile. The walls of the left and right ventricles are 1.3 and 0.4 cm thick, respectively. The endocardium is smooth and glistening. The aorta gives rise to three intact and patent arch vessels. The renal and mesenteric vessels are unremarkable.

LIVER & BILIARY SYSTEM:
The 1450 gm liver has an intact, smooth capsule and a sharp anterior border. The parenchyma is tan-brown and congested, with the usual lobular architecture. No mass lesions or other abnormalities are seen. The gallbladder contains a minute amount of green-black bile and no stones. The mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:
The 200 gm spleen has dense adhesions of the capsule.

PANCREAS:
The pancreas is autolized. No mass lesions or other abnormalities are seen.

ADRENALS:
The right and left adrenal glands are symmetric, with bright yellow cortices and grey medullae. No masses or areas of hemorrhage are identified.
GENITOURINARY SYSTEM:
The right and left kidneys weigh 150 and 175 gm, respectively. The external surfaces are intact and smooth. The cut surfaces are red-tan and congested, with uniformly thick cortices and sharp corticomedullary junctions. The pelves are unremarkable and the ureters are normal in course and caliber. White bladder mucosa overlies an intact bladder wall. The bladder contains approximately 30 ml of red urine. The prostate is normal in size, with lobular, yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities.

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, grey-white mucosa. The stomach is empty. The gastric wall is intact. The duodenum, loops of small bowel, and colon are unremarkable. The appendix is present and unremarkable.

ADDITIONAL PROCEDURES
- Documentary photographs are taken by PH3.
- Specimens retained for toxicologic testing and/or DNA identification are: vitreous, blood, urine, spleen, lung, kidney, liver, brain, bile, and psoas
- The dissected organs are forwarded with the body
- Personal effects are released to the appropriate mortuary operations representatives

MICROSCOPIC EXAMINATION
Heart: Sections show no significant pathologic abnormality.
Lungs: Sections show moderate anthracosis, atelectasis, and decomposition.
Thyroid: Sections show chronic inflammation.
Gastrointestinal tract: Sections show mucosal autolysis. Sections of appendix show a mixed, predominantly histiocytic, infiltrate of the attached soft tissue. The muscularis of the appendix has no significant inflammation.
Spleen: Sections show no significant pathologic abnormality.
Liver: Section shows no significant pathologic abnormality.
Pancreas: Section is unremarkable.
Kidney: Section is unremarkable.

TOXICOLOGY
Toxicologic analysis of bile was negative for ethanol and the blood clot was negative for illicit substances. The blood clot was positive for meperidine (0.46 mg/L), promethazine (0.23 mg/L), and diphenhydramine (0.37 mg/L).
OPINION
This Iraqi male died of peritonitis. Significant findings of the autopsy include a large amount of pus within the abdominal cavity. An anatomic source of the infection was not identified. Although trauma cannot be completely excluded as a potential source for peritonitis this is unlikely given the absence of visible injury to the organs of the abdominal cavity. Toxicology was positive for medications used for pain (meperidine), nausea (promethazine), and an antihistamine (diphenhydramine).

The manner of death is natural.

MAJ, MC, USA
Deputy Medical Examiner
CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS

REPORT OF TOXICOLOGICAL EXAMINATION

Condition of Specimens: GOOD
Date of Incident: 5/19/2004
Date Received: 6/17/2004

VOLATILES: The BILE was examined for the presence of ethanol at a cutoff of 20 mg/dL. No ethanol was detected.

DRUGS: The BLOOD CLOT was screened for amphetamines, antidepressants, antihistamines, barbiturates, benzodiazepines, cannabinoids, cocaine, dextromethorphan, lidocaine, narcotic analgesics, opiates, phencyclidine, phenothiazines, sympathomimetic amines and venlafaxine by gas chromatography, color test or immunoassay. The following drugs were detected:

Positive Narcotic Analgesics: Meperidine was detected in the blood clot by gas chromatography and confirmed by gas chromatography/mass spectrometry. The blood clot contained 0.46 mg/L of meperidine as quantitated by gas chromatography.

Positive Phenothiazine: Promethazine was detected in the blood clot by gas chromatography and confirmed by gas chromatography/mass spectrometry. The blood clot contained 0.23 mg/L of promethazine as quantitated by gas chromatography.

Positive Antihistamine: Diphenhydramine was detected in the blood clot by gas chromatography and confirmed by gas chromatography/mass spectrometry. The blood clot contained 0.37 mg/L of diphenhydramine as quantitated by gas chromatography.
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LAW ENFORCEMENT SENSITIVE

MEDCOM - 585
PRELIMINARY AUTOPSY REPORT

Name: 
SSAN: N/A
Date of Birth: BTB 1943
Date of Death: 8 FEB 2004
Date of Autopsy: 28 FEB 2004
Date of Report: 28 FEB 2004

Autopsy No.: ME 04-100
AFIP No.: Pending
Rank: Iraqi Civilian
Place of Death: Tikrit, Iraq
Place of Autopsy: BIAP Mortuary
Baghdad Airport, Iraq

Circumstances of Death: This believed to be 61 year old male Iraqi civilian was a detainee of the U.S. Armed Forces at the Detention Central Collection Facility, Tikrit, Iraq when he was discovered deceased in his bed when he failed to report to the morning head count procedure. The decedent reported a medical history of diabetes and renal disease at the time of his capture.

Authorization for Autopsy: Office of the Armed Forces Medical Examiner, IAW 10 USC 1471.

Identification: Identification is established by visual examination by CID agents.

CAUSE OF DEATH: Atherosclerotic Cardiovascular Disease

MANNER OF DEATH: Natural

PRELIMINARY AUTOPSY DIAGNOSES:

1. Atherosclerotic Cardiovascular Disease
   1. Moderate calcified atherosclerosis of the right coronary artery (50% stenosis), the left circumflex (50% stenosis) and left anterior descending branches of the left coronary artery (50-75% stenosis).
   3. Bilateral renal atrophy with intraparenchymal arteriole atherosclerosis and marked arterionephrosclerosis and cortical cysts.
   4. Cranial artery atherosclerosis of the vertebral, basilar, posterior communicating and middle cerebral arteries.

These findings are preliminary, and subject to modification pending further investigation and laboratory testing.
II. Mild to moderate decomposition.

III. Toxicology pending.

D.O.

MAJ MC USA
Deputy Medical Examiner
Name: PRK-2
SSAN: N/A
Date of Birth: BTB 1943
Date of Death: 8 FEB 2004
Date of Autopsy: 28 FEB 2004
Date of Report: 29 JUN 2004

Autopsy No.: ME 04-100
AFIP No.: 2917546
Rank: Iraqi Civilian
Place of Death: Tikrit, Iraq
Place of Autopsy: BLAP Mortuary Baghdad Airport, Iraq

Circumstances of Death: This believed to be 61 year old male Iraqi civilian was a detainee of the U.S. Armed Forces at the Detention Central Collection Facility, Tikrit, Iraq when he was discovered deceased in his bed when he failed to report to the morning head count procedure. The decedent reported a medical history of diabetes and renal disease at the time of his capture.

Authorization for Autopsy: Office of the Armed Forces Medical Examiner, IAW 10 USC 1471.

Identification: Identification is established by visual examination by CID agents. DNA testing was performed and is on file for comparison should exemplars become available.

CAUSE OF DEATH: Atherosclerotic Cardiovascular Disease

MANNER OF DEATH: Natural
FINAL AUTOPSY DIAGNOSES:

I. Atherosclerotic Cardiovascular Disease
   1. Moderate calcified atherosclerosis of the right coronary artery (50% stenosis), the left circumflex (50% stenosis) and left anterior descending branches of the left coronary artery (50-75% stenosis).
   3. Bilateral renal atrophy with intraparenchymal arteriole atherosclerosis and marked arteriopathy and cortical cysts.
   4. Cranial artery atherosclerosis of the vertebral, basilar, posterior communicating and middle cerebral arteries.

II. Mild to moderate decomposition.

III. Toxicology is positive for ethanol, acetone, 1-propanol and acetaldehyde (urine only) in the blood and urine. Drugs of abuse were not detected.
EXTERNAL EXAMINATION

The body is that of a cachetic male Iraqi national. The body weighs approximately 130 pounds, is 69 ½ inches in length and appears the reported age of 61 years. The body temperature is ambient. Rigor is present to an equal degree in all extremities. Lividity is difficult to assess because of dark skin pigmentation but is present and fixed on the posterior surface of the body, except in areas exposed to pressure. There is mild to moderate decomposition of the body with areas of skin slippage on the posterior scalp, the right wrist and anterior right lower leg and marbling of the skin of the back, buttocks, posterior surface of the arms and legs, palms of the hands and the abdomen.

The scalp hair is black and gray and the decedent has frontal baldness. Facial hair consists of a full gray and black beard and mustache. The irides are brown. The corneas are slightly cloudy. The conjunctivae are free of injuries and hemorrhages. The sclerae are free of hemorrhages. The external auditory canals, external nares and oral cavity are free of foreign material and abnormal secretions. The nasal septum and skeleton is palpably intact. The lips are without evident injury. The teeth are natural and poor condition with multiple unrepaird caries. Examination of the neck reveals no evidence of injury. The hyoid bone and thyroid cartilage are intact.

The chest is free of injuries and deformities. A 3.3 x 1.2 cm oval scar is on the anterior left costal margin and a 3.2 x 2.3 cm oval scar is in the left upper quadrant of the abdomen. No injury of the ribs or sternum is evident externally. The abdomen is flat and free of palpable masses. The external genitalia are those of a normal circumcised adult male with bilateral descended testes. The testes are free of palpable masses. The buttocks and anus are unremarkable.

The extremities show injuries that will be described below. The fingernails are intact. An 11.5 x 4.5 cm area and an are of 7.0 x 3.0 cm of non-descript black ink writing is on the medial surface and lateral surface of the left knee, respectively. There is a paper identification tag affixed to the right wrist and right second toe.

The back has a 2.5 x 2.0 cm scar immediately right of midline in the thoracic region and a 2.5 x 2.0 cm oval scar immediately below the scar just described.

CLOTHING AND PERSONAL EFFECTS

The following clothing items and personal effects are present on the body at the time of autopsy:
A blue shirt, a green sweater, a white linen undergarment, and two white socks.

MEDICAL INTERVENTION

There is no medical intervention.

RADIOGRAPHYS

Full body postmortem radiographs are obtained and demonstrates the following:
1. No long bone fractures
2. No foreign bodies
EVIDENCE OF INJURY

The ordering of the following injuries is for descriptive purposes only, and is not intended to imply order of infliction or relative severity. All wound pathways are given relative to standard anatomic position.

A 2.4 x 1.4 cm crusted abrasion and a 1.5 x 1.4 cm crusted abrasion are on the forehead. A 1.0 x 0.5 cm abrasion is on the nose.

On the volar surface of the right forearm are multiple oval purple contusions that average 1.0 cm in diameter. A 1.5 x 0.4 cm crusted abrasion and a 1.2 x 1.2 cm crusted abrasion are on the medial and the lateral surface of the left forearm, respectively.

On the posterior surface of the left hand are a 2.5 x 1.5 cm purple contusion and a 1.5 x 1.0 cm purple contusion. There is a 1.8 x 1.7 cm crusted abrasion with surrounding contusion on the lateral surface of the left knee and a 1.5 x 1.0 cm crusted abrasion immediately below the left patella.

Over the spinous processes of the lumbar spine is a 1.8 x 1.1 cm contusion.

INTERNAL EXAMINATION

HEAD:
The galea and subgaleal soft tissues of the scalp are free of injury. The calvarium is intact, as is the dura mater beneath it. There is congestion and pooling of blood over the posterior aspect of the brain from livor mortis. Clear cerebrospinal fluid surrounds the 1325 gm brain, which has unremarkable gyri and sulci. The brain parenchyma is soft and pink/red from refrigeration. Coronal sections demonstrate sharp demarcation between white and grey matter, without hemorrhage or contusive injury. The ventricles are of normal size. The basal ganglia, brainstem, cerebellum, and arterial systems are free of injury or other abnormalities. There are no skull fractures. The atlanto-occipital joint is stable. There is atherosclerosis of the vertebral, basilar and middle cerebral arteries.

NECK:
The anterior strap muscles of the neck are homogeneous and red-brown, without hemorrhage. The thyroid cartilage and hyoid bone are intact. The larynx is lined by intact gray/white mucosa. The thyroid gland is symmetric and red-brown, without cystic or nodular change. The tongue is free of bite marks, hemorrhage, or other injuries.

BODY CAVITIES:
The ribs, sternum, and vertebral bodies are visibly and palpably intact. 50 ml of serosanguineous fluid are in each hemithorax. No excess fluid is in the pericardial or peritoneal cavities. The organs occupy their usual anatomic positions.

RESPIRATORY SYSTEM:
The right and left lungs weigh 750 and 725 gm, respectively. The external surfaces are smooth and deep red-purple. The pulmonary parenchyma is diffusely congested and edematous. No mass lesions or areas of consolidation are present.
CARDIOVASCULAR SYSTEM:
The 390 gm heart is contained in an intact pericardial sac. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution, with a right-dominant pattern. Cross sections of the vessels show moderate calcified atherosclerosis of the right coronary artery (50% stenosis), the left circumflex (50% stenosis) and left anterior descending branch of the left coronary artery (50-75% stenosis). The myocardium is homogenous, red-brown, and firm. The valve leaflets are thin and mobile. The walls of the left and right ventricles are 1.3 and 0.4 cm thick, respectively. The endocardium is smooth and glistening. The aorta gives rise to three intact and patent arch vessels. The renal arteries have moderate stenosis of their origins at the aorta from aortic atherosclerosis. The mesenteric vessels are unremarkable.

LIVER & BILIARY SYSTEM:
The 1125 gm liver has an intact, smooth capsule and a sharp anterior border. The parenchyma is tan-brown and congested, with the usual lobular architecture. No mass lesions or other abnormalities are seen. The gallbladder contains about 4 ml of green-black bile and no stones. The gallbladder mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLRENE:
The 80 gm spleen has a smooth, intact, red-purple capsule. The parenchyma is maroon and congested, with distinct Malpighian corpuscles.

PANCREAS:
The pancreas is soft and yellow-tan, with the usual lobular architecture. No mass lesions or other abnormalities are seen.

ADRENALS:
The right and left adrenal glands are symmetric, with bright yellow cortices and grey medullae. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 55 and 60 gm, respectively. The external surfaces are coarsely granular with multiple renal cortical cysts, ranging from 0.3 - 1.0 cm in diameter. The cut surfaces are dark red-tan and congested, with uniformly thick cortices and sharp corticomedullary junctions. There is marked intra-renal atherosclerosis of the arterioles of the renal parenchyma. The pelves are unremarkable and the ureters are normal in course and caliber. White bladder mucosa overlies an intact bladder wall. The bladder contains approximately 100 ml of cloudy yellow urine. The prostate is normal in size, with lobular, yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities.

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, grey-white mucosa. The stomach contains approximately 500 ml of brown fluid and rare food particles. The gastric wall is intact.
The greater curve of the stomach is densely adherent to the duodenum. The duodenum, loops of small bowel, and colon are otherwise unremarkable. The appendix is present.

**ADDITIONAL PROCEDURES**

- Documentary photographs are taken by OAFME photographer.
- Specimens retained for toxicologic testing and/or DNA identification are: blood, urine, spleen, liver, lung, kidney, brain, bile, gastric contents, and psoas muscle.
- The dissected organs are forwarded with body.
- Personal effects are released to the appropriate mortuary operations representatives.

**MICROSCOPIC EXAMINATION**

Selected portions of organs are retained in formalin, without preparation of histologic slides.
OPINION

This believed to be 61 year old Iraqi male died from atherosclerotic cardiovascular disease. The mechanism of death is often cardiac arrhythmia secondary to the diseased myocardium and conduction system. The presence of systemic atherosclerosis and the marked renal changes, including renal atrophy, is suggestive of the decedent having diabetes melitus. The manner of death is natural.

D.O.

MAJ MC USA
Deputy Medical Examiner
CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS

REPORT OF TOXICOLOGICAL EXAMINATION

Condition of Specimens: GOOD
Date of Incident: Date Received: 3/3/2004

CYANIDE: There was no cyanide detected in the chest blood. The limit of quantitation for cyanide is 0.25 mg/L. Normal blood cyanide concentrations are less than 0.15 mg/L. Lethal concentrations of cyanide are greater than 3 mg/L.

VOLATILES: The BLOOD AND URINE were examined for the presence of ethanol (cutoff of 20 mg/dL), acetaldehyde, acetone, 2-propanol, 1-propanol, 1-butanol, 2-butanol, isobutanol and 1-butanol by headspace gas chromatography. The following volatiles were detected:

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<th>BLOOD</th>
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<td>Acetaldehyde</td>
<td>69</td>
<td>Trace</td>
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<tr>
<td>Ethanol</td>
<td>Trace</td>
<td>31</td>
</tr>
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<td>Acetone</td>
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<tr>
<td>1-Propanol</td>
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Trace = value greater than or equal to 1 mg/dL, but less than 5 mg/dL

DRUGS: The BLOOD was screened for amphetamine, antidepressants, antihistamines, barbiturates, benzodiazepines, cannabinoids, cocaine, dextromethorphan, lidocaine, narcotic analgesics, opiates, phenycyclidine, phenothiazines, sympathomimetic amines and verapamil by gas chromatography, color test or immunoassay. The following drugs were detected:

None were found.

Certifying Scientist: PhD
Office of the Armed Forces Medical Examiner

Director, Forensic PhD, DABFT
Office of the Armed Forces Medical Examiner
CERTIFICATE OF DEATH (OVERSEAS)

NAME OF DECEASED (Last, First, Middle) [Nom du décédé (Nom et prénom)]

GRADE: [Grade]

BRANCH OF SERVICE: Army

ORGANIZATION: Detainee in Iraq

NATIONALITY (e.g., United States) [Pays]: Iraq

DATE OF BIRTH: [Date de naissance]

SEX: [Sexe]

DATE OF DEATH: 28 Feb 2004

RELIGION: [Religion]

RACE: [Race]

MARITAL STATUS: [Etat civil]

NAME OF NEXT OF KIN: [Nom du proche parent]

STREET ADDRESS: [Adresse]

CITY OR TOWN AND STATE: [Ville et code postal]

MEDICAL STATEMENT: [Déclaration médicale]

CAUSE OF DEATH: Atherosclerotic Cardiovascular Disease

DATE OF DEATH: [Date]

AVIATION ACCIDENT: [Oui ou Non]

DATE OF DEATH: [Date]

DEPARTMENT OF DEFENSE: [DOD]

DD FORM 2064

REPLACES DA FORM 2064, 1 JAN 72 AND DA FORM 2064-RPAS, 26 SEP 78, WHICH ARE OBSOLETE.

EXHIBIT 9

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Law Enforcement Sensitive

MEDCOM - 606
PRISONER IN-PROCESSING MEDICAL SCREEN

DATE 12/15/14

COMPOUND B6-2

HISTORY BY TRANSLATOR NO

NAME OF TRANSLATOR

DO YOU HAVE ANY NEW MEDICAL PROBLEMS OR INJURIES NOW?


DO YOU HAVE A COUGH FOR MORE THAN 2 WEEKS?

DO YOU HAVE BEEN COUGHING UP BLOOD?

DO YOU HAVE BEEN LOSING A LOT OF WEIGHT?

MEDICAL PROBLEMS: DIABETES, HYPERTENSION, HEART DISEASE

HTN, IREG HR

MEDICATIONS

CAPATIN

ARE YOU ABLE TO WALK (UNASSISTED)?

ARE YOU ABLE TO FEED YOURSELF?

MEDICATIONS

NKA

HEIGHT 5'8

WEIGHT 245

PRESSURE 130/80

RESPIRATORY RATE 16

SIGNATURE

\[\text{Handwritten Signature}\]

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MEDCOM - 607

\[\text{Handwritten Note:} \text{Refer to 8F 600}\]

\[\text{Handwritten Note:} \text{Date 16 Jan 04}\]

\[\text{Handwritten Note:} \text{B6-2}\]

\[\text{Handwritten Note:} \text{Exhibit 3}\]
16 June 62  9) 4th 11% & defense injured by mine to extinction

0 92

It has multiple complaints

BF 110 60

In 1 - it reports he was punched at the cresest near while

& 19

being transported in helicopter. He reports of was done by another man.

72 hour weld with Fortshead and Campbell. He was

shaken on 11/22 and promoted when saw by Dr. White.

His 6th was no report.

May 62

(3) called of 480 for stated capt - no.

PH - BCI 440 - Leder 440 - movement. CS 15 - Fif 12 - FT 12 - MTO 11 - 32 motion

PH - Medical history- Gastroscopy 5/26 - Z+56

ST & Trachea - Mean - AS 4 - Note - Supply

Hem - Lows - 1348 - Pressure - HRR

Allergies - None - 480 - Orange with large congenital ear deformation.

Contac - AS 8 & 12 1135

UGR means - well

Contraindicated - Not for electricity or scale

A) 14 MSJ. PK. Toe by cadet haw Pasco

2 1602

P) Refer to EPT

2. Continue CS 1112 1234 PT period 13 emotion. LIT 5 6 5

3. Case and Plan discharged on gurney 24 thru today

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPARTMENT/SERVICE

RECORDS MAINTAINED AT

SPONSOR'S NAME

SSN

RELATIONSHIP TO SPONSOR

READER'S NAME

REVIEWED

DATE

USAF V2.0

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LAW ENFORCEMENT SENSITIVE

MEDCOM - 608
MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

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

31 May 64

195 - 4 lb

3 June 64

718

31 July 64

C. - 10.7

1 Aug 64

C. - 991

19 Aug 64

Physical exam. Otherwise well. No change from last visit.

15 Aug 64

Heart rate: 70. No change from last visit.

18 Aug 64

Blood pressure: 120/60. No change from last visit.

19 Aug 64

Rectal: No sphincter tone. No anal reflexes.

Allergies: None

CT-Movies are done. No change.

21 Aug 64

22 Aug 64

Interpretation: 1) FOP

2) Otherwise at D5

1) FISH or serial b-pump or check

2) Closed and plan discussed with at D5.

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPARTMENT/SERVICE

SPONSOR'S NAME

SSN/Military No.

RELATIONSHIP TO SPONSOR

PAYER NO.

REGISTRAR

CHRONOLOGICAL RECORD OF MEDICAL CARE

Patient Identification: (For type or written entries, given, name - last, first, middle, ID No or SSN, Sex, Date of Birth, Rank/Grade)

NAME: [Blank]

SSN: [Blank]

DOB: [Blank]

UNIT: [Blank]

MEDCOM - 609

FOR OFFICIAL USE ONLY
REPORT OF DETAINEE MEDICAL SCREENING:

History of Past Medical Conditions: (circle) High Blood Pressure, Diabetes, Heart Failure, Kidney Failure, Seizures, Stroke, Bleeding

Medication Allergies: (NO) (YES)  

Current Medications: (Name/Dose/Frequency/Last Taken) (NONE)

Recent Injuries: (NO) (YES)  

Exam Findings: BP: 120/80  P: 78  R: 12

Utilize Diagram and Space Below to Indicate Examination Findings.

Additional space required, continue on reverse

(FAIL) (UNIT) For Confinement
(Does) (Does Not) Require Further Eval

Name/Rank/Unit of Screener

OSIPLA OR MEDICAL FACILITY

STATUS

DEPART/SERVICE

SPONSOR'S NAME

SSN/ID NO

RELATIONSHIP TO SPONSOR

PRESIDENT IDENTIFICATION (For typed or written entries: give Name - first, last, middle, if no or SSN; Sex; Date of Birth; Rank/Grade)

Detainee Information:

Name

Control Number

Date/Time of Detention

CHRONOLOGICAL RECORD OF MEDICAL CARE

MEDCOM - 610

STANDARD FORM 500 (REV. 5-97)

Prescribed by GSA/ICMR

FIRM (41 CFR) 201-9 202-1

USAPA V.00
### MEDICAL RECORD

**DATE:** 2 May 2002

**NOTES:**

- Syncope
  - History of infarction x2, hypothyroidism, and hypoglycemia
  - Presentation: Postural syncope

**NIH:** Lightheaded (1988), Adenoma Cushing (1979)

- Hypothyroidism
- Hypoglycemia

**Past:** Headache, nausea, 1979

**Med:**

- 1. Adenoma Cushing
  - Adenoma Cushing
  - Diabetes Melitus

**SMOKING habits:**

- 1/2 to 100% Nicotine

**Med:**

- 1. Zestril 2.5 mg bid

**Med:**

- Ceftriaxone 2 g iv

**PRELIMINARY**

**SMOKING history:**

- 1/2 to 100% Nicotine

**Med:**

- K2O 9/10/21

**MEDICATIONS:**

- Paroxetine 20 mg bid
- Ceftriaxone 2 g iv

**Nursing:**

- T, P, R as needed

**ADMISSION:**

- 39 yo P/D

**RELATIONSHIP TO SPONSOR:**

- Last

**SPONSOR'S NAME:**

- First

**SPONSOR'S ID NUMBER:**

- Middle

**DEPARTMENT/RECORD MAINTAINED AT:**

- LAST

**HOSPITAL OR MEDICAL FACILITY:**

- FIRST

**REGISTER NO.:**

- M

**WARD NO.:**

- DP, PT 3/4

**PROGRESS NOTES**

Medical Record

STANDARD FORM 509 (REV. 5/1999)

Prescribed by GSAICMR FP&M 11CFR 101-11.2039/010

FOR OFFICIAL USE ONLY

EXHIBIT 3

MEDCOM - 6011
CHRONOLOGICAL RECORD OF MEDICAL CARE

FOR OFFICIAL USE ONLY
### Medication Administration Record

**Name:** [Redacted]

**Unit:** HVD

**Month:** May, 04

| Date       | 1   | 2   | 3   | 4   | 5   | 6   | 7   | 8   | 9   | 10  | 11  | 12  | 13  | 14  | 15  | 16  | 17  | 18  | 19  | 20  | 21  | 22  | 23  | 24  | 25  | 26  | 27  | 28  | 29  | 30  | 31  |
|------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| 05-03 06A  | X   | X   |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| 05-03 06B  | X   | X   |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| 05-03 06C  | X   | X   |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |
| 05-03 06D  | X   | X   |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |     |

**Note:**

- **ASW:** [Redacted]
- **3EBmy:** [Redacted]
- **25m:** [Redacted]
- **Z 0900:** [Redacted]
- **10m:** [Redacted]
<table>
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<tr>
<th>DETAINEE #:</th>
<th>0010-4</th>
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<tbody>
<tr>
<td>AGE:</td>
<td>55</td>
</tr>
<tr>
<td>MEDICATIONS:</td>
<td></td>
</tr>
<tr>
<td>Atenolol 25 qd</td>
<td></td>
</tr>
<tr>
<td>Aspirin qd</td>
<td></td>
</tr>
<tr>
<td>Zocor 40 mg qd</td>
<td></td>
</tr>
<tr>
<td>Colace 100 mg BID prn</td>
<td></td>
</tr>
<tr>
<td>Benadryl 25 mg qhs prn</td>
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</tr>
<tr>
<td>SL NTG 0.4 mg prn x3 (chest pain)</td>
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<tr>
<td>PROBLEM LIST:</td>
<td></td>
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<tr>
<td>DIAGNOSTIC TESTS:</td>
<td></td>
</tr>
<tr>
<td>GUIAC STOOL- Sept. 2003, negative</td>
<td></td>
</tr>
<tr>
<td>PEAK FLOW-</td>
<td></td>
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<tr>
<td>EKG- June 2003</td>
<td></td>
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<tr>
<td>PSA-</td>
<td></td>
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<tr>
<td>OTHER-</td>
<td></td>
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<tr>
<td>LABS:</td>
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<tr>
<td>14/1</td>
<td>10/1</td>
</tr>
<tr>
<td>3.2</td>
<td>1.5</td>
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<td>2.8</td>
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<td>7/19</td>
<td>7/15</td>
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<tr>
<td>7/19</td>
<td>7/15</td>
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<tr>
<td>PMHX:</td>
<td></td>
</tr>
<tr>
<td>MI x2</td>
<td></td>
</tr>
<tr>
<td>hypercholesterolemia</td>
<td></td>
</tr>
<tr>
<td>hypertension</td>
<td></td>
</tr>
<tr>
<td>Hemmoriod surgery (1995)</td>
<td></td>
</tr>
<tr>
<td>smoker</td>
<td></td>
</tr>
<tr>
<td>hemmoriods</td>
<td></td>
</tr>
<tr>
<td>HOSPITALIZATION SUMMARIES:</td>
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</table>

FOR OFFICIAL USE ONLY

EXHIBIT 3
<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/4/19</td>
<td>Code Not Initiated; Presenting chief complaint was in cardiac arrest since 5 AM.</td>
</tr>
<tr>
<td>3/6/19</td>
<td>Immediate evaluation in the field delayed by EMS to show that pt presented PM to jail medical C P and quickly deteriorated.</td>
</tr>
</tbody>
</table>

Upon presentation to GYNEDS full ACLS protocol was followed. CEMNA placed a 2.5 ETT at 2.0cm, placement was confirmed C G3s. Telemedical confirmed asystole. Epinephrine in the usual dosage was given x 2 rounds while performing concurrent CPR. Despite all these efforts, pt remained asystolic. No signs of life, code was stopped at 8:32. Pt's pupils were fixed, dilated. He had no response to any stimuli. He had no respiratory effort and no pulse. Time of death is 8:32.

**HOSPITAL OR MEDICAL FACILITY**

**STATUS**

**DEPARTMENT/SERVICE**

**RECORDS MAINTAINED AT**

**Sponsor's Name**

**SSN/NO**

**RELATIONSHIP TO SPONSOR**

**REGISTRATION No.**

**WARDED No.**

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

**STANDARD FORM 600 (REV. 5/81)**

**PREPARED BY SCAV/CHRT 0:00 AM 2/05/1988**

**MEDCOM - 617**
**CERTIFICATE OF DEATH OVERSEAS**

**Acé de décès (D'Outre-Mer)**

<table>
<thead>
<tr>
<th>NAME OF DECEASED</th>
<th>Date of Birth</th>
<th>Grade</th>
<th>Branch of Service</th>
<th>Social Security Number</th>
<th>Overseas Service Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Organization**

<table>
<thead>
<tr>
<th>National Serviced</th>
<th>Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRAQ I</td>
<td></td>
</tr>
</tbody>
</table>

**Race and Nationality**

- Caucasian
- Negro
- Other (Specify)

**Sex and Marital Status**

- Male
- Single
- Divorced
- Widowed

**Religion**

- Protestant
- Catholic
- Jewish

**Name of Next of Kin**

- [Redacted]

**Relationship to Deceased**

- [Redacted]

**Street Address**

- [Redacted]

**City or Town and State (Include ZIP Code)**

- [Redacted]

**Medical Statement**

**Cause of Death**

- Acute Myocardial Infarction

**Disease or Condition Directly Leading to Death**

- Coronary artery disease

**Arrhaphy**

- Cardiac pulmonary arrest

**Other Significant Conditions**

- [Redacted]

**Mode of Death**

- Natural

**Major Findings of Autopsy**

- [Redacted]

**Circumstances Surrounding Death Due to External Causes**

- [Redacted]

**Place of Death**

- [Redacted]

**I have viewed the remains of the deceased and death occurred at the time indicated and from the causes as stated above**

- [Redacted]

**DD Form 2064 USE ONLY**

- [Redacted]
Name: [Redacted]
SSAN: [Redacted]
Date of Birth: 6 DEC 1948
Date of Incident: 8 MAR 2004
Date of Autopsy: 10 MAR 2004
Date of Report: 11 MAR 2004
Autopsy No.: ME04-110
AFIP No.: Pending
Rank: EPOW
Place of Death: Baghdad, Iraq
Place of Autopsy: Baghdad
International Airport

Circumstances of Death: This 55-year-old male Enemy Prisoner of War had a history of ischemic heart disease. His past medical history includes hypertension, hypercholesterolemia, and possibly two previous myocardial infarctions. His medications included atenolol, Zocor, and aspirin, as well as sublingual nitroglycerin as needed. On the evening of 7 MAR 2004 he complained of chest pain and shortness of breath. He was brought to the medical clinic for evaluation where he became unresponsive. Resuscitation efforts, including Advanced Cardiac Life Support at a medical treatment facility, were unsuccessful.

Authorization for Autopsy: Armed Forces Medical Examiner, per 10 U.S. Code 1471

Identification: Identification is obtained by paperwork accompanying the body, including a photograph with a matching prisoner number.

CAUSE OF DEATH: Atherosclerotic Cardiovascular Disease

MANNER OF DEATH: Natural

These findings are preliminary, and subject to modification pending further investigation and laboratory testing.
PRELIMINARY AUTOPSY DIAGNOSES:

I. Atherosclerotic Cardiovascular Disease
   A. History of ischemic heart disease
   B. Cardiomegaly, marked (heart weight 620 grams)
   C. Coronary atherosclerosis, focally severe
   D. Diffuse myocardial scarring
   E. Arteriosclerotic nephrosclerosis, mild

II. Marked Pulmonary Edema

III. Remote penetrating ballistic injury of the left buttock
   A. Entrance: Inferior-medial aspect of left buttoc (scar)
   B. Wound Path: Skin, subcutaneous tissue, and muscle of left
      buttoc, muscle of proximal left thigh
   C. Recovered: Metallic foreign body encapsulated in fibrous tissue
      within muscle of proximal left thigh
   D. Wound Direction: Left to right, back to front, and downward

IV. Fractures of the 5th and 6th ribs on the right, associated with hemorrhage
    into chest wall musculature and abrasions/thermal injury of the chest
    (resuscitation efforts)

V. Laceration of the nose and abrasion of the right index finger

VI. Toxicology Pending

MD, FS, DMO
CDR, MC, USN
Chief Deputy Medical Examiner

FOR OFFICIAL USE ONLY

EXHIBIT 15
**MEDICAL RECORD**

<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION</th>
<th>(Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 JUN 04</td>
<td>8) Men, 58, exhibits frequent &amp; multiple complaints</td>
<td></td>
</tr>
<tr>
<td>12/48</td>
<td># 1 - C. Frank pain &amp; dysuria, he denies any history of venereal</td>
<td></td>
</tr>
<tr>
<td>12/48</td>
<td># 2 - He denies any gross hematuria, he gives his History then in 1973</td>
<td></td>
</tr>
<tr>
<td>12/48</td>
<td># 3 - He reports that renal pain &amp; dysuria have been x 4 times, he denies</td>
<td></td>
</tr>
<tr>
<td>12/48</td>
<td># 4 - Any 2nd pain</td>
<td></td>
</tr>
</tbody>
</table>

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

- **Facts:**
  - C. Adams presented, he states he was beaten for eight days.
  - **Situation:**
    - Taped through interpreter:
    - **9 JUN 04:** 8) Men, 58, exhibited frequent & multiple complaints.
    - **12/48:** # 1 - C. Frank pain & dysuria, denies any history of venereal.
    - # 2 - He denies any gross hematuria, gives his history then in 1973.
    - # 3 - He reports that renal pain & dysuria have been x 4 times, denies 2nd pain.

**HOSPITAL OR MEDICAL FACILITY**

<table>
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<tr>
<th>STATUS</th>
<th>DEPARTMENT/SERVICE</th>
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</tr>
</thead>
</table>

**SPONSOR’S NAME**

<table>
<thead>
<tr>
<th>SSN NO.</th>
<th>RELATIONSHIP TO SPONSOR</th>
</tr>
</thead>
</table>

**PATIENT’S IDENTIFICATION**

<table>
<thead>
<tr>
<th>ISN:</th>
<th></th>
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</thead>
</table>

**COMPOUND:**

- GANL #2

---

**FOR OFFICIAL USE ONLY**

<table>
<thead>
<tr>
<th>EXHIBIT</th>
<th>MEDCOM - 621</th>
</tr>
</thead>
</table>
1) Frank Febu. Injured Prince, unknown.
   Alleged abuse & ended after Febu.

2) Failed to close today. cited today 3:41.
   Will refer to counter surgeon for operative evaluation.
   Due to alleged sodomy.

3) Refer to CEO for investigation.

4) Case and file discussed at length with patient through interpreter.

PA  C

F. EXHIBIT 2
5/16/04  Was at Abu Ghraib.

Purposed this past May.

No pain in order of kidney.

Has blood in his urine.

Also pain referred to upper back & bladder.

He was beaten for 3 days.

States he recalls the names:

Interrogator from Egypt.

Two black soldiers.

Stated beating him & shots on back.

Placed in a small room underground.

Placed in handcuffs - very dirty.

To both wrists.

Had his head kept under water.

Did not stop until he passed out.

Then he was placed in water & wires placed on him or something.

Vomited up blood & food under water.
A) He still needs to be X-rayed.
B) He was punched by a bit of stab.
C) He was punched by a bit of stab.
D) He was punched by a bit of stab. The paramedics told him he had to go to a different hospital.
E) He was punched by a bit of stab. The paramedics told him he had to go to a different hospital.
F) He was punched by a bit of stab. The paramedics told him he had to go to a different hospital.
G) He was punched by a bit of stab. The paramedics told him he had to go to a different hospital.
### EPW/CI Medical Report

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name, MI</th>
<th>Internment Serial Num.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>EPW/CI Location</th>
<th>Birth Date</th>
<th>Sex</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-IN CAMP</td>
<td>1986/01/01</td>
<td>M</td>
<td>66</td>
<td>163</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Condition</th>
<th>Education</th>
<th>Religion</th>
<th>Marital Status</th>
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<tbody>
<tr>
<td>G-GOOD</td>
<td>B-ELEMENTARY SCHOOL</td>
<td>33-SUNNI-ISLAM</td>
<td>3-SINGLE</td>
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</table>

<table>
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<tr>
<th>Distinguishing Marks:</th>
<th>Remarks</th>
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<table>
<thead>
<tr>
<th>Hair Color</th>
<th>Eye Color</th>
<th>Race</th>
<th>Blood Type</th>
<th>Dist</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td>X-OTHER</td>
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### Examination Information

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<thead>
<tr>
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<th>Date</th>
<th>Time</th>
<th>Exam Category</th>
<th>Type of Case</th>
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<tbody>
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<td>2004/06/11</td>
<td>1:02:23 AM</td>
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<td>BC-TO BE DEFINED</td>
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</table>

<table>
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<tr>
<th>Diagnosis</th>
<th>Comments</th>
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<table>
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<tr>
<th>Disposition Type</th>
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<th>Disposition Time</th>
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</thead>
<tbody>
<tr>
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<td>2004/06/12</td>
<td>12:00:00 AM</td>
</tr>
</tbody>
</table>

### Immunizations

- 
- 
- 

Medical Officer Performing Exam
BACK PAIN, HX OF KIDNEY STONES, UNABLE TO URINATE X 1D

T- 98.0, BP- 157/84, P- 109

POSS KIDNEY STONE

REHYDRATE, TEST URINE

0102- INITIATED IV (L) ARM 1000CC NS
0111 BP- 164/95, P- 111
0130 1000CC 9% NS IV
0141: T- 97.7
0151
1000CC NS 9% IV
0153
BP 145/60, P-111
0154: 30MG IVP KETRALAC
0207: INITIATED FOLEY CATHETER, URINE OS LIGHT YELLOW
0220
SPG- 1.005, MOD BLOOD (NON-HEMOLYZED)
0222
CIPRO IV 40MG OVER 1 HR
0242
EMPTYED 1400CC CLEAR YELLOW URINE FROM FOLEY BAG
0320
250CC NS IV
0321
FOLEY REMOVED

IV DCD, RT COMP

UTI, CIPRO 500MG BID X 5D, IB 800MG TID X 5D
### EPW/CI Medical Report

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<tbody>
<tr>
<td>IN CAMP</td>
<td>1986/01/01</td>
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<td>BC-TO BE DEFINED</td>
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<table>
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#### Disposition

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<td></td>
<td>2004/06/12</td>
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</tbody>
</table>

### Immunizations

#### Medical Officer Performing Exam

---

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

MEDCOM - 828
KIDNEY PAIN UNRESPONSIVE TO CIPRO

PT ARRIVED 10 JUNE, TREATED W/ CIPRO, HAS NOT COMPLETED TREATMENT DIAGNOSED W/ UTI

UTI

CIPRO IV 400MG IN 200ML 5% DEXTROSE (R) ARM 18G.
**EPW/CI Medical Report**

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<th>Physical Condition</th>
<th>Education</th>
<th>Religion</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>F-FAIR</td>
<td>B-ELEMENTARY SCHOOL</td>
<td>33-SUNNI-ISMAM</td>
<td>S-SINGLE</td>
</tr>
</tbody>
</table>

**Distinguishing Marks:**

**Remarks**

<table>
<thead>
<tr>
<th>Hair Color</th>
<th>Eye Color</th>
<th>Race</th>
<th>Blood Type</th>
<th>Diet</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-OTHER</td>
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</table>

**Examination Information**

<table>
<thead>
<tr>
<th>Examination Number</th>
<th>Date</th>
<th>Time</th>
<th>Exam Category</th>
<th>Type of Case</th>
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</thead>
<tbody>
<tr>
<td>16055104</td>
<td>2004/06/15</td>
<td>2:58:08 PM</td>
<td>A1-TO BE DEFINED</td>
<td>BC-TO BE DEFINED</td>
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</tbody>
</table>

**Diagnosis**

**Comments**

**Disposition**

<table>
<thead>
<tr>
<th>Disposition Type</th>
<th>Disposition Date</th>
<th>Disposition Time</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>2004/06/17</td>
<td>12:00:00 AM</td>
</tr>
</tbody>
</table>

**Immunizations**

**Medical Officer Performing Exam**

FOR OFFICIAL USE ONLY

Law Enforcement Sensitive

MEDCOM - 631

EXHIBIT 9
S: injuries at abu gharib in May 04, injuries to neck, back, chest & clubs, injuries to wrists & handcuffs, injuries to rectum & giggalo

O: lungs NAD, MS - walking bent over, positive tenderness over back and L neck, COR-RSR, Lungs, CDA

A: injuries & hematuria

P: report case
**EPW/CI Medical Report**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name, MI</th>
<th>Internment Serial Num.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>EPW/CI Location</th>
<th>BirthDate</th>
<th>Sex</th>
<th>Height</th>
<th>Weight</th>
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<tbody>
<tr>
<td>C-IN CAMP</td>
<td>1986/01/01</td>
<td>M</td>
<td>66</td>
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<table>
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<tr>
<td>F-FAIR</td>
<td>B-ELEMENTARY SCHOOL</td>
<td>33-SUNNI-ISLAM</td>
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</tr>
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</table>

**Distinguishing Marks:**

**Remarks**

<table>
<thead>
<tr>
<th>Hair Color</th>
<th>Eye Color</th>
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<tbody>
<tr>
<td></td>
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**Examination Information**

<table>
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<tr>
<td>16055103</td>
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**Diagnosis**

Please see attached page

**Disposition**

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<th>Disposition Date</th>
<th>Disposition Time</th>
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**Immunizations**

<p>| | | |</p>
<table>
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<tr>
<th></th>
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</tr>
</thead>
</table>

**Medical Officer Performing Exam**

---

**FOR OFFICIAL USE ONLY**

Law Enforcement Sensitive

MEDCOM - 634
Diagnosis (From Page 1)

S: "kidney pain" x 1 d, able to urinate, says cipro no effect
O: t 97.7, bp 140/68
A: Possible UTI
P: Transport and test
I: 0636: u/a SpG 1.030, blood non-hemolyzed, pH 5.0
E: UTI, Bactrim 960 bid x 7d
<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name, MI</th>
<th>Internment Serial Num.</th>
</tr>
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<table>
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<tr>
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<th>Eye Color</th>
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<th>Blood Type</th>
<th>Diet</th>
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</thead>
<tbody>
<tr>
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<td>X-OTHER</td>
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<th>Disposition Time</th>
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<th>Immunizations</th>
</tr>
</thead>
</table>

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

MEDCOM - 637

EXHIBIT 9
Diagnosis (From Page 1)

S: With back pain, f/u for UTI med allergy to pen. Pt has taken cipro bactrim with no relief.
Back pain still strong vomitted upon arrival to aid station.

O: BP 148/69 P107 spo2 98 T 98.3

A: Kidney pain

P: IV 1000cc NS, phenegran i.v. 25 mg. 1cc NS im lu quad of buttocks 1000cc LR IV d/c 1415
EPW/CI Medical Report

Last Name  
First Name, MI  
Internment Serial Num.

C-IN CAMP

BirthDate  
Sex  
Height  
Weight

Physical Condition  
Education  
Religion  
Marital Status

F-FAIR  
B-ELEMENTARY SCHOOL  
33-SUNNI-ISLAM  
S-SINGLE

Distinguishing Marks:

Remarks

Hair Color  
Eye Color  
Race  
Blood Type  
Diet

X-OTHER

Examination Information

Examination Number  
Date  
Time  
Exam Category  
Type of Case

160551-06  
2004/07/11  
10:50:59 PM  
AI-TO BE DEFINED  
BC-TO BE DEFINED

Diagnosis

Please see attached page

Disposition Type  
Disposition Date  
Disposition Time

Disposition Date  
2004/07/11  
12:00:00 AM

Immunizations

Medical Officer Performing Exam

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EXHIBIT 9

MEDCOM - 640
Diagnosis (From Page 1)

S: UTI f/u, pt c/o LUQ pn radiating to shoulder
O: t-98.78, 169/79, p-96 no RQ pn, urine test- moderate blood
A: possible bladder infection
P: NKDA
currently taking Cirpo 500mg
Levaaquin 500mg QIDx7d
**EPW/CI Medical Report**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name, MI</th>
<th>Internment Serial Num.</th>
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<tr>
<td>C-IN CAMP</td>
<td>1986/01/01</td>
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<tr>
<td>Y-FAIR</td>
<td>B-ELEMENTARY SCHOOL</td>
<td>33-SUNNI-ISLAM</td>
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**Distinguishing Marks:**

**Remarks**

**Hair Color** | **Eye Color** | **Race** | **Blood Type** | **Diet**
---|---|---|---|---
|                  |              | X-OTHER |                 |        |

**Examination Information**

<table>
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<th>Type of Case</th>
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<td>HC-TO BE DEFINED</td>
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</table>

**Diagnosis**

Please see attached page

**Disposition Type** | **Disposition Date** | **Disposition Time**
---|----------------------|---------------------|
|                      | 2004/07/12           | 12:00:00 AM         |

**Immunizations**

**Medical Officer Performing Exam**

---

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

MEDCOM - 643

EXHIBIT 46
S: pt states he had an artificial penis put into his anus up North while incarcerated, he had bleeding following this

O: Anus extérieur hemorrhoid, oval fistula also present by exam.

A: anal fistula

P: refer for further eval.
**EPW Medical Screen Form**

39th Brigade Surgeons Office

<table>
<thead>
<tr>
<th>Date:</th>
<th>15 May 04</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td>10:15</td>
</tr>
</tbody>
</table>

### Personal Information

- **Name:** [redacted]
- **Estimated Height:** [redacted]
- **Weight:** [redacted]
- **Age:** 18

### Observations

- **Interpreted Present:** Yes
- **Understands English:** No
- **Married:** Yes

### Examination

- **General Appearance:** Healthy
- **Past Medical History:** [redacted]
- **Allergies:** [redacted]
- **Medications:** [redacted]
- **VS:**
  - **Pulse:** 80
  - **B/P:** 134/74
  - **Temp:** 97.8°F
- **HEENT:** [redacted]
- **CV:** [redacted]
- **Abdomen:** [redacted]
- **Limb/Spine:** [redacted]
- **Neurological:** [redacted]

### RX

- [redacted]

### Instruction

- [redacted]

### Fluid Intake

- **Yes:** [redacted]

### Signature

- **Signed:** [redacted]
  - **Date:** 15 May 04

---

**FOR OFFICIAL USE ONLY**

**LAW ENFORCEMENT SENSITIVE**

MEDCOM - 646

**EXHIBIT**
Brigade Surgeon
39th Brigade Combat Team
1st Cavalry Division
DETAINEE MEDICAL SCREENING FORM

DATE: 10 May

NAME: [Redacted]
AGE: 18
HEIGHT: [Redacted]
WEIGHT: [Redacted]

ALLERGIES: [Redacted]

MEDICATIONS: [Redacted]

MEDICAL HISTORY: □ ASTHMA, □ DIABETES, □ HEART DISEASE, □ TUBERCULOSIS, □ OTHER INFECTIOUS

DISEASES: • Multiple Kidney Stones, □ OPIUM USE

SMOKER: □ YES □ NO • Kidney Stones 2000

EXAM:

P: 112
BP: 78/40
APPEARANCE: □ HEALTHY, □ MALNOURISHED, □ ILL

HEENT: [Redacted]
CHEST: • CTA - Reports fluid in Deep Infiltration
CV: [Redacted]
ABDOMEN: S/I/T
MS: [Redacted]
SKIN: [Redacted]

DENTAL:

GENERAL ASSESSMENT: [Redacted]

SIGNED: [Redacted]
MEDICAL OFFICER: [Redacted]

SICK CALL: 8 May

DATE COMPLAINT


Exam: [Redacted]

1/2 - [Redacted]

1/2 May - No obvious MS change.

DISCHARGE NOTE: □ NO CHANGE IN HEALTH STATUS

DATE: 7 May

[Redacted]

[Redacted]

SIGN: [Redacted]

MEDICAL OFFICER: [Redacted]

EXHIBIT 17
BHA MEDICAL SCREENING FORM

1-82 FA, 1 BDE, 1 CAV
CAMP CUERVO, BAGHDAD
Last Revised: 11 JUL 04

Name: 6264 D259-80271
Age: 29
Date/Time of Exam: 18 Jul 2004 1902
Type: Initial / Transfer / Release

HISTORY

Current illness: (+) states no illnesses.

PMHx/Hospitalization s/Surgeries/TB: (-)

Allergies: (-)

Medicines currently taken: LORAZEPAM 2 mg q 12 hrs.

ETOH/Tobacco/Drug use: (-) no, (-) drugs

EXAM

T: 98.2 P: 70 R: 16 B/P: 108/68

General: (-) normal x/w x/m x/s x/s x/s x/s

HEENT: (-) normal x/g/l x/b/l x/p x/p x/p x/p

CX: (-) x/l x/l x/l x/l x/l x/l

ABD: (x/x)

EXT: (-)

FRONT

BACK

Is this detainee fit for interrogation / transfer / release? YES / NO

Notes: See logic part

Signature: [Blank]

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MEDCOM - 649

EXHIBIT 2
HISTORY

Current illness: 

PMHx/Hospitalizations/Surgeries/TB: 

Allergies: 

Medicines currently taken: 

EthOH/Tobacco/Drug use: 

EXAM

T: 98.6°F P: 76 R: 16 B/P: 120/80

General:

Heent:

Cx:

Abd:

Ext:

FRONT

BACK

Is this detainee fit for interrogation? YES / NO

Signature: [signature]

Date: 09.02.2007

MEDCOM - 650
EXHIBIT 2
The document contains a handwritten note that appears to be a narrative or description. The handwriting is legible but not entirely clear due to the style and the condition of the paper. The content seems to be a series of sentences or paragraphs, possibly detailing a sequence of events or circumstances. The text is not fragmented into separate sections as it appears to flow continuously from top to bottom. There are no visible headings, bullet points, or other formatting elements to indicate separation in the narrative. The handwriting is consistent throughout, suggesting it was written by one person. The note ends with the word "Home."
11/1/94 (11) 0

\[20\]
<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 JUN 04</td>
<td>BRB was called on to the site due to the fact that the subject had another episode at 1735 hrs. The guard reports that the subject was crying for 5 minutes before the episode occurred. It is not clear if the guards were able to stop the smoke or not. The intercom was used to call other guards to assist. I was informed that the subject set his own fire which did not heat the site.</td>
</tr>
<tr>
<td>11 JUN 04</td>
<td>BRB was called on to the site due to the subject's behavior. The subject was reported to be acting erratically and crying. The guards were unable to calm him down and called for assistance.</td>
</tr>
<tr>
<td>06 JUN 04</td>
<td>The subject was reported to be acting strangely and crying. The guards were unable to calm him down and called for assistance.</td>
</tr>
<tr>
<td>05 JUN 04</td>
<td>The subject was reported to be acting strangely and crying. The guards were unable to calm him down and called for assistance.</td>
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**STANDARD FORM 600 (REV. 5-97) BACK**

For Official Use Only / Law Enforcement Sensitive

MEDCOM - 655

EXHIBIT 3
**CHRONOLOGICAL RECORD OF MEDICAL CARE**

<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION</th>
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<tbody>
<tr>
<td></td>
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- Jan 1, 2023
- Feb 1, 2023
- Mar 1, 2023

**HOSPITAL OR MEDICAL FACILITY**

<table>
<thead>
<tr>
<th>STATUS</th>
<th>DEPART/SERVICE</th>
<th>RECORDS MAINTAINED AT</th>
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**TENSORS NAME**

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<tr>
<th>SNN/MO NO</th>
<th>RELATIONSHIP TO SPONSOR</th>
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**ENT'S IDENTIFICATION**

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<tr>
<th>REGISTRATION</th>
<th>NAME - LAST, FIRST, MIDDLE, ID NTH OR SSN/SEC.</th>
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<tbody>
<tr>
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**CHRONOLOGICAL RECORD OF MEDICAL CARE**

*For Official Use Only / Law Enforcement Sensitive*
<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION</th>
<th>SIGN EACH ENTRY</th>
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<td>[Handwritten Signature]</td>
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<td>11-4-24</td>
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<td>11-12-24</td>
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**Hospital or Medical Facility**

**Status**

**Department/Service**

**Records Maintained At**

**Patient's Identification**

**Sponsor's Name**

**SSN/ID No.**

**Relationship to Sponsor**

**Register No.**

**Ward No.**

**Chronological Record of Medical Care**

**Medical Record**

**STANDARD FORM 600 (REV. 6-97)**

**Prepared by: GSA/CMR**

**FIRM: 141 CTRI 201-2, 202-1**

**USAPA V3.00**

For Official Use Only / Law Enforcement Sensitive
**HOSPITAL REPORT OF DEATH**

**NAME AND LOCATION OF HOSPITAL**

Instructions: Medical Officer in attendance will:

- in one copy only, items 1 through 10 and sign item 11.
- or type entries.

Send form, without delay, to the Registrar or Administrative Officer of the Day, for necessary action and for preparation of required number of copies.

**SECTION A - ATTENDING MEDICAL OFFICER'S REPORT**

**PERSONAL DATA**

- **PATIENT DATA** (Patient's ward plate will be used to imprint identifying data if available)

- Patient's name (Last, first, middle initial) Grade, Social Security Account No., Register Number and Ward Number

- **TIME OF DEATH** (hour, day, month, year)

- **MEDICAL EXAMINER/ CORONER'S CASE**

- **RELINE**

- **CHAPLAIN NOTIFIED**

- **NAME, ADDRESS AND RELATIONSHIP OF RELATIVE OR FRIEND PRESENT AT DEATH**

**SECTION B - ADMINISTRATIVE ACTION**

<table>
<thead>
<tr>
<th>TYPE OF ACTION</th>
<th>HOUR</th>
<th>DAY</th>
<th>MONTH</th>
<th>YEAR</th>
<th>INITIALS OF RESPONSIBLE OFFICER</th>
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<tr>
<td>12. TELEGRAM TO NEXT OF KIN OR OTHER AUTHORIZED PERSON</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. POST PATIENT GENERAL NOTIFIED</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. IMMEDIATE C/O DECEASED NOTIFIED</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. INFORMATION OFFICE NOTIFIED</td>
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<td></td>
</tr>
<tr>
<td>16. POST MORTUARY OFFICER NOTIFIED</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. RED CROSS NOTIFIED</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>18. OTHER (Specify)</td>
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</tr>
</tbody>
</table>

**SECTION C - RECORD OF AUTOPSY**

- **AUTOPSY PERFORMED** (YES or NO)

- **PROVISIONAL PATHOLOGICAL FINDINGS**

- **DATE**

- **TYPE OF AUTOPSY**

- **SIGNATURE OF PHYSICIAN PERFORMING AUTOPSY**

**DATE**

- **TYPE OF REGISTRAR**

- **SIGNATURE OF REGISTRAR**

DA FORM 3894, OCT 72

REPLACES DA FORM B-257, 1 JAN 61, WHICH WILL BE USED.
<table>
<thead>
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<th>DETAINEE PREINTERROGATION EVALUATION</th>
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<tr>
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<td>ALLERGIES:</td>
<td>None</td>
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<td>MEDICATIONS:</td>
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STANDARD FORM 600 BACK (REV. 5/94)
March 04  Claybourn  Sear 50

Accused  8/12  2  days  then

per contra

Ibuprofen  800mg  TID  prn

Dip nacl  for glucose  electrolyte  ml

Ex  3/12
REQUEST

Elderly gentleman went down @ defendant's

REASON FOR REQUEST (Complaints and findings)

Elderly moderate obese male @ unknown medical history collapses in yard, he had no sx; of life @ good. Pt was intubated @ EMT by corpsman.

P/H: Asystole, pupils fixed and dilated. Lyt- good air entry & baggie, no pulse.

① Most likely massive cardiac arrest

② Code

Called Code

(Continue on reverse side)

DATE

23 May 04

REGISTRATION SHEET

Medical Record

STANDARD FORM 525 (REV. 6-92)

Prepared by USAFMCWL, PHWR 13 ESR 201-9-322-1

MEDCOM - 662

Ex 3
**EMERGENCY RESUSCITATION RECORD - PART 1**

Complete this report within 2 hours following the arrest/event. Place the original in the patient's record and provide a copy to the Nursing Supervisor.

1. **DATE:** 22 MAY 1995
2. **LOCATION OF RESUSCITATION EVENT:** Brancard 6

3. **WITNESSED ARREST:**
   - [ ] YES
   - [ ] NO
   - [ ] UNKNOWN
4. **MONITORED AT ONSET:**
   - [ ] YES
   - [ ] NO

4. **INTERVENTIONS**
   - [ ] IV Access
   - [ ] Endotracheal Tube
   - [ ] Mechanical Ventilation
   - [ ] Arterial Line
   - [ ] Central Venous Line
   - [ ] Pulmonary Artery Catheter
   - [ ] Nasogastric Tube
   - [ ] Pacemaker Device (Specify type):
   - [ ] Implantable Defibrillator / Cardioverter
   - [ ] Other (Specify):

5. **IMMEDIATE CAUSE OF ARREST / EVENT**
   - [ ] Lethal Arrhythmias
   - [ ] Hypertension
   - [ ] Respiratory Depression
   - [ ] Metabolic
   - [ ] Myocardial Infarction or Ischemia
   - [ ] Other:

6. **INITIAL RHYTHM**
   - [ ] Ventricular Fibrillation
   - [ ] Palpable Pulsating Rhythm
   - [ ] Ventricular Tachycardia
   - [ ] Brady rhythm
   - [ ] Pulseless Electrical Activity
   - [ ] Asystole

7. **FIRST RESPONSE TIMES**
   - [ ] Collapsed / Arrest Onset:
   - [ ] CPR Started:
   - [ ] IV Access:
   - [ ] Defibrillation:
   - [ ] Airway Management:
   - [ ] First Dose Epinephrine:
   - [ ] Code Team Arrived:
   - [ ] Code Team Left:

8. **RESUSCITATION ATTEMPTED**
   - [ ] YES (Check all that were used)
     - Chest Compresions
     - Defibrillation
     - Airway Management

9. **EVENT TIMES**
   - [ ] Collapsed / Arrest Onset:
   - [ ] CPR Started:
   - [ ] IV Access:
   - [ ] Defibrillation:
   - [ ] Airway Management:
   - [ ] First Dose Epinephrine:
   - [ ] Code Team Arrived:
   - [ ] Code Team Left:

10. **GLASSCOM COMA SCALE**
    - [ ] Score:

---

**EMERGENCY RESUSCITATION RECORD - PART 2**

**DATE OF DEATH:** 22 MAY 1995

**LOCATION OF DEATH:** Brancard 6

**WITNESSED DEATH:**
   - [ ] YES
   - [ ] NO
   - [ ] UNKNOWN

**MONITORED AT DEATH:**
   - [ ] YES
   - [ ] NO

**INTERVENTIONS**
   - [ ] IV Access
   - [ ] Endotracheal Tube
   - [ ] Mechanical Ventilation
   - [ ] Arterial Line
   - [ ] Central Venous Line
   - [ ] Pulmonary Artery Catheter
   - [ ] Nasogastric Tube
   - [ ] Pacemaker Device (Specify type):
   - [ ] Implantable Defibrillator / Cardioverter
   - [ ] Other (Specify):

**IMMEDIATE CAUSE OF DEATH**
   - [ ] Lethal Arrhythmias
   - [ ] Hypertension
   - [ ] Respiratory Depression
   - [ ] Metabolic
   - [ ] Myocardial Infarction or Ischemia
   - [ ] Other:

**INITIAL RHYTHM**
   - [ ] Ventricular Fibrillation
   - [ ] Palpable Pulsating Rhythm
   - [ ] Ventricular Tachycardia
   - [ ] Brady rhythm
   - [ ] Pulseless Electrical Activity
   - [ ] Asystole

**RETURN OF SPONTANEOUS CIRCULATION (ROSC)**
   - [ ] ROSC
   - [ ] DNAR
   - [ ] Considered futile
   - [ ] Death

**RESCUER IDENTIFICATION:**

**AGE:** 60
**GENDER:** MALE
**HEIGHT (in):**
**WEIGHT (lbs):**

**SCORE:** 3

---

**EX 3**

MEDCOM - 663
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MEDCOM FORM 572-R (TEST) (MICRO) AUG 95, Back

22 MAP OF.

MEDCOM - 664
ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

PRELIMINARY AUTOPSY REPORT

Name: [Redacted]
Prisoner: [Redacted]
Date of Birth: BTB 1940
Date of Death: BTB 23 May 2004
Date of Autopsy: 1 June 2004
Date of Report: 1 June 2004

Autopsy No.: ME04-386
AFIP No.: Pending
Rank: CIV
Place of Death: Abu Ghraib Prison
Place of Autopsy: BIAP Morgue

Circumstances of Death: This male died while in US custody in Abu Ghraib prison.

Authorization for Autopsy: Office of the Armed Forces Medical Examiner, LAW 10
USC 1471

Identification: BTB, DNA sample obtained

CAUSE OF DEATH: Atherosclerotic cardiovascular disease

MANNER OF DEATH: Natural

These findings are preliminary, and subject to modification pending further investigation and laboratory testing.
PRELIMINARY AUTOPSY DIAGNOSES:

I. Atherosclerotic cardiovascular disease
   A. Left anterior descending coronary artery with multifocal stenoses ranging from 50-80%
   B. Right coronary artery with multifocal stenoses ranging from 50-85%
   C. Left circumflex coronary artery with focal 50% stenosis
   D. Moderate to severe atherosclerosis of the distal aorta
   E. Thickening of the mitral valve leaflets
   F. Pulmonary congestion (right 800 grams, left 650 grams)
   G. Prominent facial suffusion
   H. Bilateral earlobe creases (Frank's sign)

II. Pleural adhesions

III. Status post appendectomy, remote

IV. Fractures of the anterior ribs (right #5, left 3-7) consistent with cardiopulmonary resuscitation

V. No significant trauma

VI. Toxicology pending

MAJ, MC, USA
Deputy Medical Examiner
ARMED FORCES INSTITUTE OF PATHOLOGY
Office of the Armed Forces Medical Examiner
1413 Research Blvd., Bldg. 102
Rockville, MD 20850
1-800-944-7912

AUTOPSY EXAMINATION REPORT

Name: [Redacted]
Prisoner # [Redacted]
Date of Birth: BTB 1940
Date of Death: BTB 22 May 2004
Date of Autopsy: 1 June 2004
Date of Report: 29 Jun 2004

Autopsy No.: ME04-386
AFIP No.: 2929618
Rank: CIV
Place of Death: Abu Ghraib Prison
Place of Autopsy: BIAP Morgue

Circumstances of Death: This male died while in US custody in Abu Ghraib prison. By report he complained of chest pain to his son and then collapsed.

Authorization for Autopsy: Office of the Armed Forces Medical Examiner, IAW 10 USC 1471

Identification: By CID, DNA sample obtained

CAUSE OF DEATH: Atherosclerotic cardiovascular disease (ASCVD)

MANNER OF DEATH: Natural
FINAL AUTOPSY DIAGNOSES:

I. Atherosclerotic cardiovascular disease
   A. Left anterior descending coronary artery with multifocal stenoses ranging from 50-80%
   B. Right coronary artery with multifocal stenoses ranging from 50-85%
   C. Left circumflex coronary artery with focal 50% stenosis
   D. Moderate to severe atherosclerosis of the distal aorta
   E. Thickening of the mitral valve leaflets
   F. Pulmonary congestion (right 800 grams, left 650 grams)
   G. Prominent facial suffusion
   H. Bilateral earlobe creases (Frank’s sign)

II. Pleural adhesions
III. Status post appendectomy, remote
IV. Fractures of the anterior ribs (right #5, left #3-7) consistent with cardiopulmonary resuscitation
V. No significant trauma
VI. Toxicology negative
EXTERNAL EXAMINATION
The body is that of a thin male appearing greater than 50 years of age and measuring 69 inches in length and weighing approximately 160 pounds. Lividity is posterior, purple, and fixed. Rigor is passing.

The scalp is covered with gray hair in a normal distribution. There is a gray mustache and beard. Corneal clouding obscures the irides and pupils. The external auditory canals are unremarkable. The ears are significant for bilateral creases of the caroloss (Frank’s sign). There is prominent facial suffusion. The nares are patent and the lips are atraumatic. The nose and maxillae are palpably stable. The teeth appear natural with partial upper plates.

The neck is straight, and the trachea is midline and mobile. The chest is symmetric. The abdomen is flat. The genitalia are those of a normal adult male. The testes are descended and free of masses. Pubic hair is present in a normal distribution. The buttocks and anus are unremarkable.

The upper and lower extremities are symmetric and without clubbing or edema.

Identifying marks and scars include a 3 1/2 inch oblique scar on the right lower quadrant of the abdomen. On the posterior right arm and forearm is a 6 x 3 1/2 inch area of depigmentation of the skin and scar. On the midline of the lower back is a 1/4 inch scar.

There is early decomposition consisting of skin slippage and vascular marbling.

CLOTHING AND PERSONAL EFFECTS
The following clothing items and personal effects are present on the body at the time of autopsy:
- Brown shirt
- Gray underpants
- Gray t-shirt
- White shirt

MEDICAL INTERVENTION
- Endotracheal tube in the oropharynx that enters the trachea
- Intravenous catheter (IV) in the back of the left hand
- Electrocardiograph (EKG) pads on the chest

RADIOGRAPHS
A complete set of postmortem radiographs is obtained and demonstrates the following:
No radiopaque projectiles or foreign matter

EVIDENCE OF INJURY
There are fractures of the right 5th and left 3rd-7th ribs on the anterior aspects.
INTERNAL EXAMINATION

HEAD:
The galeal and subgaleal soft tissues of the scalp are free of injury. The calvarium is intact, as is the dura mater beneath it. Clear cerebrospinal fluid surrounds the 1250 gm brain, which has unremarkable gyri and sulci. Coronal sections demonstrate sharp demarcation between white and grey matter, without hemorrhage or contusive injury. The ventricles are of normal size. The basal ganglia, brainstem, cerebellum, and arterial systems are free of injury or other abnormalities. There are no skull fractures. The atlanto-occipital joint is stable.

NECK:
The anterior strap muscles of the neck are homogenous and red-brown, without hemorrhage. The thyroid cartilage and hyoid are intact. The larynx is lined by intact white mucosa. The thyroid is symmetric and red-brown, without cystic or nodular change. The tongue is free of bite marks, hemorrhage, or other injuries.

The cervical spine is intact and there is no paraspinal muscular hemorrhage.

BODY CAVITIES:
The sternum and vertebral bodies are visibly and palpably intact. No excess fluid is in the pleural, pericardial, or peritoneal cavities. The organs occupy their usual anatomic positions.

There are fractures of the anterior left ribs 3-7 and the right 5th rib on the anterior aspect.

RESPIRATORY SYSTEM:
There are dense fibrous adhesions of both pleural cavities. The right and left lungs weigh 800 and 650 gm, respectively. The external surfaces are deep red-purple. The pulmonary parenchyma is diffusely congested and edematous. No mass lesions or areas of consolidation are present.

CARDIOVASCULAR SYSTEM:
The 400 gm heart is contained in an intact pericardial sac. The epicardial surface is smooth, with minimal fat investment. The coronary arteries are present in a normal distribution, with a right-dominant pattern. Cross sections of the vessels show 50-80% multifocal stenoses of the left anterior descending coronary artery, focal 50% calcific stenosis of the left circumflex coronary artery, and 50-75% multifocal stenoses of the right coronary artery with a focal 85% stenosis. The myocardium is homogenous, red-brown, and firm. The mitral valve is thickened and fibrotic but there are no vegetations. The remaining valve leaflets are thin and mobile. The walls of the left and right ventricles are 1.4 and 0.4 cm thick, respectively. The endocardium is smooth and glistening. The aorta has moderate to severe atherosclerosis and gives rise to three intact and patent arch vessels. The renal and mesenteric vessels are unremarkable.
LIVER & BILIARY SYSTEM:
The 1800 gm liver has an intact, smooth capsule and a sharp anterior border. The parenchyma is tan-brown and congested, with the usual lobular architecture. No mass lesions or other abnormalities are seen. The gallbladder contains a minute amount of green-black bile and no stones. The mucosal surface is green and velvety. The extrahepatic biliary tree is patent.

SPLEEN:
The 200 gm spleen has a smooth, intact, red-purple capsule. The parenchyma is maroon and congested, with distinct Malpighian corpuscles.

PANCREAS:
The pancreas is firm and yellow-tan, with the usual lobular architecture. No mass lesions or other abnormalities are seen.

ADRENALS:
The right and left adrenal glands are symmetric, with bright yellow cortices and grey medullae. No masses or areas of hemorrhage are identified.

GENITOURINARY SYSTEM:
The right and left kidneys weigh 175 and 200 gm, respectively. The external surfaces are intact and smooth. The cut surfaces are red-tan and congested, with uniformly thick cortices and sharp corticomedullary junctions. The pelves are unremarkable and the ureters are normal in course and caliber. White bladder mucosa overlies an intact bladder wall. The bladder contains approximately 10 ml of cloudy urine. The prostate is normal in size, with lobular, yellow-tan parenchyma. The seminal vesicles are unremarkable. The testes are free of mass lesions, contusions, or other abnormalities.

GASTROINTESTINAL TRACT:
The esophagus is intact and lined by smooth, grey-white mucosa. The stomach contains approximately 50 ml of dark green liquid. The gastric wall is intact. The duodenum, loops of small bowel, and colon are unremarkable. The appendix is surgically absent.

ADDITIONAL PROCEDURES
- Documentary photographs are taken by PH383072
- Specimens retained for toxicologic testing and/or DNA identification are: blood, urine, spleen, liver, lung, kidney, adipose, brain, bile, gastric, and psoas
- The dissected organs are forwarded with the body
- Personal effects are released to the appropriate mortuary operations representatives

MICROSCOPIC EXAMINATION
Selected portions of organs are retained in formalin, without preparation of histologic slides.
TOXICOLOGY

Toxicologic analysis of blood and bile was negative for ethanol and drugs of abuse. Cyanide was not detected.

OPINION

This elderly Iraqi male died of atherosclerotic cardiovascular disease (blockage of the arteries that supply blood and oxygen to the heart). The rib fractures noted at autopsy are consistent with cardiopulmonary resuscitation (CPR). There was no significant trauma.

The manner of death is natural.

MAJ, MC, USA
Deputy Medical Examiner
OFFICE OF THE ARMED FORCES MEDICAL EXAMINER
ARMED FORCES INSTITUTE OF PATHOLOGY
WASHINGTON, DC 20306-5000

CONSULTATION REPORT ON CONTRIBUTOR MATERIAL

AFIP DIAGNOSIS

REPORT OF TOXICOLOGICAL EXAMINATION

Condition of Specimens: GOOD
Date of Incident: 5/23/2004 Date Received: 6/17/2004

VOLATILES: The BLOOD AND BILE were examined for the presence of ethanol at a cutoff of 20 mg/dL. No ethanol was detected.

CYANIDE: There was no cyanide detected in the blood. The limit of quantitation for cyanide is 0.25 mg/L. Normal blood cyanide concentrations are less than 0.15 mg/L. Lethal concentrations of cyanide are greater than 3 mg/L.

DRUGS: The BLOOD was screened for amphetamine, antidepressants, antihistamines, barbiturates, benzodiazepines, cannabinoids, cocaine, dextromethorphan, lidocaine, narcotic analgesics, opiates, phenylcyclidine, phenothiazines, sympathomimetic amines and verapamil by gas chromatography, color test or immunoassay. The following drugs were detected:

None were found.

Certifying Scientist, Forensic Toxicology Laboratory
Office of the Armed Forces Medical Examiner

Director, Forensic Toxicology Laboratory
Office of the Armed Forces Medical Examiner
| Medication / Dose / Time | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|-------------------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| **PZA 500 mg**          |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 4 pills each day        |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| **Rifampin 300 mg**    |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 2 P.O. daily           |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| **INH 300 mg**         |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| one each day           |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| **Ethambutol 500 mg**  |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
| 3 pills each day       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |
HAS Tuberculosis
Referred Compensate 0.2 to Medical City
For last 3 days of Medication
OFFICE OF THE ARMED FORCES MEDICAL EXAMINER
BAGHDAD DETACHMENT

PRELIMINARY AUTOPSY REPORT

Name:  [Redacted]
Date of Birth:  01 January 1977
PW Number:  11672
Date of Death:  12 July 2003
Place of Death:  EPW Camp, Baghdad International Airport, Baghdad, Iraq
Date of Autopsy:  13 July 2003
Place of Autopsy:  Baghdad International Airport Compound, Baghdad, Iraq

CLINICAL DIAGNOSES:
1. Hemoptyis
2. Death in Custody

PATHOLOGIC DIAGNOSES:
A. RESPIRATORY SYSTEM:
1. Cavitary Lesion- Right Lung
2. Multiple Caseating Granulomata- Right Lung
3. Blood Within Tracheobronchial Tree
4. Focal Consolidation- Bilateral Lungs
5. Bilateral Pleural Adhesions

B. CARDIOVASCULAR SYSTEM
1. Pericardial Effusion- 30 cc.

C. GENITOURINARY SYSTEM
1. Absent Right Testicle

D. NO EVIDENCE OF SIGNIFICANT TRAUMA

CAUSE OF DEATH: MASSIVE HEMOPTYSIS DUE TO CAVITARY PULMONARY TUBERCULOSIS
MANNER OF DEATH: NATURAL

[Signature and Stamp]
CAPT MC USN
Regional Armed Forces Medical
<table>
<thead>
<tr>
<th>SPECIMEN/AMOUNT</th>
<th>SPECIMEN/AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liver</td>
<td>Right Hand</td>
</tr>
<tr>
<td>Spleen</td>
<td>Brain</td>
</tr>
<tr>
<td>Kidney</td>
<td>Left Hand</td>
</tr>
</tbody>
</table>

**INCIDENT/ACCIDENT DETAILS**: Victim was apprehended on 10 Jul 03 in possession of a pipe bomb. He was subsequently transported to Camp Cropper detention facility. At approximately 0445, 12 Jul 03, victim was observed coughing up blood. Medical personnel attempted to assist but was negative. He died 0525.

**CHAIN-OF-CUSTODY (CO)**

- Released by: [Redacted]
- Received by: [Redacted]
- Date & Time: [Redacted]
- Purpose of Transfer: [Redacted]
CERTIFICATE OF DEATH (OVERSEAS)

NAME OF DECEASED:

DATE OF DEATH:

PLACE OF DEATH:

CITY OR TOWN AND STATE:

COLOUR:

MARITAL STATUS:

RELIGION:

CAUSE OF DEATH:

MODIFIED CONDITION IF ANY, LEADING TO PRIMARY CAUSE:

UNDERLYING CAUSE:

OTHER SIGNIFICANT CONDITIONS:

MODE OF DEATH:

DATE OF DEATH:

PLACE OF DEATH:

CIRCUMSTANCES SURROUNDING DEATH DUE TO EXTERNAL CAUSES:

SIGNATURE:

DATE:

AVIATION ACCIDENT:

REMARKS:

FOR OFFICIAL USE ONLY

MEDCOM - 678
63yo O presenta con
Corto de reaparición y
Tocando mucho con Sonaje
por favor de Cojer
Poca del pecho
(CXR) PA y lateral
No Bronquitis o Tbcularosis

Crecina

Ruego venga a las 20:00h de hoy (13-5-03) para realizar la RX expiración 34
hoy al am... --- hecha en el >
13 May 03

Chief Complaint
1350 hrs
Pt. 88 yrs
Pt. 155 lbs
100% O2

2055

13 May 03

X-ray is done. Return to 1705 hrs.

SSG

[Signature]

17 Jan 38

FOR OFFICIAL USE ONLY

MEDCOM - 680

EXHIBIT 34
14 May

Paciente con tos y expectoración hemoptica
AP: normales a sano, de predominio del L
Rx: Imagenes radiograficas, neumonomia.
Lobulos medios y superiores de pres
Ref: 3 pacientes con pros inflamatorias
cortadas
Se prescriben a paciente que sea liberado o
administrado para vender la especifica

Diagn: Tuberculosis pulmonar

Tratamos con ciprofloxacin.

NAME: [Redacted]
DOB: 17 Jan 20

FOR OFF. USE ONLY
MEDCOM - 681
4 May 03

Chester Park

Fractura por arma de fuego de tubo del hueso
11 de ambas extremidades, tratada con fijación
externa y después con escayola
Rx: Fisioterapia en evaluación

1. Mantener escayola
descayola 3 semanas más
17 MAY 03

Paciente que refiere fue golpeado hace 4 días. Desde entonces presenta dolor a la movilización articulación hombro y muñeca izq. No hematomas, ni signos de contusión en hombro; inflamación.

Rx de hombro y muñeca.

Presenta además una ecocidox en región coracoidea como consecuencia (según refiere) de haber sido arrastrado.

Tto.: - Curita local de la íntima
- Inmovilización de la muñeca
- Buñuel 600 12/12h
CLINIC HISTORY:

Traumatic osteoarthritis of right elbow (4 days ago) in old injury (Gulf war).
When he was 6 years old probably epiphysiolyis or fracture-dislocation.
Nothing to do, only pills analgesics-AINE,s.

DIAGNOSTIC: Traumatic osteoarthritis of right elbow.
CLINIC HISTORY:

Hematoma in posterior region of left elbow with pain in epitroclea and epicondyle. X-rays suggest small fragment (acute or old) of epicondyle, because he was operated in the past of humeral fracture, consolidated actually (with osteosynthesis).

I recomended brachial splient that was refused by the patient waiting for evolution. He wanted pills AINE,s and so it was done.

DIAGNOSTIC: Traumatic hematoma of left elbow.

26, may, 2003

[Signature]

Tool, Commander EMATCEN
**DATE**

**DIMENSION**

**Medical Record**

**Patient's Identification** (For typed or written entries give: Name, Sex, Age, race, grade, rank, unit, hospital or medical facility)

<table>
<thead>
<tr>
<th>0180-04-CID259-00227</th>
<th>9965-04-CID789</th>
</tr>
</thead>
</table>

| MEYER STTEN | HAUSER | 1/10/04 |

**Progress Notes**

- Slight irritation last evening
- No pain, headache, swelling, or blisters
- Reports thermal burn left ear
- Noted 5's + wounds Ant. 2 knee

**Ext.**

- Ant knees noted + erythema + multiple blisters, noted + singe
- Blisters appear 2nd degree, burns + necrotic margins

A/P

- 2nd degree burn + blister

1. Continue Bacitracin typically to affected area.
2. Start Neosporin 4-6x PW for severe pain.
3. Continued daily dressing as will use silveroxide due to

L-6  Meyer 1-2

B-2

(Continue on reverse side)
**Theater Trauma Registry Record**

For use of this form, see DA PAM XXX; the proponent agency is OTSG.

### Individual Information
- **SITE DESIGNATION:** 
- **CASUALTY NAME:** [redacted]
- **CASUALTY SSN:** [redacted]
- **DATE OF BIRTH:** 09/02/44
- **GENDER:** Female
- **UNIT:** [redacted]

### Arrival Information
- **ARRIVAL METHOD:** Walked
- **ARRIVAL DATE:** 03/10/04
- **ARRIVAL TIME:** 1200

### Injuries
- **Injury Type:** Punctured Wound
- **Location:** Other
- **Wound Description:** Brown Eyebrow 20"
- **Injury Description:** Abrasion
- **Wound Status:** Open

### Medical Treatment
- **VENTILATION:** O2 IN
- **MEDICAL CARE provided:** MEDCOM - 637
- **DISPOSITION:** RTD
- **EVACUATED TO:** MEDCOM - 637

### Comments
- [Redacted]

**For Official Use Only**

Law Enforcement Sensitive

**0180-04-CID259-8227**

**0065-04-CID789**
31 year old male, denies for physical.

PMH: "had a hard job" 4 mo. ago

PSH: 0 meds 0 allergies

SH: 0

Vitals: HT 6'0" wt 69 KG, 132/82 P 61 R 16

Height: 6'0" Age: 30

HEENT: Mouth moist, pale, multiple fillings

No evidence of active disease.

CHEST: Com: 0 findings

NICK: Spine, S1, S2, S3, S4

CL: I, CTA, (b) good FE

CV: S1, S2, FM A

MID: S1, S2, NT (b)

EHL: 6/6 - multiple ones of papules over (b) knees

Skin: Several old scars on back no bruising

Neuro: 2k reflexes all 4 limbs good strength

No MCL injury no lateral shift present

NP: (1) healthy young 50% no acute injury or illness

(2) old trauma event by severe 0

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPART/ SERVICE

0(0)-2

SPONSOR'S NAME

SEN/MID 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.)

ISN: 0(0)-4

COMPOUND: 1873 30 yr.

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 500 (REV. 5-97)

Prescribed by GSA/CMR

FIRMR (41 CFR) 2019.202-1

USAPA V2.00
#### Theater Trauma Registry Record

**0180-04-CID259-80227**

**For use of this form, see Ltr. PAM 15-3, the proposed agency is OSG**

**MTF DESIGNATION:**

<table>
<thead>
<tr>
<th>Rtn/Dep</th>
<th>CASUALTY SSN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>15/4</td>
<td></td>
</tr>
</tbody>
</table>

**Arrive DTG:**

<table>
<thead>
<tr>
<th>ARRIVAL METHOD:</th>
<th>Non-MED GND</th>
</tr>
</thead>
<tbody>
<tr>
<td>WALKED</td>
<td></td>
</tr>
<tr>
<td>CARRIED</td>
<td></td>
</tr>
<tr>
<td>Non-MED AIR</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
</tr>
</tbody>
</table>

**Wound DTG:**

<table>
<thead>
<tr>
<th>WOUNDED BY:</th>
<th>UNK</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENEMY</td>
<td></td>
</tr>
<tr>
<td>FRIENLY</td>
<td></td>
</tr>
<tr>
<td>CIVILIAN</td>
<td></td>
</tr>
<tr>
<td>TRAINING</td>
<td></td>
</tr>
<tr>
<td>SELF ACCIDENT</td>
<td></td>
</tr>
<tr>
<td>SELF NON-ACCIDENT</td>
<td></td>
</tr>
<tr>
<td>SPORTS-RECREATION</td>
<td></td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
</tr>
</tbody>
</table>

**PROTECTION:**

- **GLOVE PROTECTION**
- **FACE PROTECTION**
- **HELMET**
- **PLAK VEST**
- **CEMENT PLATE**
- **EYE PROTECTION**

**TRIAGE CATEGORY:**

- **IMMEDIATE**
- **DELAYED**
- **MINIMAL**
- **EXPECTANT**

**GLASSWOMAN COMA SCALE (GCS):**

<table>
<thead>
<tr>
<th>W</th>
<th>V</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>8</td>
<td>12</td>
</tr>
</tbody>
</table>

**NHSA:**

<table>
<thead>
<tr>
<th>TIME</th>
<th>2132</th>
<th>220</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulse</td>
<td>140</td>
<td>120</td>
</tr>
<tr>
<td>Temp</td>
<td>95</td>
<td>96</td>
</tr>
<tr>
<td>SpO2</td>
<td>16</td>
<td>18</td>
</tr>
</tbody>
</table>

**TX & PROCEDURES:**

- **SEDATED**
- **CHEM**
- **PARALYZED**
- **INTUBATED**
- **CRIE**
- **NEEDLE DECOMP**
- **CHEST TUBE**
- **COLLOID**
- **CRYSTALLOID**
- **TRANSFUSION**
- **TOURNOUET**
- **COLLAR / C-spine**
- **HEMOSTATIC DEVICES**
- **OXYGEN**
- **RBC**
- **FPP**
- **CRYO**
- **PRB**
- **HBOC**
- **FRESH WHOLE BLD**

**DISPOSITION:**

- **RTD**
- **DECEASED**
- **URGENT**
- **URGENT SURGICAL**
- **ROUTINE**
- **DEATH**

**MEDCOM - 690**

---

**DIAGNOSIS:**

- **TRAUMATIC INJURY**
- **ABRASION**
- **2 cm, L. ARM**
- **ABRASION**
- **1 cm, D. ARM**

**START:**

- **VENT ON:**
- **ICU IN:**
- **ICU OUT:**

**PROVIDER:**

- **SPECIALTY:**
- **DATE:**
- **DEATH:**

**FOR OFFICIAL USE ONLY:**

- **LAW ENFORCEMENT USE ONLY:**

---

**EDCOM Test Form 1391, OCT 2001**
Theater Trauma Registry Record
For use of this form, see DA PAM XXX, the proponent agency is OTSG

<table>
<thead>
<tr>
<th>TIME</th>
<th>BP</th>
<th>PULSE</th>
<th>RESP</th>
<th>SpO2</th>
<th>MENTAL Status</th>
<th>DRUG</th>
<th>DOSE</th>
<th>ROUTE</th>
<th>DTG</th>
</tr>
</thead>
<tbody>
<tr>
<td>0800</td>
<td>110</td>
<td>18</td>
<td></td>
<td></td>
<td>A V P U</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0810</td>
<td>112</td>
<td>14</td>
<td></td>
<td></td>
<td>A V P U</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0815</td>
<td>110</td>
<td>16</td>
<td></td>
<td>97.8</td>
<td>A V P U</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0845</td>
<td>110</td>
<td>16</td>
<td></td>
<td></td>
<td>A V P U</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0900</td>
<td>160</td>
<td>17</td>
<td></td>
<td></td>
<td>A V P U</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTES: PT. RECEIVED H2O/IV REHYDRATION 4 HOURS AGO DURING THIS SHIFT.

Discharge Summary Information (Diagnosis, Procedures and Complications)

Head and Neck:

Chest:

Abdomen:

Upper:

Pelvis:

Lower:

Skin:

Cause of Death at:

ANATOMIC:

[ ] Airway [ ] Head [ ] Neck [ ] Chest [ ] Abdomen [ ] Pelvis [ ] Extremity (Upper/Lower) [ ] Other

PHYSIOLOGIC:

[ ] Breathing [ ] CNS [ ] Hemorrhage [ ] Total Body Disruption [ ] Sepsis [ ] Multi-organ failure [ ] Other

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT

MEDCOM - 691
<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/04</td>
<td>20:58 Showered, drank 500ml water</td>
</tr>
<tr>
<td>05/04</td>
<td>0000 - 0030 Slept 30 min</td>
</tr>
<tr>
<td>05/04</td>
<td>SLEPT &gt; 00:30</td>
</tr>
<tr>
<td>05/04</td>
<td>0115 Drank 60ml</td>
</tr>
<tr>
<td>05/04</td>
<td>Drank water 0300 SLEPT 7:00</td>
</tr>
<tr>
<td>05/04</td>
<td>SLEPT 7:00</td>
</tr>
<tr>
<td>05/04</td>
<td>0400 SLEEPING</td>
</tr>
<tr>
<td>05/04</td>
<td>0700 SLEEPING</td>
</tr>
<tr>
<td>05/04</td>
<td>0730 RETURN TO DETENTION (6/17/87 14:00)</td>
</tr>
</tbody>
</table>

HOSPITAL OR MEDICAL FACILITY

STATUS

DEPART./SERVICE

RECORDS MAINTAINED AT

SPONSOR'S NAME

SSN/ID NO.

RELATIONSHIP TO SPONSOR

REGISTRATION NO.

WARD NO.

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

NAME (LAST, FIRST) 05/04

SSN:

DOB:

UNITY:

RANK:

SEX:

STATUS: (AD, NG, R)

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT USE ONLY

EXHIBIT 7

MEDCOM - 692
<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/12</td>
<td>Hypertension, elevated blood pressure, general discomfort.</td>
</tr>
<tr>
<td>12/13</td>
<td>Prescribed medication: A+1 3 times daily, and other treatments.</td>
</tr>
<tr>
<td>12/14</td>
<td>Continued elevation of blood pressure, and treated with medication.</td>
</tr>
</tbody>
</table>

**NAME (LAST, FIRST)**

- SSN: [Redacted]
- DOB: 01/01/44
- UNIT: [Redacted]
- RANK: [Redacted]
- SEX: [Redacted]

**STATUS: (AD, NG, R)**

- FOR OFFICIAL USE ONLY
- LAW ENFORCEMENT USE ONLY

**EXHIBIT**

**MEDCOM - 693**
3/8/04 1700 - 2100  Rest 16  Pt doing leg exercises for 30 min.
1800 - 2100 R 16  Pt doing exercises 30 min  doing sit downs. Exercise
for 20 min. 1845 Pt taking 3000 mg of Tylenol. 2100 Pt W 98.2

02/17 R 16  Chest examination Pt W 99.0
Pt 1914 R 16  Pt planning w/ spiritually"Pt received abrasions 4 shins and
2 knees.  

2013 T 16  Core temp 99.6  2013 H 0

[Signature]

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 800 (REV. 6-87)

PRESCRIBED BY GSA/CMA

FIRM: (41 CFR) 201-9.202-1

INSP: USAF 7000

MEDCOM - 694

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT USE ONLY

EXHIBIT

3.01
MARCH 8

2100 2100 PT placed in Furo Betts on Glutar Dimonium / Lom

2200 2200 PT sitting up, Tabber, P.O.R. 12

2300 2300 PT at P.O.R. T-46.0°F P.O.R. 12

2400 2400 P1 AO X 3 T-36.8°F P.O.R. 12

H.M.2

03/12/92

NAME: (LAST, FIRST)
SSN:
DOB:
UNIT:
RANK:
SEX:
STATUS: (AD, NG, R)

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 100 (REV. 6-97)
Prepared by: GS/AMWR
FIRMR (41 CFR 201-9, 202-1)

EXHIBIT

MEDCOM - 695
09 Mar 04
Assumed Hx. Watch

06:00
V.S.: P 70 R 12 T 97.0 F血 reviewed A 80 X 3.

06:45
By fire, slept 30 min.

07:00
T 97 P 70 R 12

07:15
Also 90 R 16

07:45
Pt drank 17 oz. H2O i.n. Assistance

08:15
P 80 R 12

08:05
P 80 R 12. Pt cooperative A 80 X 3 sitting by fire in warm blanket x 15 min. Pt unstable, falls limp while transporting.

AYE TO

08:09
PM 2

HOSPITAL OR MEDICAL FACILITY
STATUS
DEPARTMENT/DEPARTMENT
RECORD MAINTAINED AT

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

PATIENT IDENTIFICATION: (For typed or written name, give: last, first, middle; ID No or SSN; Sex; Date of Birth; Race/zipcode.)

NAME: (Last, First)
SSN:
DOB:
UNIT:
RANK:
SEX:

STATUS: (AD, NG, R)

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 800 (REV. 1-77)

Prescribed by GSA/CMR

FIRM: (41 CFR) 201-1.220-1

USAPA V2.00

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT USE ONLY

MEDCOM - 696

EXHIBIT

123
09 MARCH 04  

**MEDICAL RECORD**

**DATE**

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

**0900**  
Assume medical duties @ 0800.

**0800**  
IT A/D  F & R 10, Temp 96.5°F.

**0900**  
P/H R10.

**1000**  
P/H R10, showered.

**1100**  
P/H R10.

**1115**  
Drank 30 cc water.

**1200**  
P/H R12 turn-over to MM.

**HOSPITAL OR MEDICAL FACILITY**

**NAME (LAST, FIRST)**

**SSN:**

**DOB:**

**UNIT:**

**RANK:**

**SEX:**

**STATUS:** (AD. NG. R)

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT USE ONLY

**EXHIBIT**
<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 March 04</td>
<td>1600 Assumed to Watch Pt Sleeping NAP</td>
</tr>
<tr>
<td>1600</td>
<td>P 90 RBS</td>
</tr>
<tr>
<td>1700</td>
<td>It's Sleeping 1pm 5000 18pr</td>
</tr>
<tr>
<td>1600</td>
<td>P It's Sleeping 90 R 2hr x 16 or</td>
</tr>
<tr>
<td>1700</td>
<td>It's Awake 4 30 5000 H&amp;F + Food 7/10 x 5 20lpr</td>
</tr>
<tr>
<td>2000</td>
<td>Pt drink 110 5r 20 pr</td>
</tr>
<tr>
<td>2005</td>
<td>Turned overWatch Patient on bed</td>
</tr>
</tbody>
</table>

HOSPITAL OR MEDICAL FACILITY

SPONSORS NAME

SSN/ID NO.

RECORDS MAINTAINED AT

STATUS

DEPARTMENT/SERVICE

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.

03/04

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT USE ONLY

MEDCOM - 700

EXHIBIT
<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>09MAR94</td>
<td>Assumed W/H, HM Z, R110 R20 T97</td>
</tr>
<tr>
<td>2010</td>
<td>Pt by fire, sitting on blanket, AEd x3 verbally responds to questions/commands. Pt falls limp.</td>
</tr>
<tr>
<td>2050</td>
<td>15 min sleep</td>
</tr>
<tr>
<td>2100</td>
<td>R110 R20 T97.5 R</td>
</tr>
<tr>
<td>2145</td>
<td>Pt drank 12oz water (degree) 5oz H20</td>
</tr>
<tr>
<td>2200</td>
<td>P 100 P 18 T97.0</td>
</tr>
<tr>
<td>2215</td>
<td>Slept 15 min by fire, Ao x3</td>
</tr>
<tr>
<td>2345</td>
<td>P110 Resp 18 temp -97.4°F</td>
</tr>
<tr>
<td>2338</td>
<td>Pt cleaned 2 soap H20, addressed knees extensions</td>
</tr>
<tr>
<td></td>
<td>Bedside solution, Pt ambulated under own control to head 2 shoes, Pt defect &amp; elevated. (R) 45° MEDCAL</td>
</tr>
<tr>
<td></td>
<td>2 small abrasion (1cm) from rocks, placed shoes on for all further ambulations</td>
</tr>
<tr>
<td>2340-2350</td>
<td>Sitting in chair by fire, drank 10oz H20</td>
</tr>
</tbody>
</table>

**ND ET A**

**Hin B**

**HOSPITAL OR MEDICAL FACILITY**

**STATUS**

**DEPARTMENT/SERVICE**

**RECORDS MAINTAINED AT**

**SPONSOR'S NAME**

**SSN/WO 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.**

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

**Medical Record**

**STANDARD FORM 600 (REV. 1-97)**

**Prepared by: GSARCMR**

**FIRMR (41 CFR) 201-4.202-1**

**UNAPPA V2.00**

**STATUS: (AD, NG, R)**

**FOR OFFICIAL USE ONLY**

**LAW ENFORCEMENT USE ONLY**

**EXHIBIT 158**

**MEDCOM - 701**
<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 MAR 04</td>
<td>PT IS AWARE ORIENTED Signs Sitting -</td>
</tr>
<tr>
<td>001</td>
<td>COOL - Fed rice/drank 2c cc H2O</td>
</tr>
<tr>
<td>01030</td>
<td>V/S P 98 R 14K NAD</td>
</tr>
<tr>
<td>0300</td>
<td>Noted position to sit and remain seated</td>
</tr>
<tr>
<td>0045</td>
<td>PT in prone position, sleeping</td>
</tr>
<tr>
<td>0145</td>
<td>PT still sleeping</td>
</tr>
<tr>
<td>0200</td>
<td>2c cc H2O given P.O.</td>
</tr>
<tr>
<td>0300</td>
<td>Sleeping, NAD</td>
</tr>
<tr>
<td>0400</td>
<td>Sleeping, NAD</td>
</tr>
</tbody>
</table>

**HOSPITAL OR MEDICAL FACILITY**

**SPONSOR’S NAME**

**SSN/ID NO.**

**RELATIONSHIP TO SPONSOR**

**PATSNETS IDENTIFICATION**

(Full typed or written entry. Give Name - last, first, middle + ID No or SSN. Sex; Date of Birth. Rank/Grade.)

**NAME:(LAST, FIRST)**

**SSN:**

**DOB:**

**UNIT:**

**RANK:**

**SEX:**

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

Medical Record

STANDARD FORM 600 (REV. 6-67)

Precribed by GSA/CMBR

14 CFR 201-9.202-1
<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>03-11-04</td>
<td>0000 Pt in Recumbent, flatus, no pain, no fever, no weight gain.</td>
</tr>
<tr>
<td></td>
<td>Pt kept a bed, P 128 R 13 F 98.6, no new abnormality.</td>
</tr>
<tr>
<td></td>
<td>Pt appeared to be doing very well as expected.</td>
</tr>
<tr>
<td></td>
<td>All abnormalities treated w/ decongestion. Pt A.O.V. Talkative.</td>
</tr>
<tr>
<td></td>
<td>Pt received water at this time.</td>
</tr>
<tr>
<td></td>
<td>0000 Pt stood up and walked 20-30 meters, no dizziness or nausea.</td>
</tr>
<tr>
<td></td>
<td>Urinated Pt walked under own power and stumbled on returning.</td>
</tr>
<tr>
<td></td>
<td>Feeling Pt very complainant. P 118 R 16 F 99.6°</td>
</tr>
<tr>
<td>01.7</td>
<td>Pt drank water (approx) 120 ml</td>
</tr>
<tr>
<td>02.0</td>
<td>Pt drank water P 118 R 16 F 97.9°</td>
</tr>
<tr>
<td>02.5</td>
<td>Pt laying by F. Pt, no complaints Pt H. P 110 R 17 F 99.6°</td>
</tr>
<tr>
<td>02.55</td>
<td>Pt was requerued by H.</td>
</tr>
</tbody>
</table>
MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

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

3/11/04
ASUMED MEDICAL DUTIES, PT. AWAKE ON

03:00
SIDE NA, ORIENTED X 3, TALKING & TRANSLATOR

SITTING UPRIGHT IN CHAIR, TALKING & TRANSLATOR

03:42
PT. DRANK APROX 20 CC H2O, P 98, R 12, T 98.6

04:24
DRANK 20 CC H2O SITTING BY FIRE, NA

04:40
SLEEPING ON SIDE, NA

05:30
AWAKE, SPO 92, R 12, T 98.6

06:06
AWAKE, RESPONSIVE, ORIENTED X 3, NA

PROBABLY RECEIVED BY H17

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 5-97)

Fatal by GSA/CMR

FIRMA 41 CFR 201-5.202-1

WBPPC V1.00

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT USE ONLY

EXHIBIT

MEDCOM - 704
0180-04-CID259-80227

23/11/04 MEDICAL WATCH ASSIGNED BY H/CO @ 0611 1/5 P34
12 1.982 @ PT ASLEEP WITH BLANKET AWAKENED FOR VITALS AT 0430 THEN ASLEEP AGAIN ON SIDE ON COT.
26/11 P36 R12 PT AWAKENED FOR 250ML WATER AND EGO
SANDWICH COMPUTER TOILETED WELL BACK SLEEP.
27/11 PT AMBULATED TO TOILET AND ASSISTANCE DRANK 250ML WATER.
28/11 P36 R12 ASLEEP.
0800 P31 R12 AWAKES, SIT ON CHAIR A40 X 3
0950 WATCH PROMPTLY BELIEVED BY H/CO.
<table>
<thead>
<tr>
<th>DATE</th>
<th>Symptom/Action</th>
<th>Temperature</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-11:00</td>
<td>Pt laying down on cot, cool, or absent manner, change IV line</td>
<td>99.6°F</td>
<td></td>
</tr>
<tr>
<td>11:00</td>
<td>Pt laying on back on cot, P 86 R 12 T 98.5°F</td>
<td></td>
<td>Pt is compliant</td>
</tr>
<tr>
<td>12:00</td>
<td>Pt defecated, walked with aid to Peri-Post and then walked with support or falling, Pt is standing in each with hands raised above head</td>
<td>78.8°F R 12 T 98.5°F</td>
<td></td>
</tr>
<tr>
<td>12:30</td>
<td>Pt drank 30 cc water</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:00</td>
<td>Pt laying on cot, P 86 R 12 T 99.7°F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13:45</td>
<td>Pt drank 30 cc H2O</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Primary Survey

Airway: Patent Mechanically maintained by N/A
Breathing: Spontaneous Assisted by N/A
Circulation:

Pulse: Present Absent
Color: Normal Abnormal
Cap refill: Normal Delayed

@1949
Initial Vital Signs: b/p 110/70, pulse 110, Resp 12, Pulse Ox N/A, Temp 98.8

Secondary Survey

Skin: SEE PM NOTES
Head: Normocephalic, Atraumatic, Soft to palpation
Neck: Soft to palpation
Heart: WNL
MNGS:

Chest: Clear to 2 Fingers
Abdo:

Urogenital: Normal
Ext: SEE PR NOTES
Spinal:
Neuro: 0/11/10 X 3

GLASGOW COMA SCORE

<table>
<thead>
<tr>
<th>EYES OPEN</th>
<th>BEST VERBAL RESPONSE</th>
<th>BEST MOTOR RESPONSE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous</td>
<td>Confused</td>
<td>Obligatory Commands</td>
<td>4/4/6</td>
</tr>
<tr>
<td>To Speech</td>
<td>Inappropriate sounds</td>
<td>Localizes Pain</td>
<td>3/3/3</td>
</tr>
<tr>
<td>To Pain</td>
<td>Inappropriate sounds</td>
<td>Withdraws to Pain</td>
<td>2/2/2</td>
</tr>
<tr>
<td>None</td>
<td>None</td>
<td>Flexes to Pain</td>
<td>1/1/1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expands to Pain</td>
<td>1/1/1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>None</td>
<td>1/1/1</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

GLASGOW COMA TOTAL

Systolic Blood Pressure

<table>
<thead>
<tr>
<th>130/80</th>
<th>120/70</th>
<th>60-75</th>
<th>80-90</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Respiratory Rate

<table>
<thead>
<tr>
<th>16-24/min</th>
<th>12-16/min</th>
<th>6-9/min</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

FOR OFFICIAL USE ONLY
LAW ENFORCEMENT USE ONLY

EXHIBIT 110

MEDCOM - 707
Breathing:

Circulation:

Other:

**Vital Signs**

<table>
<thead>
<tr>
<th>Time</th>
<th>BP</th>
<th>Pulse</th>
<th>Resp</th>
<th>Pulse Ox</th>
<th>Temp</th>
<th>GCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>19:44</td>
<td></td>
<td>110</td>
<td>12</td>
<td>98/70</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>20:20</td>
<td></td>
<td>100</td>
<td>12</td>
<td>98/70</td>
<td>15</td>
<td></td>
</tr>
</tbody>
</table>

**Transfer Instructions:**

**NOTES:** PM 4/28 @ 19:50 SITTING IN CHAIR BY EILE ANSWERING QUESTIONS. HE IS COMFORTABLE AND IN NO DISTRESS. PM 4/28 PRESENTED HIM FROM DETENTION FACILITY WHERE HE HAS RECEIVED MEDICAL ATTENTION. HE HAS NO PERCUSSION. ON DUTY @ 19:50 4/24/05. PT HAS DIFFICULTY WALKING. HE QUARRELS. FOOT 1. FOOT TENDON SLOW SWELLING, BURSTING ON THE TIPS OF 1ST AND 2ND TOES. NERVOUS, PREDICTABLE. FOOT PULSE SLOW, CARRÉAL. NO SWELL. FOOT SWELL. FOOT SWELL.

PM 4/29 @ 02:45 PT SITTING. HX AS ABOVE. NO A'S. UNDERSKINABLE CONDITION. OTHER THAN DERMAL TO 02 PAIN. UPPER & LOWER ASPECT. CARRÉAL. TENDON PULLS PRESENT.
Breathing:

Circulation:

Other:

Vital Signs

<table>
<thead>
<tr>
<th>Time</th>
<th>B/P</th>
<th>Pulse</th>
<th>Resp</th>
<th>Pulse Ox</th>
<th>Temp</th>
<th>GCS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Blood Components

<table>
<thead>
<tr>
<th>Unit #</th>
<th>Type</th>
<th>Time</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Transfer Instructions:

NOTES: 1/2 AS ABOVE, H2O + more provided
12:00 Taken by HUMV 7C

Prepared By:
<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/100</td>
<td>Pulse 110, R 14, B/P 132/78</td>
</tr>
<tr>
<td>19 MAR 04</td>
<td>AWARE, O X 3, TALKING &amp; INTERPRETATION</td>
</tr>
<tr>
<td></td>
<td>THIS PC (DEFENDANT) WAS TRANSFERRED HERE FROM</td>
</tr>
<tr>
<td></td>
<td>MEDICAL INSTRUMENT CAMP HE HAS A HISTORY OF</td>
</tr>
<tr>
<td></td>
<td>SEVERAL VISITS IN THE LAST WEEK. PC FORMS ARE ON RECORD. P.E.</td>
</tr>
<tr>
<td></td>
<td>GON A/C X 3, ADAMATIC, ARM &amp; LEG 31 Y.O. ABSTRACTED BY</td>
</tr>
<tr>
<td></td>
<td>HIMSELF. GON, NEK, &amp; MULS</td>
</tr>
<tr>
<td></td>
<td>HX: ADAMATIC, E: REMOTEC. 7: TH'S WALK, VAG CLEV.</td>
</tr>
<tr>
<td></td>
<td>NEK: ADAMATIC, TH'S MUDAN &amp; JUD.</td>
</tr>
<tr>
<td></td>
<td>HEART: NEURAL H &amp; M VAGuem. PAIN ACROSS</td>
</tr>
<tr>
<td></td>
<td>CHEST: ADAMATIC, LUNG: SOUNDS, CLEAR HEART</td>
</tr>
<tr>
<td></td>
<td>ADAMATIC, TH'S MUDAN &amp; JUD.</td>
</tr>
<tr>
<td></td>
<td>CERVICAL: SOUNDS</td>
</tr>
<tr>
<td></td>
<td>PELVIS: ADAMATIC, S MOBILE</td>
</tr>
<tr>
<td></td>
<td>RETAIL: ADAMATIC</td>
</tr>
<tr>
<td></td>
<td>NECK: W/3, 12 MRR, W/3, REFRESH (UN)</td>
</tr>
<tr>
<td></td>
<td>ABDOMEN NOTED (KNEE). TALKED PAIN TO</td>
</tr>
<tr>
<td></td>
<td>DELIVERY HOSP. SAME TYPE創WALK TO (KNEE)</td>
</tr>
<tr>
<td></td>
<td>MRR IN ADAPT. 5.6 CM DIA.</td>
</tr>
<tr>
<td></td>
<td>ABDOMINAL CAVITY/MASSAGE, RED FISSURE, RACEMOUS</td>
</tr>
</tbody>
</table>

**HOSPITAL OR MEDICAL FACILITY**

**Sponsor's Name**

**Patient Identification**: (If type of written envelope, give: Name - last, first, middle; ID No or SSN; Sex: Date of birth; Rank/Grade)

**Register No**

**Ward No**

**Chronological Record of Medical Care**

**Standard Form 600 (Rev. 6-97)**

Prescribed by GS/CMR

**Firm** (41 CFR 301-9,202) 100-A-00

**Exhibit** 29
<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/20</td>
<td>CONDUCTIVE INJURY, R.I. SITTING, CALM, ANSWERING QUESTIONS VERY COMPLIANT,</td>
</tr>
<tr>
<td>2/24</td>
<td>STILL CONDUCTIVE INJURY, R.I.</td>
</tr>
<tr>
<td>0100</td>
<td>SITTING BY FIRE, NA, D</td>
</tr>
<tr>
<td>0300</td>
<td>SITTING BY FIRE, NA</td>
</tr>
<tr>
<td>0500</td>
<td>SITTING TO Curb in room, NA</td>
</tr>
<tr>
<td>0900</td>
<td>D R.I. TO Curb in room, NA</td>
</tr>
<tr>
<td>1200</td>
<td>P.I.D. TO AMBULATES TO TOLE, ASSISTANCE, DRY STILLS, NO BLOOD</td>
</tr>
<tr>
<td>1215</td>
<td>ASLEEP IN CHAIR</td>
</tr>
<tr>
<td>1330</td>
<td>AWAKENED TO P.I.D. DRY STILLS, NO BLOOD</td>
</tr>
<tr>
<td>1400</td>
<td>DRY R.I. EXternally, NO BLOOD</td>
</tr>
<tr>
<td>1500</td>
<td>AWAKENED, ABDOMINAL DRAINAGE, D.R.I. COMA, G/O</td>
</tr>
<tr>
<td>1700</td>
<td>D.S. TO ARGINOSIS ON KNEES, BOTH CLEANED &amp; BANDAGED, MACITRIN APPLIED</td>
</tr>
<tr>
<td></td>
<td>DRY STILLS, D.S.</td>
</tr>
<tr>
<td></td>
<td>ALSO 1ST &amp; 2ND DIGITS, CLEARED +</td>
</tr>
<tr>
<td></td>
<td>DRESSINGS IN THE SAME MANNER</td>
</tr>
<tr>
<td></td>
<td>SLIGHT SWELLING, NOTE TO L FOOT, N.T. 15</td>
</tr>
<tr>
<td></td>
<td>SITTING &amp; L FOOT ELEVATED</td>
</tr>
<tr>
<td>1900</td>
<td>STILL SITTING &amp; FOOT ELEVATED, NO A</td>
</tr>
<tr>
<td></td>
<td>T 98.6, P 100, R 12, B/R 130/88</td>
</tr>
<tr>
<td>2000</td>
<td>RETURN TO DETAINMENT, AMBULATED, 15</td>
</tr>
<tr>
<td></td>
<td>well, slight edema to L FOOT</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>LAW ENFORCEMENT USE ONLY</td>
</tr>
<tr>
<td></td>
<td>STANDARD ENFORCEMENT (REV. 07/97) BACK</td>
</tr>
<tr>
<td></td>
<td>MEDCOM - 711</td>
</tr>
<tr>
<td></td>
<td>MEDICAL UNIT, 12-14 HOURS EACH NIGHT</td>
</tr>
</tbody>
</table>
Wound area S/9 on shins, inguinal last evening.

Pain this C swelling & blistering.

Reports thermal burn left leg.

Noted 3/4 wound ant. b. knee.

O/A w/s

q/c

LT & RL Ant knee noted 4 erythema + multiple blisters noted on 1st tissue appears 2nd degree burn & necrotic margins.

A/P 2nd degree burn on blister 9/26.

1. Continued Bacitracin typically to affected areas.
2. Ointment 4-6/PM for severe pain.
3. Continued daily dressing as will use silverdine directly.

(Continue on reverse side)
13 MAR 04 11:16 HOURS

1. LFTs, CK X 1 time normal.
2. ↓ IV Fluid rate to 75 cc/hr.

List Time Order Noted and Sign (3/32):

NURSING UNIT ROOM NO. BED NO.

14 MAR 04 08:02 HOURS

1. LFTs, CK this AM.
2. Pt. may shower, e guard in attendance (3/32).

List Time Order Noted and Sign (3/32):

NURSING UNIT ROOM NO. BED NO.

14 MAR 04 08:05 HOURS

1. Flexeril 10 mg prn bid
2. prn muscle spasm (neck pain)

List Time Order Noted and Sign (3/32):

NURSING UNIT ROOM NO. BED NO.
CLINICAL RECORD - DOCTOR'S ORDERS

0180-04-CID259-80227

DATE OF ORDER: 11 May 04
TIME OF ORDER: 1805

1. Admit to 1 EW
2. Dx: multiple abrasions/contusions
3. Condition: Stable
4. Allergies: N/OD
5. Vital signs per ward protocol
6. Activity: bedrest & bedpan
7. Record I/O

Encourage hydration
Diet: regular, may supplement with milk
Ensure patient adequately hydrated
IVF: NS 125 cc/hour until first leg day, then LK 125 cc/hour
MEDS: Toradol 15 mg IV Q8H
Morphine sulfate 2.4 mg 6:30 AM
Pen prob 8:00 PM
Pain control
Toradol
Begin Metamucil 800 mg TID
Colace 100 mg QID
Keflex 250 mg QD
Acetaminophen 25-50 mg TID
Intake through mouth
Output through mouth
Serial digits

Service:

Orders:

01 May 04
1005

1. IVF Toradol
2. Begin Metamucil 800 mg TID
3. Colace 100 mg QID
4. Keflex 250 mg QD
5. Acetaminophen 25-50 mg TID
6. Intake & output through mouth

NURSING UNIT
Room No.
Bed No.

PATIENT IDENTIFICATION

MEDCOM - 715
EMERGENCY CARE AND TREATMENT

TRANSPORTATION TO HOSPITAL

PRIVATE VEHICLE ☑ AMBULANCE

CURRENT MEDS. (Attach care plan sheet)

CRYSTAL METH

HISTORY OBTAINED FROM

PATIENT ☑ OTHER (Specify)

PATIENT'S HOME ADDRESS OR DUTY STATION (City, State and ZIP Code)

ALLEGIES NKDA

CHIEF COMPLAINT(S) (include symptoms, duration)

Crasprophile pain Neck pain

VITAL SIGNS

TIME 11:53

B/P 131/81

PULSE 110

RESP 17

TEMP 99.5

WT 160

CATEGORY (See reverse)

EMERGENT LANDMARK

NON-URGENT

ORDERS

IN TUBS

SBG 1-0-12

A1G 1-0-12

500/600/400/200

ASSOCIATED DIAGNOSIS

Multiple abrasions

ECCHYMOSIS

DISPOSITION (check all that apply)

FULL DUTY

QUARTERS

24 HR

48 HR

72 HR

MODIFIED DUTY UNTIL:

DAY 20

MONTH 01

YEAR 20

REFERRED TO (indicate clinic)

EMERGENCY TODAY

72 HOURS ROUTINE

ADMIT. TO HOSP. UNIT/ SERVICE

CONDITION UPON RELEASE

IMPROVED

UNCHANGED

TIME OF RELEASE: 1805

(continues on SF 507 if needed)

31 years

FOR OFF LAW ENFORC

MEDCOM - 715
1. DATE OF PROCEDURE/ ADMISSION: 11 MAR 04
2. ADMITTING DIAGNOSIS: Multiple contusions/ abrasions
3. PERTINENT LAB/ X-RAY FINDINGS:
   - No fracture on X-rays.
   - CK ULTs: 311 U, ALT 188, AST 328, total 3.6
4. PROCEDURES/ TREATMENT/ HOSPITAL COURSE:
   - Pain control: Motrin, occasional
   - Muscle spasm treated: Flexeril, Ketter 3/1, 4 days.
5. FINAL DIAGNOSIS AND CONDITION AT DISCHARGE:
   - Condition improved; pt ambulatory.
   - Dx: Multiple contusions/ abrasions.
6. ACTIVITY:
   - As tolerated.
7. DIET:
   - Regular
8. MEDICATIONS:
   - Motrin 800 mg po tid
   - Flexeril 10 mg po bid
   - Ketter 250 mg po qid x 3 more days
9. INSTRUCTIONS TO HOME HEALTH PROVIDER:
   - To P.A. may need to periodically check CK, ULTs to continue to document decreasing levels; bloodwork can be brought to CSIT and processed.
10. FOLLOW-UP APPOINTMENTS/ POINT OF CONTACT & PHONE:
    - NA
11. COMPLETED BY:
    - Dr. [Signature]

I HAVE RECEIVED A COPY OF AND UNDERSTAND THESE INSTRUCTIONS.

[Signature]

PREVIOUS VERSIONS ARE OBSOLETE
Admit note: Pt brought over from F.R.C. 1150.
Pt. saying fluid 4 x 3, translating, assisting with 4 x 3,-running with 4 x 3.
15 mg IV given in admission for pain.
Fluoro 3P, abs, vs. symmetrical. BRN: mass.
Back & chest. Senses are intact on all sides.
Fingers are distal an, ecthymis.
Gastro 3. Decubitus 5 MU. T dewclaw
as per my orders. Breathing on S.O.S. @ this time.

12MAR47 AM
Pt awake. Scattered abrasions to chest and back, (8) knees.
0130: Swollen, dry, small abrasions to legs: (8) feet swollen.
Feet and toes: cap refill 2.2 sec. Pt able to slightly move toes, unable to flex.

[Further notes redacted and obscured]

12MAR47 AM
Second bag LR 6 f 2.5/hr.
12 Mar 04

1100

1200

1400

1730

1900

Pt. 70 yo. F. Pt. lying flat, head on C/S, back. B. pub. and legs.

Urinalysis: PT, has multiple abrasions and scratches to face, hands, arms, and body by B/A. Patient was noted to have a 30% chance of infection. +1 filling volume in C/S, +1 L/B. Pt. had a tenderness in cap - refill 1/3 sec. to B/p. Normal B/P.

Pt. was able to ambulate with a slow shuffle. Patient voided 100 cc of amber-colored urine. 3 diff. TLC. Rigid, flexible.

17 Mar 04

Pt. had 40% of bruises on C/S, states pain level of 4. Used a pain med. and voided 100 cc of amber-colored urine.

19 Mar 04

NS: note: Pt. awake. Scratches and abrasions unchanged, 

Pt. is bleeding. Pedal pulses +2, currently, feet still swollen, cap refill < 3 sec, to all extremities. Pt. cla. slight ache to C/S foot and belly button. Pt. refuses a pain med. IVF, difficulty. New bag of LR at 125 cc/hang. Pt. talking by guard at bedside. Feet elevated. L/H.
Physician Progress Note

12-Mar-02: Pt #2 admitted last evening for pain control. Monitoring of multiple abrasions/ecchymoses and foot swelling sustained during capture. Tolerated regular diet overnight. Less pain in feet but able to ambulate & assist for using restroom. Fevers.

10:08 AM: Pt T: 98.6, R: 110, BP 170/600

Gen: 4 + O3, cooperative, convalescent
MS: (B) feet/ankles = slight I + edema
Erythema noted. Dorsalis pedis pulse palpable. Edema on foot, ankle.

Att 3 +
Arterial 62
Alt 185
Arm 51
CIV 2.1
CK 210,000
GOT 7
GPT 5.7

Pt 14.9
P TT 31.6

(1) Multiple abrasions/ecchymoses
(2) Pedal to ankle edema
(3) Will begin reflex to prophylaxis for infection
(4) Will change to oral pain med (Motrin + Demerol)
(5) Begin ceface
(6) May ambulate c assist as tolerated.

10:09 AM: Pt T: 98.6

CPR, med. assist.
13 Mar 04

1115

MS: V swelling, edema in feet, ankles, persistent.

Blood blisters, ecchymoses to knee and ankle, fibula.

Improving. Both dorsalis pedis pulses equal.

Bilateral, no tenderness to palpation of feet.

Abrasion, healing, no evidence of infection.

A: Multiple abrasions, contusions.

B: Foot swelling, resolving.

C: 1) Will outline L/F, CP today.

2) IV fluid rate to 750 mL/hr.

Encourage PO fluids.

3) Continue pain control.

[Signature]

CPT, MC, USA
13 Mar 04: NG note: Pt pulled IV out while sleeping. 20G to
0330 FA inserted. C another bag of LR instilling. Pt back
to sleep.

13 Mar 04
0930 NG note: Scattered abrasions to upper chest & gluts.
Large abrasions to back, knees, shins. bilateral feet,
swollen & black Edema on toes. Pedal pulses 2+. A
ambulated well with little assistance. 21" to 24" femurs,
running 121. 125 c/o s. redness or swelling to site.
Pt 1/10 pain. C neck starts unable to turn head from
side to side or look up. At my Demerol IV given
per pm pain orders. A sitting up in bed eating
breakfast to this time.

13 Mar 04  Progress Note
1115 C: 10/3 receiving pain control/hydration for
multiple abrasions/contusions. V pain in feet ->
B better than C per pt. Able to ambulate better
for short distances. Pain meds helping. Tolerating
regular diet. N/Po.

117/70 P 75 R 18 T 97.3 F Max 99.2
I/O ~ 2500/ 2190

Bx: Hx0x3; in NAD, conversant, cooperative

MEDCOM - 721
<table>
<thead>
<tr>
<th>DATE</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(O) 103/62 p75 R116 T97.9°F I/O ~1800/1825</td>
</tr>
<tr>
<td></td>
<td>Gen: A+Ox3, in NAD.</td>
</tr>
<tr>
<td></td>
<td>MS: Full ROM to shoulders, some discomfort.</td>
</tr>
<tr>
<td></td>
<td>C/O: Shoulder abduction, mild tenderness to cervical musculature - no deformity. Resolving ecchymoses on leg. V. swelling to feet. Dorsalis pedis pulses.</td>
</tr>
<tr>
<td></td>
<td>O: 1. CK, LFTS this AM.</td>
</tr>
<tr>
<td></td>
<td>2. Flexed long pool for muscle spasm.</td>
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<tr>
<td></td>
<td>3. Pt may shower &amp; go ahead in attendance.</td>
</tr>
<tr>
<td></td>
<td>4. Will consider d/c later today or tomorrow.</td>
</tr>
</tbody>
</table>

14 March 08 - D/c, resting in bed at 15mm. 25.5% Air. 8 feet are slightly low swollen, pedal pulse present. Pt. no pain in C/O shoulder reflexes present except tender. Approx. 50% of meals Tod & F, IV, 

Thur to Fri 03/28, USS. 2D
MPLEX

3/27/20

Fr eval. V51 IVP's. LE burning 25C/54F. Had stab incision on PEA. PEA for possible infection. Fr currently only pain on amb. or pain on C/AB should arise. Given scheduled reassessment 5/2 and denied for 100 mg PO QSO.


Fr is fearful. Will minimize.

Fr has good pressure at bedside.

1306-2

1/27/20

Fr MO pain. Has pt. with dress on back. Given 125 mg PO Q8H. Maintained q 45 mins. Fr pain is 8/10 in Q45 mins. Fr MO pain is 5/10. Fr MO pain is 8/10.

Motion. Mobility. Fr 85% for amb. Fr 110% in Q8H. Fr 110% in Q45 mins. Fr MO pain is 5/10. Fr MO pain is 8/10. Fr MO pain is 110%. Fr MO pain is 110%.

Fr MO pain is 8/10. Fr MO pain is 8/10. Fr MO pain is 8/10.

Fr MO pain is 8/10. Fr amb. on 2 blockers. Fr has calm, cooperative, mild folklife react.

14MAR04 Program Note

1/3/04: HD#3 - improving discomfort from multiple

abnormal/continuous. Improvement in swelling

1/3/04: HD#4 - improving discomfort from multiple

abnormal/continuous. Improvement in swelling
<table>
<thead>
<tr>
<th>DATE</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>14 MArch 4</td>
<td>NSW: Left shoulder abrasion-turbid alt &amp; some white pus.</td>
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<tr>
<td>2330</td>
<td>2x2 C bacitracin applied to shoulder, no swelling, decreased pulses,</td>
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<tr>
<td></td>
<td>cap refill &lt;3 secs to all extremities, IVF, infusion at resting eyes open</td>
</tr>
<tr>
<td>14 MArch 4</td>
<td>NSW: Note: Pt cla body pain, after explaining side effects</td>
</tr>
<tr>
<td>2345</td>
<td>of Flexeril, pt accepted the path med Flexeril 10mg PO given.</td>
</tr>
<tr>
<td>15 MArch 4</td>
<td>Progress Note</td>
</tr>
<tr>
<td>1030</td>
<td>6. HR: S- improving contusions/abrasions, down swelling, ambulating better. Pain in neck, better w/ Flexeril, tolerating regular diet but no appetite. Showed improvement yesterday &amp; guard present.</td>
</tr>
<tr>
<td>3/14</td>
<td>C/O: 15/67 P96 R14 T98.1°F. Urine output 1200 cc.</td>
</tr>
<tr>
<td></td>
<td>Gen: Alkx3, w/ NAD.</td>
</tr>
<tr>
<td></td>
<td>MS: bruising healing, swelling to feet, only</td>
</tr>
<tr>
<td></td>
<td>LFTs: improving +1 edema. Dorsalis pedis pulses.</td>
</tr>
<tr>
<td></td>
<td>(A): Multiple abrasions/contusions</td>
</tr>
<tr>
<td></td>
<td>Improved foot swelling</td>
</tr>
<tr>
<td></td>
<td>(P): 1 Pt meets criteria for transfer to EPW Camp</td>
</tr>
<tr>
<td></td>
<td>(2) Will continue Motrin + Flexeril</td>
</tr>
</tbody>
</table>

**Progress Notes**

- Medical Record
- Standard Form 509 (Rev. 5/1999)
- Prescribed by GSA/CMH PHMR (41-CPR) 10111120191130
- USAF V1 00

**MEDCOM - 724**
3 lyo Iraqi 67 EPW captured in raid 4d ago sustained multiple abrasions, contusions and ecchymoses during episode & subsequent questioning. Brought to EPW camp today unable to walk 2° pain in feet / legs & chest pain / difficulty breathing & bladder/bowel problems.

PMHx - migraine, HTN Meds - atenolol, propranolol
PSTx - none & All: NKDA

PHYSICAL EXAMINATION 129/84 RHB R.7 T97.5° F Ozsat 98%
Gen: client, oriented, cooperative, communicative through interpreter
Exam: tachycardic but regular, blood pressure 129/84
Chest/Back: multiple abrasions to back, b) shoulders, chest, & right arm
Auscultation: clear, resonant to palpation
MS: & gross distortions to pinch fingers/nipples (B) unilateral
PTT - 11.4
INR - 1.0
AST - 20
ALT - 8
AMY - 125
ALP - 240
Creatinine - 1.0
LFTs - normal

IMP: multiple abrasions
ECCHYMOSIS
(B) left arm pain/swelling

Plan: 1) admit to ICU for observation, & IV hydration
2) Pain control

RPM/2 01/27/04 01/27/04
01/27/04 01/27/04
<table>
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<td>OF ADMISSION</td>
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<td>CLINIC SVC</td>
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<td>NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE</td>
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<td>ADDRESS OF EMERGENCY ADDRESSEE</td>
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<tr>
<td>PHONE NO.</td>
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<tr>
<td>DATE OF THIS ADMISSION</td>
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<tr>
<td>32. UNITS OF WHOLE BLOOD/COMPONENT TRANSFUSED</td>
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<tr>
<td>33. TYPE OF REASON(S) FOR TREATMENT</td>
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<tr>
<td>34. DIAGNOSES/OPERATIONS AND SPECIAL PROCEDURES</td>
<td>Multiple abrasions / lacerations</td>
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<td>35. CAUSE OF INJURY</td>
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<tr>
<td>36. DATE OF DISPOSITION</td>
<td></td>
</tr>
<tr>
<td>25. TYPE DISPOSITION</td>
<td></td>
</tr>
<tr>
<td>26. DATE OF DISPOSITION</td>
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**Selected Administrative Data**

- CHECK IF CONTINUED ON REVERSE

**Diagnoses/Operations and Special Procedures**

Multiple abrasions / lacerations
<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10FEB04</td>
<td>0400 Assumed to watch, received</td>
</tr>
<tr>
<td></td>
<td>Inferred from HMM</td>
</tr>
<tr>
<td></td>
<td>Pt. Diaper, P90.4 R199.8 R T93.9°F</td>
</tr>
<tr>
<td></td>
<td>0500 Pt. sneezing P92 P R16.5 R T92.6°F</td>
</tr>
<tr>
<td></td>
<td>0600 Pt. gaishing P94.5 P R148.5 T96.3°F</td>
</tr>
<tr>
<td></td>
<td>0700 Pt. requires to use lavatory and</td>
</tr>
<tr>
<td></td>
<td>Irritated T C-20</td>
</tr>
<tr>
<td></td>
<td>0800 Foul odor T96.1°C</td>
</tr>
<tr>
<td></td>
<td>0900 Pt. sneezing P94 R A T93.5°F</td>
</tr>
<tr>
<td></td>
<td>0900.7</td>
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**HOSPITAL OR MEDICAL FACILITY**

**STATUS**

**DEPARTMENT/SERVICE**

**RECORDS MAINTAINED AT**

**SPONSOR'S NAME**

**SSN/ID NO.**

**RELATIONSHIP TO SPONSOR**

**PATIENT'S IDENTIFICATION**

| R08-4 |

**FOR OFFICIAL USE ONLY**

**LAW ENFORCEMENT USE ONLY**

**MEDCOM - 727**

**FOR OFFICIAL USE ONLY**

**LAW ENFORCEMENT USE ONLY**

**MEDCOM - 727**
08/22
Pt conscious, alert in standing position. P 88 R 14 T 96.8
P 91 R 12 T 97.8
Pain of urine
1200 Pt noy3 Alkalotic Resistent to all commands
P 82 R 12 T 98.13
1037 MR6 Care change on Distress 0 Feet Isolated 2nd
Division. Anterior Medial Anterior Midline on sunny side
when moving to standing position from recumbent
Position
1108 P 82 R 14 T 97.8
1200 P 90 R 12 T 97.8 Tended arm PR 70

OSMNA
PSRN

SAK.

0180-04-CID259-80227
AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD
CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE
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</thead>
<tbody>
<tr>
<td>3/10/04</td>
<td>HM 1200 ASSUMED MEDICAL DUTIES AT 1200</td>
</tr>
<tr>
<td></td>
<td>1200 P110 R12 FEET SWOLLEN FROM STANDING, FEET FEMALE</td>
</tr>
<tr>
<td></td>
<td>210 P100 R16</td>
</tr>
<tr>
<td>1345</td>
<td>CLEANED AND WASHED ABDOMENS TO 2ND METATARSALS</td>
</tr>
<tr>
<td>1350</td>
<td>DRANK 8 OZ OF WATER</td>
</tr>
<tr>
<td>1354</td>
<td>PROPERLY RELIEVED BY HM</td>
</tr>
<tr>
<td>1410</td>
<td>PT SLEEPING</td>
</tr>
<tr>
<td>1441</td>
<td>PROPERLY RELIEVED BY HM</td>
</tr>
<tr>
<td>1415</td>
<td>P88 R12</td>
</tr>
<tr>
<td>1500</td>
<td>PT AMBULATES WITH ASSISTANCE TO TOILET</td>
</tr>
<tr>
<td>1510</td>
<td>P86 R14</td>
</tr>
<tr>
<td>1515</td>
<td>PT DRANK 8 OZ OF ORANGE SODA, BUT REFUSED TO EAT</td>
</tr>
<tr>
<td>1520</td>
<td>PT SLEEPING</td>
</tr>
<tr>
<td>1525</td>
<td>DT 1200 NOTED FEET SWOLLEN AND ELEVATED BLANKETS</td>
</tr>
<tr>
<td>1625</td>
<td>PT P120, 0% PAINFUL FEET, NO DISCOLORATIONS EXCEPT ABDOMENS</td>
</tr>
<tr>
<td></td>
<td>NOTED PROXIMITY OF REFLUX, SWELL PADS, DISCOLOR, ULCER ABOVE PIVOTION</td>
</tr>
<tr>
<td></td>
<td>FEET</td>
</tr>
<tr>
<td>1628</td>
<td>PROPERLY RELIEVED BY HM</td>
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</tbody>
</table>

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

**FOR OFFICIAL USE ONLY**

**LAW ENFORCEMENT USE ONLY**

**MEDCOM - 729**
<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 MAR 04</td>
<td>Pt. is in supine position, feet elevated.</td>
</tr>
<tr>
<td>1702</td>
<td>NAD V/S P 66 R 12 T 96.1</td>
</tr>
<tr>
<td>1717</td>
<td>25cc (max) H2O given, still supine</td>
</tr>
<tr>
<td>1426</td>
<td>Ate 2 mg cracker, 20 cc H2O.</td>
</tr>
<tr>
<td>1907</td>
<td>Awake supine, NAD</td>
</tr>
<tr>
<td>2019</td>
<td>Supine, legs elevated to reduce edema. To pedals, shunt, edema.</td>
</tr>
<tr>
<td>2030</td>
<td>Distal pulses intact, Cap refill WNL (01)</td>
</tr>
<tr>
<td>2030</td>
<td>Properly relieved by HAZ (02)</td>
</tr>
</tbody>
</table>

**Hospital or Medical Facility**

**Status**

**Depart./Service**

**Records Maintained At**

**Patient's Identification**

<table>
<thead>
<tr>
<th>SSN/ID No.</th>
<th>Relationship to Sponsor</th>
</tr>
</thead>
</table>

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

**Medical Record**

**STANDARD FORM 600 (REV. 8-97)**

**Prescribed by GSACMR**

**FIRM (41 CFR 201-3.202-1)**

**USAPPC V1.00**

**FOR OFFICIAL USE ONLY**

**LAW ENFORCEMENT USE ONLY**

**EXHIBIT**

MEDCOM - 730
**MEDICAL RECORD**

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8MAR04</td>
<td>ASSUMED WATCH FROM PO THE TIME 0930.</td>
</tr>
<tr>
<td>2600</td>
<td>AMBULATED TO HEAD + SHOES UNDER HIS OWN CONTROL. AT TARD 1x2. AT APPEARS TO BE VERY TALKATIVE. AT DRANK 10oz COKE COLA VS PIZZERO. RESP DEEP &amp; REGULAR.</td>
</tr>
<tr>
<td>2215</td>
<td>AT ATO 3x3 TARP 14 PULSE 118 RRR Lungs clear all fields. PEAK X2. ALL ABRASIONS CLEARED &amp; COVERED &amp; REASSIGNED. All abrasions healing, 5 signs of infection. AT tolerated procedure well/very cooperative. AT sitting in chair by fire, feet elevated.</td>
</tr>
<tr>
<td>2300</td>
<td>AT 138R: 14. PULSE RRR, EKTOPH.</td>
</tr>
<tr>
<td>2.317</td>
<td>Placed PT: ON Cot NEXT TO Fire BLM Recumbent AS.</td>
</tr>
<tr>
<td>2350</td>
<td>SLEPT 1HR. AT DRANK 26oz M&amp;O, VS PIZZERO.</td>
</tr>
</tbody>
</table>

---

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

**Medical Record**

STANDARD FORM 500 (REV. 8-97)
Prescribed by GSA/ACMR
FIRM (41 CFR) 201-202-1 USAPE 01-00

FOR OFFICIAL USE ONLY

LAW ENFORCEMENT USE ONLY

EXHIBIT:

MEDCOM - 731
15 June 04
10:23 hrs.

REPORT OF DETAINEE MEDICAL SCREENING:

History of Past Medical Conditions: (circle) High Blood Pressure, Diabetes, Heart Failure, Kidney Failure, Seizures, Stroke, bleeding Ulcers, Chronic Bowel problems, Thyroid...

Medication Allergies: NO (YES) List -

Current Medications: (Name/Dose/Frequency/Last Taken) (NONE)

Sw med s

Recent Injuries: NO (YES) Describe - OF unknown type

Exam Findings: BP: 151/80 Pulse: 103 Resp: 12 T: 98.3 (F)

Utilize Diagram and Space Below to Indicate Examination Findings.

If additional space required, continue on reverse

Gen: WELL, NW, NL gait.

Lms: CTAB

Ext: WNL

Hepat: WNL

FIT (UNFIT) For Confinement

(Docs) (Does) Not Require Further Eval

CPT, SP, PA-C

DETAINEE INFORMATION:

Name: 

Last: 

First:  

Middle: 

Control Number: 054-6

Date/Time of Detention: 

For Official Use Only

Law Enforcement Sensitive

MEDCOM - 732
<table>
<thead>
<tr>
<th>Date</th>
<th>Subjective: Age 27 (M</th>
<th>F</th>
<th>DOB: 1977</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ANY NEW MEDICAL ILLNESS OR INJURY?</td>
<td>paid in back of neck</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ANY HISTORY OF TB?</td>
<td>YES/NO</td>
<td>IF YES, WHEN AND HOW WERE YOU TREATED?</td>
</tr>
<tr>
<td></td>
<td>COUGH &gt; 2 WEEKS?</td>
<td>YES/NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>COUGHING UP BLOOD:</td>
<td>YES/NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ANY WEIGHT LOSS?</td>
<td>YES/NO</td>
<td>IF YES, HOW MUCH AND IN WHAT TIME FRAME?</td>
</tr>
<tr>
<td></td>
<td>ANY HISTORY OF HTN?</td>
<td>YES/NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ANY HISTORY OF CAD?</td>
<td>YES/NO</td>
<td>IF YES, ANY HISTORY OF MI?</td>
</tr>
<tr>
<td></td>
<td>ANY HISTORY OF DM?</td>
<td>YES/NO</td>
<td>IF YES, HOW LONG?</td>
</tr>
<tr>
<td></td>
<td>ANY CHRONIC MEDICAL CONDITIONS NOT MENTIONED ABOVE?</td>
<td>YES/NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CURRENT MEDICATIONS:</td>
<td>0/80.2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MEDICATION ALLERGIES:</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ABLE TO WALK UNASSISTED?</td>
<td>YES/NO</td>
<td>ABLE TO FEED YOURSELF?</td>
</tr>
<tr>
<td></td>
<td>ANY MISTREATMENT SINCE BEING DETAINED?</td>
<td>YES/NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HISTORY OBTAINED THROUGH TRANSLATOR?</td>
<td>YES/NO</td>
<td>NAME:</td>
</tr>
<tr>
<td></td>
<td>HOSPITAL OR MEDICAL FACILITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>STATUS</td>
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<td>DEPARTMENT/SERVICE</td>
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<tr>
<td></td>
<td>ODDS MAINTAINED AT</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SPONSOR'S NAME</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SSN/A DE</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>RELATIONSHIP TO SPONSOR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PATIENT'S IDENTIFICATION:</td>
<td>(For typed or written entries, give: Name - last, first, middle, ID No or SSN; Sex; Date of Birth; Rank/Grade.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>REGISTER NO.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>WARD NO.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For Official Use Only
Law Enforcement Sensitive
FOR OFFICIAL USE ONLY
MEDCOM - 733
OBJECTIVE:

HEIGHT: 5'4"  WEIGHT: 243
BP: 179 PULSE: 97 RESP: 80 O2%: 100  TEMP:

MEDICS SIGNATURE:

REFER TO PA OR MD IMMEDIATELY IF:

CURRENTLY HAVING CHEST PAIN, ABNORMAL MENTAL STATUS OR ANY OTHER CONCERNS

MD/PA REVIEW NOTE:

1) 27 YO G 6 Arouses promptly for command. Pt reports he was punched in the stomach 4 days ago by assailant forces, he denies any current injury or pain from incident.

2) Lungs clear to ausc.
   Poststenotic = no rales, no edema or stenosis.

3) Wound History

4) Ref to CTR

I, ... and plan discharged at length pt.

Though interpreted.

For Official Use Only
Law Enforcement Sensitive

MEDCOM - 734

STANDARD FORM 600

Exhibit 7-3
**MEDICAL RECORD**

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

**DATE**

26 JAN 04

**DETAINEE IN-PROCESSING MEDICAL SCREEN**

**SUBJECTIVE**

**AGE** 22 **M**P **DOB:** 1982

**ANY NEW MEDICAL ILLNESS OR INJURY?**

Hyperpigmentation 3-7 days

**ANY HISTORY OF TB?** YES / NO **IF YES, WHEN AND HOW WERE YOU TREATED?**

**COUGH > 2 WEEKS?** YES / NO

**COUGHING UP BLOOD?** YES / NO

**ANY WEIGHT LOSS?** YES / NO **IF YES, HOW MUCH AND IN WHAT TIME FRAME?**

**ANY HISTORY OF HTN?** YES / NO

**ANY HISTORY OF CAD?** YES / NO **IF YES, ANY HISTORY OF MI? YES / NO WHEN?**

**ANY HISTORY OF DM?** YES / NO **IF YES, HOW LONG?**

**ANY CHRONIC MEDICAL CONDITIONS NOT MENTIONED ABOVE?** YES / NO

**CURRENT MEDICATIONS:**

**MEDICATION ALLERGIES:**

**ABLE TO WALK UNASSISTED?** YES / NO **ABLE TO FEED YOURSELF?** YES / NO

**ANY MISTREATMENT SINCE BEING DETAINED?** YES / NO

**HISTORY OBTAINED THROUGH TRANSLATOR?** YES / NO **NAME:**

**HOSPITAL OR MEDICAL FACILITY**

**STATUS**

**DEPARTMENT/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.)

**NAME:**

**SN:**

**COMPOND:**

**FOR OFFICIAL USE ONLY**

**LAW ENFORCEMENT SENSITIVE**

**MEDCOM - 735**

**EXHIBIT 2**
86 JON 04

OBJECTIVE:

HEIGHT: 5'5"  WEIGHT: 117

BP: 125/79  PULSE: 86  RESP.  O2%:  TEMP:

MEDICS SIGNATURE: N/A

REFER TO PA OR MD IMMEDIATELY IF:

CURRENTLY HAVING CHEST PAIN, ABNORMAL MENTAL STATUS OR ANY OTHER CONCERNS

MD/PA REVIEW NOTE:

86 JON 04  S) 32 y/o J. Durison presents for medical reprocessing and reports while being interrogated he was punched in the

chest, and choked, and punched in the neck. He

reports this happened 6 days ago at the 11-mothane inst.

FH - Single uneventful delivery any current disease

GH - 6 L.P. shots

NC - XRs, XSS, ENT-NC

PMH -

Necho: CN II - XL, C4 - T2 NODE, L1 - S2 MUSCLE GYMS PRE dipping

Neck -

Jaw -

Neck -

Iv'nt - NC, Nick - upper 5 adequacy/egonomy

Loops - CN V, Heart NR, Ao - Ecg.

Genitals - NC, No T. On - Nox - As well

Integument - No nude ehmor - 6 hairs of hygienization o

p) 1. MedCARD PCE

2. Con. Hypothesis 0 etiology

p) 1. Ref to PA

2. F/U PCE

FOR OFFICIAL USE ONLY

STANDARD FORM 500 (REV. 8-97) BACK

MEDCOM - 736

EXHIBIT
PRISONER IN-PROCESSING MEDICAL SCREEN

NAME: [Redacted]  
DATE: 5/5/04  
HISTORY BY TRANSLATOR: [ ] YES [ ] NO  
NAME OF TRANSLATOR: [Redacted]  
COMPOUND: [Redacted]  
DOB: 1974  
ISN: [Redacted]  
AGE: [Redacted]

1) DO YOU HAVE ANY NEW MEDICAL PROBLEMS OR INJURIES NOW?  
   Severe lacerations secondary to cuts from pistol  
   Injuries to both wrists was hit on the head repeatedly  
   No

2) HAVE YOU HAD TUBERCULOSIS? IF YES, WHEN AND HOW WERE YOU TREATED?  
   No

   A) HAVE YOU HAD A COUGH FOR MORE THAN 2 WEEKS?  
      YES [ ] NO [ ]

   B) HAVE YOU BEEN COUGHING UP BLOOD?  
      YES [ ] NO [ ]

   C) HAVE YOU BEEN LOSING WEIGHT?  
      YES [ ] NO [ ]

3) CHRONIC MEDICAL PROBLEMS (DIABETES, HTN, HEART DISEASE):  
   [ ]

4) MEDICATIONS:  
   NONE

5) ARE YOU ABLE TO WALK UNASSISTED?  
   YES [ ] NO [ ]

6) ARE YOU ABLE TO FEED YOURSELF?  
   YES [ ] NO [ ]

7) ALLERGIES:  
   [ ]

8) PULSE: 100  
   BLOOD PRESSURE: 108/88  
   RESPIRATORY RATE: 16  
   WEIGHT: 175  
   HEIGHT: 5'7"

SIGNATURE: [Redacted]

A YES TO QUESTIONS 1-4 REQUIRES REFERRAL TO MD OR PA, UNLESS MINOR PROBLEM. 
FOR QUESTION 1, A NO TO QUESTION 6 OR 7 ALSO REQUIRES MD/PA EVALUATION.

MD/PA FOLLOW UP NOTE

DATE: 5/4/04

ASSESSMENT: Refer to SP 600 dated 5/4/04

RECOMMENDATIONS:

SIGNATURE: [Redacted]
### MEDICAL RECORD

<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/28/74</td>
<td>1. Documented by medic for evaluation and report.</td>
</tr>
<tr>
<td>6/18/74</td>
<td>He was hit on the head repeatedly and hit on right side.</td>
</tr>
<tr>
<td>6/20/74</td>
<td>1. Shingles. No reports. 2. Had an appendectomy 3 weeks ago.</td>
</tr>
<tr>
<td>7/28/74</td>
<td>Otherwise stable. Was obtained through interpreter.</td>
</tr>
<tr>
<td>8/12/74</td>
<td>2. Urinalysis of AMO vs. clinical/interpretation. Gait - NL</td>
</tr>
<tr>
<td></td>
<td>Height - 6'2&quot;. Body weight: 160. Current height appears to be 66&quot;.</td>
</tr>
<tr>
<td></td>
<td>Chiro: O.K.</td>
</tr>
<tr>
<td></td>
<td>SH: 1. Pinky fingers showed swelling. 2. Need to testicles &amp; scrotal masses.</td>
</tr>
<tr>
<td></td>
<td>MED: 9. Integumentary -</td>
</tr>
<tr>
<td></td>
<td>Allergies: None.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOSPITAL OR MEDICAL FACILITY</th>
<th>STATUS</th>
<th>DEPARTMENT/SERVICE</th>
<th>RECORDS MAINTAINED AT</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SPONSOR'S NAME</th>
<th>SSN/ID NO.</th>
<th>RELATIONSHIP TO SPONSOR</th>
</tr>
</thead>
</table>

**PATIENT'S IDENTIFICATION: (For typed or written entries, given Name - last, first, middle; ID No. or SSN; Sex; Date of Birth; Race/Gender) | REGISTER NO. | WARD NO. |

**ISN #** 0(9)-4

**COMPOUND #**

---

**FOR OFFICIAL USE ONLY**

**LAW ENFORCEMENT SENSITIVE**

**MEDCOM - 738**

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

**Medical Record**

**STANDARD FORM 600 (REV. 6-87)**

**Prescribed by GSA/CMR**

**FIRMR (41 CFR) 201-9.202-1**

**USAFA V2.00**

**EXHIBIT D**
**Detainee Preinterrogation Evaluation**

**Date:** 23 Nov 01

**Patient Complaint/Concerns:**
- 30 y/o 8 detained who reports 23 days ago receiving maltreatment for 3 days at the Milan airport

**ALLERGIES:**

- **MEDS:**
  - **SCHX:** Tob: 0
  - **PSHx:** A & A

**BP:** 124/78

**P:** 84

**R:** 16

**WEIGHT:** 76 kg

**O:**
- **GENERAL:** Normal
- **HEENT:** Normal
- **NECK:** Normal
- **LUNGS:** Normal
- **CARDIAC:** Normal
- **ABDOMEN:** Normal
- **EXTREMITIES:** Scar (2) similar take, well healed compared to prior appearance per pt

**PMHx:**
- **HTN:** Y
- **DM:** Y
- **TB:** Y
- **CAD:** Y

**RX:**
- Hep A, Hep B, MMR, Td: Given (Patient Refused)

**MD:**
- Hepatitis
- Phlebitis
- Td: Given

**Occurrence:**
- CID 325-650 mg 84-64 H
- Mon Headache

**Sex:** M

**Date:** 1974

---

**Notes:**
- Initial: M.C. UXAF
- Initial: M.D.
<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>31. May</td>
<td>S. Deyle, Detained refused by CSR to complete</td>
</tr>
<tr>
<td>6/5</td>
<td>H + P</td>
</tr>
<tr>
<td>15/5/94</td>
<td>broken by elevator doors. He reports he was hit by</td>
</tr>
<tr>
<td>8/5</td>
<td>and on his or shoulder, he has a scar where they</td>
</tr>
<tr>
<td>T. 1/9/94</td>
<td>Located him. Otherwise his or legs to include</td>
</tr>
<tr>
<td>R. 18</td>
<td>&amp;</td>
</tr>
</tbody>
</table>

**Medical Record**

- **Hospital or Medical Facility**: [Redacted]
- **Status**: [Redacted]
- **Department/Service**: [Redacted]
- **Records Maintained At**: [Redacted]
- **Sponsor's Name**: [Redacted]
- **SSN**: [Redacted]
- **Relationship to Sponsor**: [Redacted]
- **Register No.**: [Redacted]
- **Ward No.**: [Redacted]

**Chronological Record of Medical Care**

- **Medical Record**
  - **Standard Form 600 (Rev. 6-97)**
  - **Prescribed by USAF/CODRR**
  - **Firm**: (41 CFR 201-6, 202-1)
  - **USAFA V1.00**
  - **FOR OFFICIAL USE ONLY**
  - **MEDCOM - 740**

**Patient Identification**

- **Name**: [Redacted]
- **SSN**: [Redacted]
- **DOB**: [Redacted]
- **Unit**: [Redacted]
Primary Survey

Airway: Patent, Mechanically Maintained.

Breathing: Spontaneous, Auscultated.

Circulation: Pulsus Palpable. Abnormal. CPR.

Color: Normal. Abnormal.

Cap refill: Normal. Delayed.

Secondary Survey

Initial Vital Signs: Ht 5'5, Wt 200, Pulse 115, Resp 20, Blood Pressure 90/60, Temp 98.8.

Jaw Worn: A+OD, A-OS.

HR: Regular, 94/min.

RR: 20, tidal volume adequate, no paradox.

SpO2: 94% on room air.

Primary survey:

Chest:

Chest X-ray: Normal, no evidence of trauma, no fractures.

Orthostatic test:

Blood Pressure: 120/80.

Respiratory Rate: 20.

Temperature: 98.8.

Glasgow Coma Score:

Eye Opening:

- Spontaneous: 4
- To Pain: 3
- No Pain: 1

Verbal Response:

- Spontaneous: 4
- Inappropriate: 3
- Inaudible/Inaudible: 2
- None: 1

Motor Response:

- Spontaneous: 5
- Localizes Pain: 4
- Withdraws to Pain: 3
- Extends to Pain: 2
- None: 1

Total: 15

Ranking Trauma Score:

- [Glasgow Coma Score]
- [Systemic Blood Pressure] 70-90
- [Respiratory Rate] 18-24

Total: 16

For:

MEDCOM - 741

33
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Cage #</th>
<th>Detainee Name</th>
<th>Name:</th>
<th>DOB</th>
<th>Age</th>
<th>Physician</th>
<th>Unit:</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>4/4/2004</td>
<td></td>
<td>#4</td>
<td></td>
<td></td>
<td>22/feb</td>
<td>72</td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>BP</th>
<th>Pulse</th>
<th>Resp</th>
<th>Temp</th>
<th>Height</th>
<th>Weight</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>175</td>
<td></td>
</tr>
</tbody>
</table>

### Allergies or any medications: YES [X] NO

### Currently taking any medications: YES [X] NO

### Has been on a diet or medication? YES [X] NO

### Past Medical History: YES [X] NO

### Past medical history, if any: [ ]

### Past surgical history: YES [X] NO

### History of drug use: YES [X] NO

### Current medications: YES [X] NO

### Communicable Diseases: YES [X] NO

### Communicable diseases, if any: [ ]

### Symptoms, if any: [ ]

### Physical Exam:

#### Height:

#### Lungs:

#### Heart:

#### Abdomen:

#### Skin:

### Identifying Marks:

### Fit for Questioning? YES [X] NO

### Remarks:

- Severe allergy
- New Long back

---

For official use only / Law enforcement sensitive
<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screener, Team #</td>
<td>DTG:</td>
</tr>
<tr>
<td>Capture Tag Number</td>
<td>Capturing Unit</td>
</tr>
<tr>
<td>Biographical Information</td>
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<tr>
<td>First:</td>
<td>Middle:</td>
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<td>Last:</td>
<td>Nickname:</td>
</tr>
<tr>
<td>Sex:</td>
<td>F</td>
</tr>
<tr>
<td>DOB/POB:</td>
<td>28 Feb 90, Mosul</td>
</tr>
<tr>
<td>Mental Status:</td>
<td>S</td>
</tr>
<tr>
<td>Spouse Name:</td>
<td></td>
</tr>
<tr>
<td>Children/Name/Age</td>
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</tr>
<tr>
<td>Religion:</td>
<td>SUNNI MUSLIM</td>
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<td>Citizenship:</td>
<td>IRAQI</td>
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<td>Nationality:</td>
<td>IE</td>
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<td>Tribe:</td>
<td>AL SABAWI</td>
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<tr>
<td>Ethnicity:</td>
<td>ARAB</td>
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<td>Weight:</td>
<td></td>
</tr>
<tr>
<td>Hair Color:</td>
<td></td>
</tr>
<tr>
<td>Home address:</td>
<td>AL KARAMA, Mosul, TGT 121</td>
</tr>
<tr>
<td>Phone #:</td>
<td></td>
</tr>
<tr>
<td>Lives with:</td>
<td>WIFE, KIDS, MOTHER</td>
</tr>
<tr>
<td>Reason for Capture (Target #, Known Extremist/Terrorist......)</td>
<td>TGT 121</td>
</tr>
<tr>
<td>Capture Data</td>
<td>Place of Capture: TGT 121</td>
</tr>
<tr>
<td>Date/Time of Capture</td>
<td>Captured Documents/Currency</td>
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<tr>
<td>Captured Documents/Currency:</td>
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</tr>
<tr>
<td>Captured Weapons/Equipment:</td>
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</tr>
<tr>
<td>Circumstances of Capture / Mission at time of capture:</td>
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<tr>
<td>Education</td>
<td>EXHIBIT:3</td>
</tr>
</tbody>
</table>

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MEDCOM - 743
Level of Education: 9th Grade  
Degree:  
School:  
Specialized Training: Electrician  
Language Proficiency  1 = Native  2 = Good  3 = Poor  
Lang: Arabic  2  2  1  
Employment  
Current  Nineva Power Plant  
Duties  Electrician  
Location  Nineva, MOSUL  
Previous  
Duties  
Location  
Previous  
Duties  
Location  
Additional Skills  
Military Service  
Branch of Serv: Army  
Rank: PVT  
Service Number:  
Military Training: Driver  
Military Experience  
Full Unit Designation: Kobil Basic Training (Inf)  
Dates: 05 Mar 88 - 90  
Duty Pos: Driver  
Add Duties:  
Full Unit Des:  
Dates:  
Duty Pos:  
Add Duties:  
Full Unit Des:  
Dates:  
Duty Pos:  
Add Duties:  
Category (1A = Highest / 3C = Lowest):  
Cooperation: 1  
Knowledge: A  
Screeen Observations  
Physical Condition: Good  
Mental State: Alert  
Attitude:  
Additional Observations:  
Recommended Approach:  
Screeen Comments:  

EXHIBIT: 3  
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MEDCOM - 744
SCRENNING REPORT

Screener, Team #: 0384
Capture Tag Number: 0394
Capturing Unit:

Biographical Information

First: 0384
Middle: 0384
Last: 0384
Nickname:
Sex: M / F DOB/POB: 22 Feb 70 Mosul Karana
Marital Status: S W Spouse Name:
Children/Name/Age: 6 kids
Religion: Sunni
Citizenship: 1 Z
Nationality: 1 Z
Ethnicity: Arab
Height: 173 Weight: 675 Hair Color: black

Home address: A1 karana Mosul
Phone #: NA
Lives with: Mother, wife and kids

Reason for Capture (Target #, Known Extremist/Terrorist....)
- DM/CS

Capture Data

Date/Time of Capture
Place of Capture
Captured Documents/Currency:
Captured Weapons/Equipment:
Circumstances of Capture / Mission at time of capture:

EXHIBIT: 3

For Official Use Only / Law Enforcement Sensitive

MEDCOM - 745
<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>197427</td>
<td>Valium 5mg. T. po q HS prescriber: max 3 tabs/week</td>
</tr>
</tbody>
</table>

**EDICAL RECORD**

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

<table>
<thead>
<tr>
<th>DATE</th>
<th>SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)</th>
</tr>
</thead>
<tbody>
<tr>
<td>197427</td>
<td>Valium 5mg. T. po q HS prescriber: max 3 tabs/week</td>
</tr>
</tbody>
</table>

**SPECIAL OR MEDICAL FACILITY**

**STATUS**

**DEPARTMENT**

**RECORDS MAINTAINED AT**

**IDENTIFICATION**

<table>
<thead>
<tr>
<th>NAME</th>
<th>SSN/ID NO.</th>
<th>RELATIONSHIP TO SPONSOR</th>
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<tbody>
<tr>
<td>Impound V-A</td>
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</table>

**For Official Use Only / Law Enforcement Sensitive**

**EXHIBIT: 3**

**MEDCOM - 746**
<table>
<thead>
<tr>
<th>Date: 19 May 04</th>
<th>Patient Complaint / Concerns</th>
<th>Allergies:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Heart Complaint</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>BP: 126/74</th>
<th>P: 84</th>
<th>R: 16</th>
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<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Weight: 73kg</th>
<th>O:</th>
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<table>
<thead>
<tr>
<th>General:</th>
<th>Normal</th>
<th>Abnormal</th>
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<tr>
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<table>
<thead>
<tr>
<th>Head &amp; Eye:</th>
<th>Normal</th>
<th>Abnormal</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Neck:</th>
<th>Normal</th>
<th>Abnormal</th>
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<table>
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<tr>
<th>Lungs:</th>
<th>Normal</th>
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<table>
<thead>
<tr>
<th>Cardiac:</th>
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<th>Abnormal</th>
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<table>
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<tr>
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<th>Normal</th>
<th>Abnormal</th>
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<table>
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<tr>
<th>Extremities:</th>
<th>Normal</th>
<th>Abnormal</th>
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</thead>
<tbody>
<tr>
<td></td>
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</table>

PMHx: HT: Y N | Cardiac: Normal Abnormal |
| DM: Y N     | Abdomen: Normal Abnormal |
| TB: Y N     | Extremities: Normal Abnormal |

| A/P: 0: Legam 0: Episodic Anxiety |
| Hep A, Hep B, MMR, Td: Given / Patient Refused |

Medication taken: Valium 3mg 7po of HS p.r.n. Stress level. May = Next 12 months.

Timothy J. Knorr, M.D.
Major, USAF, MC

ISN: [ ] Sex: M

Camp: [ ] DOB: 1978

Exhibit: 3
DATE: 8/31/94

NAME:   AGE: 37   HEIGHT: 5'8"   WEIGHT: 150

ALLERGIES:   NO   YES:   Glen glory

MEDICATIONS:   None

MEDICAL HISTORY:   ○ ASTHMA,   ○ DIABETES,   ○ HEART DISEASE,   ○ TUBERCULOSIS,   ○ OTHER INFECTIOUS

DISEASES:   OPIUM USE

SMOKER:   YES   NO

EXAM:

P: 100   BP: 140/90   APPEARANCE:   ○ HEALTHY,   ○ MALNOURISHED,   ○ ILL

HEENT:   PERCU   CHEST:   ○ 7/8

CV:   MURMUR,   collateral,   ABIOM:   0/10   S/N: 0   L: 0/10

MS:   Score P: 0   Skin:   0

DENTAL:

GENERAL ASSESSMENT:

SIGNED:   [Signature]

MEDICAL OFFICER:

SICK CALL:

DATE: 8/24/94   COMPLAINT:   Chest muscle pain with lateral chest X-rays

DIAGNOSIS:   P: 100   BP: 110/70

MEDICATIONS:   None

DATE: 8/25/94

DISCHARGE NOTE:   NO CHANGE IN HEALTH STATUS

SIGNED:   [Signature]

MEDICAL OFFICER:

10/24/94   [Signature]

MEDCOM - 748
<table>
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<td>T</td>
<td></td>
</tr>
<tr>
<td>PULSE OX</td>
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<tr>
<td>ALLERGIES</td>
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<tr>
<td>WM/N</td>
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<td>MEDS</td>
<td></td>
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<tr>
<td>PSH</td>
<td></td>
</tr>
<tr>
<td>FMH</td>
<td></td>
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</tbody>
</table>

**Symptoms, Diagnosis, Treatment, Treating Organization:**

- 3 fractures of ribs, but who breath table/chest hurts
- breath w/f/vue e/o lung problems x chest but from bre

**Other Notes:**

- X ray only needed.
DATE: 09 May 04
NAME: 
AGE: 30
HEIGHT: 180cm
WEIGHT: 90

ALLERGIES: X NO  O YES: ____________________________

MEDICATIONS: ____________________________

MEDICAL HISTORY:  O ASTHMA,  O DIABETES,  O HEART DISEASE,  O TUBERCULOSIS,  O OTHER INFECTIOUS
DISEASES: X NO  O YES: OPIUM USE

SMOKER: X YES  O NO

EXAM:
P: 102  BP: 114/88 APPEARANCE:  O HEALTHY,  O MALNOURISHED,  O ILL
HEENT:  O PCIe
CHEST:  O/0  O/0  CTA
CV:  RRR
ABDOMEN:  3/4 T
MS:  IVIV
SKIN:  1/0
DENTAL:  O Good  O Poor  O/0  O Other: Treatment

GENERAL ASSESSMENT:  C good -

SIGNED:  SS
[CLS, 91 W]
MEDICAL OFFICER:  [CLS, 91 W]

SICK CALL:
DATE: 09 May 04
COMPLAINT:  O Chf Fx - C/T  O Sore Throat  O Abnormal Breathing  O Shortness of Breath  O Headache  O Other
DX/IX:

11 May 04: Reports being beaten by U.S. forces about 3 weeks ago with resultant pain of chest and where leg reports electric shocks applied to leg again

Exam:  DFSC. EXAM, OP 0.6, 0.8 of lesion. No CAT = conjunctival hemorrhages. Can't intact heart RRR & IV 0.02. Chest CTA 0. Gauze expansion & TTP over internal chest wall. No healing oozes anywhere. Scattered insect bites. Gait: Speed, Walk.

DISCHARGE NOTE:  O NO CHANGE IN HEALTH STATUS
DATE: 09 May 04
will give Matrix PAN

No pain medicine
Chf on breathing
CFT, MC

12 May 04: No obvious ms changes

OVER FOR 12 May 04
Exam

MEDCOM - 750
NAME:  
AGE: 37  
HEIGHT: 5'8"  
WEIGHT: 150

MEDICATIONS: ☐ NO  ☐ YES  ☐ not prescribed  ☐ not due now

MEDICAL HISTORY: ☐ ASTHMA  ☐ DIABETES  ☐ HEART DISEASE  ☐ TUBERCULOSIS  ☐ OTHER INFECTIOUS

DISEASES:  ☐ OPID USE

SMOKER: ☐ YES  ☐ NO

P: 150  BP: 140/94  APPEARANCE: ☐ HEALTHY  ☐ MALNOURISHED  ☐ ILL

HEENT:  ☐ RAPID  CHEST:  ☐ PTA

CV:  ☐ PUMP  STAGGER  BLOOD ABNORMALITIES  ☐ WEAK  SKIN  ☐ JERKY

MS:  ☐ TAN  SKIN  ☐ FLORAL

DENTAL: ☐ OK  TREATED  ☐ NOT TREATED  ☐ REQUIRES FURTHER TREATMENT

GENERAL ASSESSMENT:

SIGNED: ☐ ☐ MEDICAL OFFICER: ☐  
(CLS, 911W)  ☐  
(MC, DC, MS)

SICK CALL:

DATE:  
COMPLAINT:  
DX.mx: 

DISCHARGE NOTE: ☐ NO CHANGE IN HEALTH STATUS  
DATE:  

SIGNED: ☐  ☐ MEDICAL OFFICER: ☐  
(CLS, 911W)  ☐  
(MC, DC, MS)
**Detainee Medical Screening Form**

**Date:** 1/2/2017

**Name:**

**Be:** 30, **Height:** 180, **Weight:** 90

**Allergies:**

**Medications:**

**Medical History:**

- **Asthma:**
- **Diabetes:**
- **Heart Disease:**
- **Tuberculosis:**
- **Other Infectious Diseases:**

**Opium Use:**

**Smoker:**

**Exam:**

- **P. 102 BP 148/80**
- **Appearance:**
- **Healthy,** **Maldnourished,** **I'll**
- **Chest:**
- **CXR**
- **Abdomen:**
- **Skin:**

**Dental:**

**General Assessment:**

**Sign:**

**Medical Office:**

**Sick Call:**

**Date:**

**Complaint:**

- **1/2/2017**
- **C. E. E.**
- **N 5-1**
- **Chronic* Tension**

**Exam:**

- **PERC, EOMI, OLEA of lesions, NECAT, no conjunctival hemorrhage. CNS intact.**
- **Heart RRR, D+V, Chest CTA 1 cm expansion, 4 D+P over lateral chest wall. No healing eczema anywhere. Scattered insect bites. Gait aperistaltic.**

**Discharge Note:**

- **No change in health status**

**Sign:**

**Medical Office:**

**CPT, MC**

---

**MEDCOM - 752**
<table>
<thead>
<tr>
<th>EPW/CI Location</th>
<th>Birth Date</th>
<th>Sex</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>T-TRANSFER</td>
<td>1979/01/01</td>
<td>M</td>
<td>69</td>
<td>154</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Condition</th>
<th>Education</th>
<th>Religion</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-ELEMENTARY SCHOOL</td>
<td>33-SUNNI-ISLAM</td>
<td></td>
<td>M-MARRIED</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Distinguishing Marks:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Remarks</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Hair Color</th>
<th>Eye Color</th>
<th>Race</th>
<th>Blood Type</th>
<th>Diet</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X-OTHER</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Examination Information**

<table>
<thead>
<tr>
<th>Examination Number</th>
<th>Date</th>
<th>Time</th>
<th>Exam Category</th>
<th>Type of Case</th>
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<tbody>
<tr>
<td>15198901</td>
<td>2004/03/02</td>
<td>9:02:07 PM</td>
<td>AL-TO BE DEFINED</td>
<td>BC-TO BE DEFINED</td>
</tr>
</tbody>
</table>

**Diagnosis**

Please see attached page

**Disposition**

<table>
<thead>
<tr>
<th>Disposition Type</th>
<th>Disposition Date</th>
<th>Disposition Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2004/03/03</td>
<td>12:00:00 AM</td>
</tr>
</tbody>
</table>

**Immunizations**

**Medical Officer Performing Exam**

---

**FOR OFFICIAL USE ONLY**

Law Enforcement Sensitive

MEDCOM - 753

EXHIBIT 18
S: Earache primary to injury in a fight x 2 days

0: Erythema present

A: Otitis externa

P: Tylenol 500 mg tid x 5 days, Gentec ointment bid x 3 days, Augmentin 500 mg bid x 5 days
<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name, MI</th>
<th>Internment Serial Num.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>EFW/CI Location</th>
<th>BirthDate</th>
<th>Sex</th>
<th>Height</th>
<th>Weight</th>
</tr>
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<tbody>
<tr>
<td>T-TRANSFER</td>
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<td>M</td>
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<tbody>
<tr>
<td>B-ELEMENTARY SCHOOL</td>
<td>33-SUNNI-ISLAM</td>
<td>X-MARRIED</td>
<td></td>
</tr>
</tbody>
</table>

| Distinguishing Marks: | |
|-----------------------||

<table>
<thead>
<tr>
<th>Remarks</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Hair Color</th>
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<th>Diet</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>X-OTHER</td>
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<table>
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<tr>
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<tr>
<th>Immunizations</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Medical Officer Performing Exam
S: tried to hang himself in tent, spent one minute suspended; x 20, p 92, no abrasions on neck, lungs clear

A: Major depression

P: Restraints x 2 h, 5 mg fast aci, haloperidol IM, 40 mg qd Paxil x 30 d
<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name, MI</th>
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</tr>
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<tbody>
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<table>
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<tr>
<th>Comments</th>
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Medical Officer Performing Exam
S: c/o MP's beating him up: no abrasions found anywhere (ankles, wrists, elbows, etc.) no lacerations, no contusions
A: depression (pt has hx of depression)
P: continue to monitor
Medic witnessed incident and states that the MP's took the detainee to the ground in order to handcuff him because he was resisting them. Pt. has been refusing rx's.
<table>
<thead>
<tr>
<th>** Last Name **</th>
<th>** First Name, MI **</th>
<th>** Intermum Serial Num. **</th>
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<tbody>
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<th>** Sex **</th>
<th>** Height **</th>
<th>** Weight **</th>
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** Distinguishing Marks: **

** Remarks: **

<table>
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<th>** Time **</th>
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<th>** Type of Case **</th>
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** Diagnosis: ** Please see attached page

** Disposition Information: **

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<th>** Disposition Date **</th>
<th>** Disposition Time **</th>
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<tbody>
<tr>
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<td>2004/03/19</td>
<td>12:00:00 AM</td>
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** Immunizations: **

Medical Officer Performing Exam
S: corn on rt foot O: corn on foot A: removal of plantar corn needed P: removal under LA, keflex 500 mg qid x 5d, tylenol 500 tid x 5d
S: Suture removal right foot
O: Wound healing appropriate
A: Sutures need removed
P: Sutures removed
<table>
<thead>
<tr>
<th>Diagnosis (From Page 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>S: corn</td>
</tr>
<tr>
<td>O: corn on R foot</td>
</tr>
<tr>
<td>A: needs removal</td>
</tr>
<tr>
<td>P: surgical removal under LA, 5cc Marcaine, 4 sutures</td>
</tr>
<tr>
<td>Amoxicil 500 tid x 7d, tylenol 500 tid x 5d, dsg chge 8 Apr, sut rem 11 Apr</td>
</tr>
</tbody>
</table>
Last Name | First Name, MI | Internment Serial Num.
--- | --- | ---
N/A | N/A | N/A

EPW/CI Location | Birth Date | Sex | Height | Weight
--- | --- | --- | --- | ---
T-TRANSFER | 1979/01/01 | M | 69 | 154

Physical Condition | Education | Religion | Marital Status
--- | --- | --- | ---
B-ELEMENTARY SCHOOL | 33-SUNNI-ISLAM | M-MARRIED

Distinguishing Marks:

Remarks

Hair Color | Eye Color | Race | Blood Type | Diet
--- | --- | --- | --- | ---
X-OTHER | X-OTHER | X-OTHER | X-OTHER | X-OTHER

Examination Information

Examination Number | Date | Time | Exam Category | Type of Case | Comments
--- | --- | --- | --- | --- | ---
15198907 | 2004/04/06 | 9:15:57 AM | AI-TO BE DEFINED | BC-TO BE DEFINED | Please see attached page

Diagnosis

Please see attached page

Disposition Type | Disposition Date | Disposition Time
--- | --- | ---
| 2004/04/11 | 12:00:00 AM

Immunizations

Medical Officer Performing Exam
S: dag change
O: wound dirty
A: 0 s/s infection
P: dag changed, returned to sick call 11APR04 for suture removal
<table>
<thead>
<tr>
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<th>Internment Serial Num.</th>
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<th>Race</th>
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<td>2:49:14 PM</td>
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<table>
<thead>
<tr>
<th>Immunizations</th>
</tr>
</thead>
</table>

Medical Officer Performing Exam

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

MEDCOM - 768
Diagnosis (From Page 1)

S: Day 1chg to R foot
O: Suture p surgery
A: Healing wound s infection
P: Cleaned and dressed as ordered
**EPW/CI Medical Report**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name, MI</th>
<th>Internment Serial Num.</th>
</tr>
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</table>

<table>
<thead>
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**Distinguishing Marks:**

**Remarks**

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<th>Diet</th>
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**Examination Information**

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**Diagnosis**

Please see attached page

**Disposition**

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<tr>
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**Immunizations**

Medical Officer Performing Exam
Diagnosis (From Page 1)

S: DSG CHNG, S/P CORN REMOVAL
O: GOOD MARGIN/GRANULATION, O S/S INF. NOTED
A: SUTURE REMOVAL & DRSG CHNG
P: BACTRACIN APPLIED DSG CHNG, LOCALIZED CLEANSING, RTC IF S/S INF NOTED
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<tbody>
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<td>Race</td>
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<td>Immunizations</td>
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<tr>
<td>Medical Officer Performing Exam</td>
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</tbody>
</table>
S: MULTIPLE SMALL SEBACIOUS CYSTS IN THE FACE AND BOTH EYELIDS

O:

A: REMOVAL OF SEBACIOUS CYSTS

P: KEFLEX CAP 250MG QID 5D
   IBUPROFEN 800MG TID 5D
<table>
<thead>
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<th>Height</th>
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<tbody>
<tr>
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**Diagnosis**

Please see attached page

**Disposition**

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<tbody>
<tr>
<td></td>
<td>2004/04/15</td>
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**Immunizations**

Medical Officer Performing Exam
S: dsg change, some pain
O: wound open, stitches removed, 0 s/s infection
A: needs dsg change
P: IB 800mg TID x5d, dsg changed
<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name, MI</th>
<th>Internment Serial Num.</th>
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<tbody>
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| Distinguishing Marks: |

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Diagnosis

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Immunizations

Medical Officer Performing Exam

---

FOR OFFICIAL USE ONLY
Law Enforcement Sensitive

MEDCOM - 776
refill meds: paxil 20mg bid--16 pills for 8 days
<table>
<thead>
<tr>
<th>Last Name</th>
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**Remarks**

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**Diagnosis**

Please see attached page

**Disposition**

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</table>

**Immunizations**

Medical Officer Performing Exam

---

*FOR OFFICIAL USE ONLY*

Law Enforcement Sensitive

MEDCOM - 778
S: o/n/v dizziness, tooth pain
O: 0 emesis noted
  bp 120/96, p 80, t 98.7, r 20, ps02 98%
A: dyspepsia
P: zantac 150mg bid x14d
  acetaminophen 500mg bid x14d
**LIST ANY YES RESPONSES IN RAMARKS SECTION ON REVERSE SIDE OF FORM**

**DATE:** 7/26/04

**AGE:** 23

- [ ] (Y) Allergies
- [ ] (Y) Recent illness/injury
  - [X] Left Thigh/Groin
- [ ] (Y) Dental Problems
- [X] Pain
- [ ] (Y) History of psychological problems (Date)
- [X] Chronic health problems or infectious diseases
- [ ] (Y) Previous Suicide Attempts (Date)
- [ ] Females only; Are you pregnant?
- [X] History of alcohol abuse/treatment (Date)
- [X] Current medications
- [ ] Current physical complaint(s)
  1. Cough/Sputum Production
  2. Rash
  3. Diarrhea/Vomiting
  4. Night sweats
  5. Pain
  6. Exposure to TB
  7. Lice/Other infestation
  8. Contagious disease in the past 12 months?
  9. Other:

---

**FOR MEDICAL PERSONNEL USE ONLY**

**DETAINEE'S INITIALS:**

**HIV/TUBERCULOSIS QUESTIONNAIRE**

Do you have a history or, do you presently have any of the following symptoms or conditions:

- [X] Persistent cough/shortness of breath
- [X] Cough with blood and/or dry cough
- [X] Unexplained weight loss/diarrhea X 2 weeks
- [X] Unexplained persistent fever
- [X] Night Sweats
- [X] Swollen glands/lymph nodes
- [X] Prolonged fatigue or run-down feeling
- [X] Loss of appetite and or white patches in mouth
- [X] Recent exposure to someone with TB
- [X] Past abnormal X-Ray (Date)
- [X] Hepatitis B series completed
- [X] Previous TB infection or treatment
- [ ] Stomach surgery, Kidney failure, Blood disorders
- [ ] Scars, birthmarks, tattoos:
  1. 
  2. 
  3. 
  4. 
  5. 
  6. 

---

**PATIENT'S IDENTIFICATION**

**RECORDS MAINTAINED AT:**

**FOR OFFICIAL USE ONLY**

**Sponsor:**

**STATUS:**

**RANK/GRADE:**

**ORGANIZATION:**

---

**DETAINEE:**

**SEX:**

---

**MEDCOM - 780**
### PHYSICAL APPEARANCE

<table>
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<tr>
<th>Clean, well groomed</th>
<th>(Y) (N)</th>
<th>Tremors, sweating</th>
<th>(Y) (N)</th>
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</thead>
<tbody>
<tr>
<td>Rashes, needle marks</td>
<td>(Y) (N)</td>
<td>Exposure to tuberculosis</td>
<td>(Y) (N)</td>
</tr>
<tr>
<td>Body deformities</td>
<td>(Y) (N)</td>
<td>Infestations</td>
<td>(Y) (N)</td>
</tr>
<tr>
<td>Cuts, bruises, lesions</td>
<td>(Y) (N)</td>
<td>Confinement Phys. Date:</td>
<td></td>
</tr>
</tbody>
</table>

### VITAL SIGNS

- Weight: 57.5
- Height: 67.0
- Temp: 97.5
- B/P: 120/78
- Pulse: 70
- Resp: 20

<table>
<thead>
<tr>
<th>PPD given:</th>
<th>HIV drawn:</th>
<th>RPR drawn:</th>
</tr>
</thead>
</table>

**Physical Exam:** Within normal limits
- Head: (Y) (N)
- Lungs/Chest: (Y) (N)
- LAB (If available)
- Back: (Y) (N)
- CBC:
- Heart: (Y) (N)
- U/A:
- Extremities: (Y) (N)
- Chest X-Ray: [Image]

**MENTAL STATUS**
- Alert, well oriented (Y) (N)
- Long and short term memory intact
- Experiencing hallucinations, delusions, or feelings of paranoia
- Calm, cooperative

### DISPOSITION

- Cleared for basic transfer procedures (Y) (N)
- Cleared for litter transfer procedures
- NOT medically cleared for transfer 3 days (days/weeks)

**Recommended type of confinement:**
- Normal
- Solitary
- Other: Explain

I do not have any SUICIDAL and or HOMICIDAL feelings at this time. If I develop any such ideas or plans, I will notify a staff member before acting on such feelings or ideas. (SIGH)

Date/Time Information transmitted to component surgeon's office

Infection Control recommendations
- Standard Precautions
- Contact/Droplet Precautions
- Airborne Precautions

### SCREENER

MEDICAL STAFF SIGNATURE

SCREENER

MEDICAL STAFF SIGNATURE

FOR OFFICIAL USE ONLY

MEDCOM - 781

Exhibit 3