Standard Form 89
Revised August 1965
Prescribed by Bureau of the Budget
FPMR (41 CFR) 101-11.4

REPORT OF MEDICAL HISTORY

THIS INFORMATION IS FOR OFFICIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
Wichtrich, Alfonso Rudolph	07	
Toltca Highway Klm 19 1/2, El Magueyito, Cuajimalpa, Mexico, D.F.	5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
7. SEX: M	8. RACE: White	9. BRANCH OF SERVICE: Military 6 Civilian 1 1/2	10. DEPARTMENT, AGENCY, OR SERVICE	11. ORGANIZATION UNIT
12. DATE OF BIRTH: Oct 30 1915	13. PLACE OF BIRTH: Chihuahua, Chih, Mex.	14. NAME, RELATIONSHIP AND ADDRESS OF NEXT OF KIN: Rae Wichtrich - Wife - Same as above.
10	15. EXAMINING FACILITY OR EXAMINER'S ADDRESS	06 16. OTHER INFORMATION: W. 185 Ht. - 6'3" (2/17/53)

17. STATEMENT OF EXAMINEE'S PRESENT HEALTH IN OWN WORDS. (Follow by descriptions of past illnesses, if complete enter)

Health normal - feel fine - no complaints.

18. FAMILY HISTORY

RELATION	AGE	STATE OF HEALTH	IF DEAD CAUSE OF DEATH	AGE AT DEATH
FATHER			Pneumonia	86
MOTHER			"	76
SPOUSE	46	Normal		
BROTHERS AND SISTERS	53	"		
	52		Tuberculosis	52
	51	"		
	50	"		
			Combat W.W II	33
CHILDREN	22	Excellent		
	19	"		
	14	"		
	12	"		
	8	"		

19. HAS ANY BLOOD RELATION (Parent, brother, sister, other than husband or wife)

YES	NO	(Check each item)	RELATION
X		HAD TUBERCULOSIS	Sister
	X	HAD SYPHILIS	
X		HAD DIABETES	Mother
	X	HAD CANCER	
	X	HAD KIDNEY TROUBLE	
	X	HAD HEART TROUBLE	
	X	HAD STOMACH TROUBLE	
	X	HAD RHEUMATISM	
	X	HAD ASTHMA, HAY FEVER, HIVES	
	X	HAD EPILEPSY (Fits)	
	X	COMMITTED SUICIDE	
	X	BEEN INSANE	

20. HAVE YOU EVER HAD OR HAVE YOU NOW (Place check at left of each item)

YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)
X		SCARLET FEVER, ERYSIPELAS	X		GOITER	X		TUMOR, GROWTH, CYST, CANCER	X		TRICK OR LOCKED KNEE
X		DIPHTHERIA	X		T. B. (TUBERCULOSIS)	X		RUPTURE	X		FOOT TROUBLE
X		RHEUMATIC FEVER	X		SWOLLEN GLANDS (Neck, groin)	X		APPENDICITIS	X		NEURITIS
X		SWOLLEN OR PAINFUL JOINTS	X		ASTHMA	X		PILES OR RECTAL DISEASE	X		PARALYSIS (Any, kind)
X		MUMPS	X		SHORTNESS OF BREATH	X		FREQUENT OR PAINFUL URINATION	X		EPILEPSY OR FITS
X		WHOOPING COUGH	X		PAIN OR PRESSURE IN CHEST	X		KIDNEY STONE OR BLOOD IN URINE	X		CAR, TRAIN, SEA, OR AIR SICKNESS
X		FREQUENT OR SEVERE HEADACHE	X		CHRONIC COUGH	X		SUGAR OR ALBUMIN IN URINE	X		FREQUENT TROUBLE SLEEPING
X		DIZZINESS OR FAINTING SPELLS	X		PALPITATION OR POUNDING HEART	X		BOILS	X		FREQUENT OR TERRIFYING NIGHTMARES
X		EYE TROUBLE	X		HIGH OR LOW BLOOD PRESSURE	X		VENEREAL DISEASE	X		DEPRESSION OR EXCESSIVE WORRY
X		EAR, NOSE OR THROAT TROUBLE	X		CRAMPS IN YOUR LEGS	X		RECENT GAIN OR LOSS OF WEIGHT	X		LOSS OF MEMORY OR AMNESIA
X		RUNNING EARS	X		FREQUENT INDIGESTION	X		ARTHRITIS OR RHEUMATISM	X		BED WETTING
X		CHRONIC OR FREQUENT COLDS	X		STOMACH, LIVER OR INTESTINAL TROUBLE	X		BONE, JOINT, OR OTHER DEFORMITY	X		NERVOUS TROUBLE OF ANY SORT
X		SEVERE TOOTH OR GUM TROUBLE	X		GALL BLADDER TROUBLE OR GALL STONES	X		LAMENESS	X		USE OF DRUG OR NARCOTIC HABIT
X		SINUSITIS	X		JAUNDICE	X		LOSS OF ARM, LEG, FINGER, OR TOE	X		EXCESSIVE DRINKING HABIT
X		HAY FEVER	X		ANY REACTION TO SERUM, DRUG OR MEDICINE	X		TROUBLE OR STIFFNESS OF KNEE OR ELBOW	X		HOMICIDAL TENDENCIES

21. HAVE YOU EVER (Check each item)			22. FEMALES ONLY. HAVE YOU EVER—	23. COMPLETE THE FOLLOWING
X	WORN GLASSES	X	ATTEMPTED SUICIDE	BEEN PREGNANT	AGE AT ONSET OF MENSTRUATION
X	WORN AN ARTIFICIAL EYE	X	BEEN A SLEEP WALKER	HAD A VAGINAL DISCHARGE	INTERVAL BETWEEN PERIODS
X	WORN HEARING AIDS	X	LIVED WITH ANYONE WHO HAD TUBERCULOSIS	BEEN TREATED FOR A FEMALE DISORDER	DURATION OF PERIODS
X	STUTTERED OR STAMMERED	X	COUGHED UP BLOOD	HAD PAINFUL MENSTRUATION	DATE OF LAST PERIOD
X	WORN A BRACE OR BACK SUPPORT	X	BEEN RENDERED UNCONSCIOUS AFTER INJURY OR CONCUSSION	HAD IRREGULAR MENSTRUATION	QUANTITY ☐ NORMAL ☐ EXCESSIVE ☐ SCANTY

24. HOW MANY JOBS HAVE YOU HAD IN THE PAST THREE YEARS?	25. WHAT IS THE LONGEST PERIOD YOU HELD ANY OF THESE JOBS?	26. WHAT IS YOUR USUAL OCCUPATION?	27. ARE YOU (Check one)
1	MONTHS 14	Business Management	X RIGHT HANDED ☐ LEFT HANDED

4/Rs