

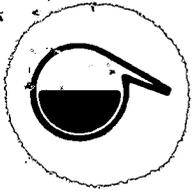
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MARYLAND MEDICAL LABORATORY INC.

Main Office: Pathology Building
1901 Sulphur Spring Road, P.O. Box 24080
Baltimore, Maryland 21227-0580

BALTO. AREA (301) 247-9100 / WASH. AREA (301) 596-0560

PATHOLOGISTS:
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TOXICOLOGISTS:
YALE H. CARLAN, Ph.D.
DAVID L. BLACK, Ph.D.
VIROLOGISTS/IMMUNOLOGISTS:
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HELENE M. PAXTON, M.A., M.T. (ASCP)

PHYSICIAN

NORTH ARUNDEL CARDIAC
FITNESS & CARDIAC REHAB.
CENTER
200 HOSPITAL DRIVE
GLEN BURNIE MD 21061

PATIENT

ONEILL, JOHN

(C-1)

PATIENT NAME	DATE	AGE	SEX	LAB NUMBER	LABORATORY REPORT
ONEILL, JOHN	11/22/85	33	M	A85726936	

CLINICAL MICROSCOPY:

COLOR===== YELLOW-MODERATE TURBIDITY SP. GRAV.=== 1.025
 PH===== 6.0 PROTEIN===== 3+
 GLUCOSE===== NEG. ACETONE===== 3+
 BILIRUBIN=== NEG. BLOOD===== NEG.
 LEUK. EST.== NEG.

MICROSCOPIC:

WBC/HPF===== 0 RBC/HPF===== 0
 EPITH. CELLS/HPF===== 0-2 MUCUS===== SLIGHT
 AMORPHOUS URATES===== MARKED

CONFIRMATORY TEST FOR PROTEIN IS 1+

CHEMISTRY:

LDH===== 154	UNITS(70-200)	GLUCOSE===== 86	MG/DL(65-115)
SGOT===== 30	UNITS(0-50)	CHOLESTEROL 196	MG/DL(152-237)
SGPT===== 25	UNITS(0-50)	BUN===== 10	MG/DL(8-22)
ALK PHOS=== 115	UNITS(35-130)	CREATININE= 1.2	MG/DL(0.9-1.4)
TOT. BILI== 1.4	MG/DL(0.2-1.4)	*BU/CR RATIO 8.3	(10-25)
DIR. BILI== 0.3	MG/DL(0.0-0.4)	*URIC ACID== 9.8	MG/DL(3.5-8.4)
*IND. BILI== 1.1	MG/DL(0.1-1.0)	CALCIUM===== 10.3	MG/DL(8.7-10.6)
TOT. PROT.== 7.9	GM/DL(6.3-8.2)	*PHOSPHATES= 1.7	MG/DL(2.7-4.6)
ALBUMIN===== 5.0	GM/DL(3.7-5.5)	SODIUM===== 137	MEQ/L(137-147)
GLOBULIN=== 2.9	GM/DL(1.8-3.5)	*POTASSIUM== 5.5	MEQ/L(3.7-5.3)
A/G RATIO== 1.72	(1.10-2.60)	CHLORIDE=== 104	MEQ/L(97-110)
		CO/2===== 28	MEQ/L(22-32)

TRIGLYCERIDE===== 133 MG/DL (57-214)
 HDL-CHOLESTEROL===== 32 MG/DL (28-63)
 % HDL-CHOLESTEROL===== 16.3 % (15-75)
 C-TOTAL/C-HDL RATIO===== 6.1

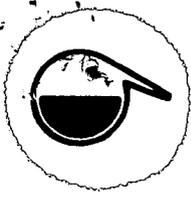
(CALCULATED RISK FACTOR *)
 (RATIO)
 ()
 (3.43) .5X)
 (4.97) 1X)
 (9.55) 2X)
 (23.39) 3X)

6-1-86
 ENCLOSURE
[Signature]

(* RISK FACTOR REPRESENTS THE)
 (LIKELIHOOD OF DEVELOPING ASCVD.)
 (AVERAGE RISK = 1X.)

SIGNATURE

DATE REPORTED



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PATIENT

ONEILL, JOHN

(C-1)

PATIENT NAME	DATE	AGE	SEX	LAB NUMBER	LABORATORY REPORT
ONEILL, JOHN	11/22/85	33	M	A85726936	

CONTINUATION OF REPORT

IMMUNOHEMATOLOGY:

BLOOD GROUP (ABO)----- A
BLOOD TYPE=RHO (D)----- POSITIVE
BLOOD GROUP=DU----- NOT INDICATED

IMMUNOLOGY:

RAPID PLASMA REAGIN (SCREEN)---- NON-REACTIVE
(NORMAL: NON-REACTIVE)
(SIGNIFICANT: REACTIVE)

IMMUNOGLOBULIN E----- 11.4 IU/ML (0-100)
(NON ALLERGIC: ALLERGIC)
(0-20 64% 0%)
(20-100 34% 35%)
(>100 2% 65%)

SIGNATURE

(COMPLETED)

11/26/85
DATE REPORTED

DESIRABLE WEIGHT RANGES

MALES				FEMALES			
Height	Small Frame	Medium Frame	Large Frame	Height	Small Frame	Medium Frame	Large Frame
5'4"	117 - 138	123 - 149	131 - 163	5'0"	96 - 114	101 - 124	109 - 138
5'5"	120 - 142	126 - 153	134 - 167	5'1"	99 - 118	104 - 128	112 - 141
5'6"	124 - 146	130 - 157	138 - 173	5'2"	102 - 121	107 - 131	115 - 144
5'7"	128 - 151	134 - 163	143 - 178	5'3"	105 - 124	110 - 135	118 - 149
5'8"	132 - 155	138 - 167	147 - 183	5'4"	108 - 128	113 - 139	121 - 152
5'9"	136 - 161	142 - 172	151 - 187	5'5"	111 - 132	117 - 144	125 - 156
5'10"	140 - 165	146 - 177	155 - 193	5'6"	114 - 135	120 - 149	129 - 161
5'11"	144 - 169	150 - 183	160 - 198	5'7"	118 - 140	124 - 153	133 - 165
6'	148 - 174	154 - 188	164 - 204	5'8"	122 - 144	128 - 157	137 - 169
6'1"	152 - 179	158 - 194	169 - 209	5'9"	126 - 149	132 - 162	141 - 174
6'2"	156 - 184	163 - 199	174 - 215	5'10"	130 - 154	136 - 166	145 - 179
6'3"	160 - 188	168 - 205	178 - 220	5'11"	134 - 158	140 - 171	149 - 185
6'4"	169 - 198	178 - 216	188 - 231	6'0"	138 - 163	144 - 175	153 - 190
6'5"	174 - 204	182 - 222	192 - 238				

4. Examinee's frame is small medium large

5. Considering the above weight table, the examinee's frame, and other individual physical characteristics, I consider his/her present weight Satisfactory Excessive Deficient

6. Under proper medical supervision, employee should lose _____ pounds
 gain _____ pounds

Remarks: _____



 S _____ iner

11/22/80

 Date

b6
b7c

12-23-86

SUBJECT ONEILL, JOHN P.

Mail pertaining to prior medical matters is maintained in the captioned employee's official personnel file, PERSONNEL RECORDS SUBUNIT, RECORDS SECTION, RECORDS MANAGEMENT DIVISION (RMD).

See 67-80008-2026X3 for authority.

FILE NUMBER 67 - 679605-M

DO NOT REMOVE FROM FILE

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME O'NEILL, JOHN P.			2. GRADE AND COMPONENT OR POSITION SPECIAL AGENT		3. IDENTIFICATION NO. 147-42-1004	
4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code) n/a			5. PURPOSE OF EXAMINATION FITNESS FOR DUTY		6. DATE OF EXAMINATION 11/22/85	
7. SEX M	8. RACE Caucasian	9. TOTAL YEARS GOVERNMENT SERVICE MILITARY _____ CIVILIAN _____		10. AGENCY	11. ORGANIZATION UNIT	
12. DATE OF BIRTH 2/6/52		13. PLACE OF BIRTH		14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN		
15. EXAMINING FACILITY OR EXAMINER AND ADDRESS Life Resources, 200 Hospital Dr., LL-10 Glen Burnie, MD 21061				16. OTHER INFORMATION		
17. RATING OR SPECIALTY			TIME IN THIS CAPACITY (Total)		LAST SIX MONTHS	

CLINICAL EVALUATION		
NOR- MAL	(Check each item in appropriate column; enter "NE" if not evaluated.)	ABNOR- MAL
<input checked="" type="checkbox"/>	18. HEAD, FACE, NECK AND SCALP	
<input checked="" type="checkbox"/>	19. NOSE	
<input checked="" type="checkbox"/>	20. SINUSES	
<input checked="" type="checkbox"/>	21. MOUTH AND THROAT	
<input checked="" type="checkbox"/>	22. EARS—GENERAL (Int & ext. canals) (Auditory acuity under items 70 and 719)	
<input checked="" type="checkbox"/>	23. DRUMS (Perforation)	
<input checked="" type="checkbox"/>	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
<input checked="" type="checkbox"/>	25. OPHTHALMOSCOPIC	
<input checked="" type="checkbox"/>	26. PUPILS (Equality and reaction)	
<input checked="" type="checkbox"/>	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
<input checked="" type="checkbox"/>	28. LUNGS AND CHEST (Include breasts)	
<input checked="" type="checkbox"/>	29. HEART (Thrust, size, rhythm, sounds)	
<input checked="" type="checkbox"/>	30. VASCULAR SYSTEM (Varicosities, etc.)	
<input checked="" type="checkbox"/>	31. ABDOMEN AND VISCERA (Include hernia)	
<input checked="" type="checkbox"/>	32. ANUS AND RECTUM (Hemorrhoids, fistular) (Prostate, if indicated)	
<input checked="" type="checkbox"/>	33. ENDOCRINE SYSTEM	
<input checked="" type="checkbox"/>	34. G-U SYSTEM	
<input checked="" type="checkbox"/>	35. UPPER EXTREMITIES (Strength, range of motion)	
<input checked="" type="checkbox"/>	36. FEET	
<input checked="" type="checkbox"/>	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
<input checked="" type="checkbox"/>	38. SPINE, OTHER MUSCULOSKELETAL	
<input checked="" type="checkbox"/>	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
<input checked="" type="checkbox"/>	40. SKIN, LYMPHATICS	
<input checked="" type="checkbox"/>	41. NEUROLOGIC (Equilibrium tests under item 72)	
<input checked="" type="checkbox"/>	42. PSYCHIATRIC (Specify any personality deviation)	
<input checked="" type="checkbox"/>	43. PELVIC (Females only) (Check how done)	
	<input type="checkbox"/> VAGINAL <input type="checkbox"/> RECTAL	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

1/2/86. Annual physical w/HL.

310 WAS ADVISED ON 12/4/85 THAT IT WILL BE NECESSARY FOR HIM TO WEAR CORRECTIVE LENSES WHILE DRIVING A GOVERNMENT VEHICLE

ENCLOSURE

67-11-8361

3 JAN 25 1986

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)																																																																									
<table border="0"> <tr><td>0</td><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td><td></td></tr> <tr><td>0</td><td></td><td></td><td></td></tr> </table> Restorable teeth				0	1	2	3	32	31	30		0				<table border="0"> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td></td><td></td><td></td></tr> </table> Non-restorable teeth				1	2	3	32	31	30				<table border="0"> <tr><td>x</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td></td><td></td><td></td></tr> </table> Missing teeth				x	2	3	32	31	30				<table border="0"> <tr><td>x</td><td>x</td><td>x</td></tr> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td>x</td><td>x</td><td>x</td></tr> </table> Replaced by dentures				x	x	x	1	2	3	32	31	30	x	x	x	<table border="0"> <tr><td>(x)</td><td></td><td></td></tr> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td>(x)</td><td></td><td></td></tr> </table> Fixed Partial dentures				(x)			1	2	3	32	31	30	(x)		
0	1	2	3																																																																						
32	31	30																																																																							
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I	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	F																																																								
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REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

we

45. URINALYSIS: A. SPECIFIC GRAVITY				46. CHEST X-RAY (Place, date, film number and result)			
B. ALBUMIN 3+		D. MICROSCOPIC					
C. SUGAR -							
47. SEROLOGY (Specify test used and result) RPR(NL)		48. EKG WNL		49. BLOOD TYPE AND RH FACTOR A+		50. OTHER TESTS Uric Acid 9.8. K+5.5 P1.7	

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT 72 1/2		52. WEIGHT 200		53. COLOR HAIR brown		54. COLOR EYES brown		55. BUILD: <input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM <input checked="" type="checkbox"/> HEAVY <input type="checkbox"/> OBESE			56. TEMPERATURE 98°								
57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)													
A. SITTING		B. RECUMBENT		C. STANDING (3 min.)		A. SITTING		B. AFTER EXERCISE		C. 2 MIN. AFTER		D. RECUMBENT		E. AFTER STANDING 3 MIN.					
SYS. 120 DIAS. 88		SYS. 116 DIAS. 88		SYS. 116 DIAS. 96		68		80		70		66		72					
59. DISTANT VISION				60. REFRACTION				61. NEAR VISION											
RIGHT 20/ 40		CORR. TO 20/ 20		D.Y.		S.		C.X		20/20		CORR. TO		D.Y.					
LEFT 20/ 40		CORR. TO 20/ 20		D.Y.		S.		C.X		20/20		CORR. TO		D.Y.					
62. HETEROPHORIA (Specify distance)																			
ES°		EX°		R. H.		L. H.		PRISM DIV.		PRISM CONV.		PC		PD					
63. ACCOMMODATION				64. COLOR VISION (Test used and result)				65. DEPTH PERCEPTION (Test used and score)				UNCORRECTED							
RIGHT LEFT				15h/nl.								CORRECTED							
66. FIELD OF VISION				67. NIGHT VISION (Test used and score)				69. RED LENS TEST				68. INTRAOCULAR TENSION							
70. HEARING				71. AUDIOMETER						72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)									
RIGHT WV		/15 SV		/15		350 258		500 312		1000 1024		2000 2048		4000 4096		8000 8144		16000 16288	
LEFT WV		/15 SV		/15		RIGHT		15		5		10		5		15			
						LEFT		15		5		5		15					

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

• Proteinuria hyperkalemia
 • hyperuricemia All mild

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)						76. A. PHYSICAL PROFILE					
1) Repeat Urinalysis 2) Repeat uric acid, for SMA 6.						P U L H E S					
						B. PHYSICAL CATEGORY					
77. EXAMINEE (Check)						A B C E					
A. <input checked="" type="checkbox"/> IS QUALIFIED FOR											
D. <input type="checkbox"/> IS NOT QUALIFIED FOR											
78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER											
79. TYPE			SIGNATURE			79. TYPE			SIGNATURE		
[]			[]			[]			[]		
80. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)						SIGNATURE					
[]						[]					
81. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY						SIGNATURE					
[]						[]					
						NUMBER OF ATTACHED SHEETS					
						[]					

SSAN 197-42-1004 RANK CIV.
 NAME: O'NEIL, JOHN P.
 (Last) (First) (MI)
 UNIT FBR DUTY PHONE 205-8080

SPECIMEN/LAB RPT NO

URINALYSIS

19

URGENCY

ROUTINE

TODAY

PRE-OP

STAT

PATIENT STATUS

BED

OUTPATIENT

NP

DOM

SPECIMEN SOURCE

ROUTINE

OTHER (Specify):

PATIENT'S MED. RECORD

Enter in above space PATIENT IDENTIFICATION—TREATING FACILITY—WARD NO —DATE

REQUESTING PHYSICIAN'S SIGNATURE
MED EXAM

REPORTED BY [Signature] MD DATE

TECH

LAB ID NO

REMARKS

TEST(S)	SPECIMEN TAKEN		RESULTS
	DATE	TIME	
		A.M. P.M.	
			REQUESTED (X)
			ROUTINE
			COLOR
			SPECIFIC GRAVITY
			UROBILINOGEN
			OCCULT BLOOD
			BILE
			KETONES
			GLUCOSE
			PROTEIN
			pH
			MICROSCOPIC
			WBC
			RBC
			EPITH
			WBC
			RBC
			HYALINE
			GRAVULAR
			BACTERIA
			CRYSTALS
			MUS
			TRITE
			BENCE-JONES PROTEIN
			HEMOSIDERIN
			HCG

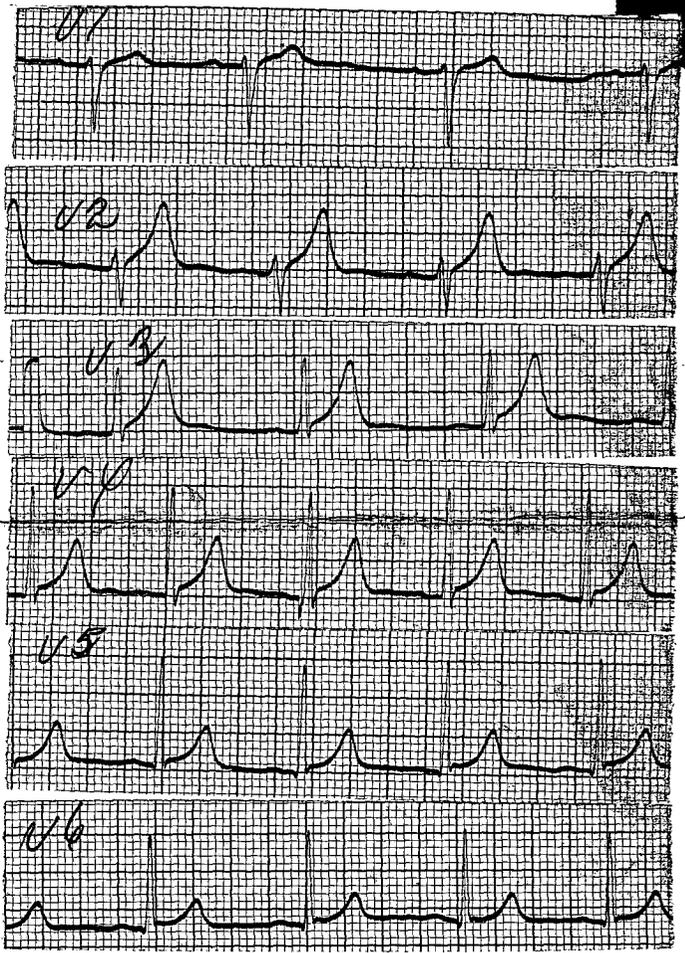
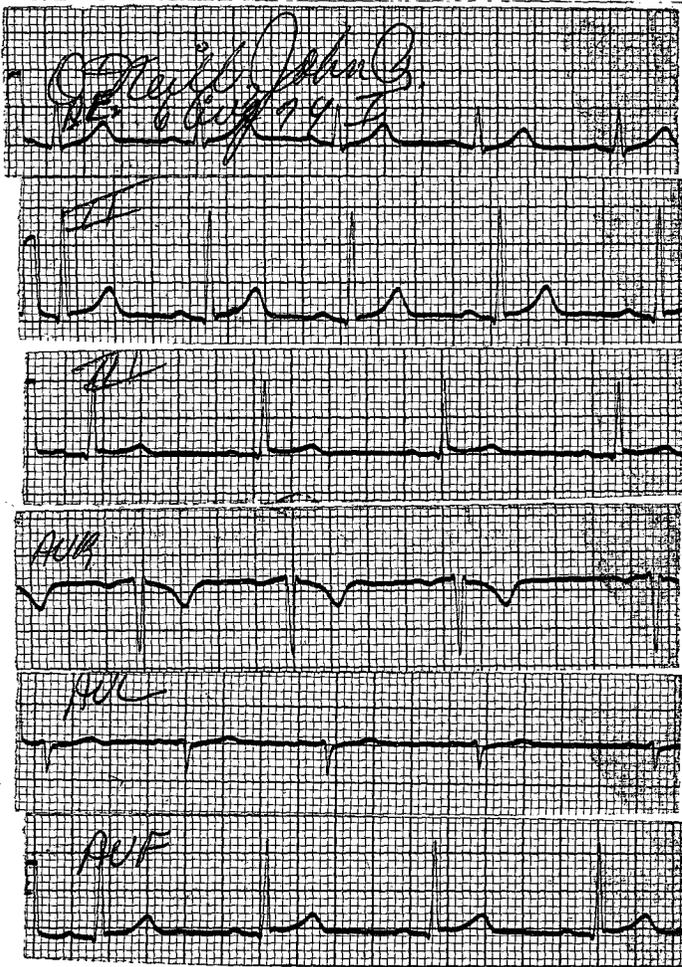
CPT MSC Laboratory

550-104

URINALYSIS

Standard Form 550 (Rev. 4-77)
 General Services Administration and Interagency
 Committee on Medical Records FPMR 101-11.606-6

b6
b7c



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 YALE H. CAPLAN, PH.D.



PHYSICIAN

CENTRAL MEDICAL CENTER
 11350 MCCORMICK RD. 102
 HUNT VALLEY MD 21031

(2/1)

PATIENT

ONEILL, JOHN P

PATIENT NAME	DATE	AGE	SEX	LAB NUMBER	LABORATORY REPORT
ONEILL, JOHN P	10/18/82	0	M	A697103	

HEMATOLOGY:

RBC=====	5.09	MEGA. (4.7=6.1)	WBC=====	6.2	KILO. (4.8=10.8)
HGB=====	15.7	GM/DL (14=18)	BANDS=====	2	% (0=10)
HCT=====	45.6	% (40=54)	POLYS=====	60	% (45=70)
MCV=====	90	CUU. (80=94)	LYMPHS=====	30	% (15=40)
MCH=====	30.6	UUG. (27=32)	MONOS=====	5	% (1=10)
MCHC=====	34.7	% (32=36)	EOSIN=====	3	% (0=3)
			BASOS=====	0	% (0=1)
			ATYP LYMPH==	0	% (0)

COMMENT:

PLATELETS===== ADEQUATE

SEDIMENTATION RATE===== 7 MM/HR (0=10)

CLINICAL MICROSCOPY:

COLOR=====	YELLOW-CLEAR	SP. GRAV.===	1.020
PH=====	6.0	PROTEIN=====	NEG.
GLUCOSE=====	NEG.	ACETONE=====	NEG.
BILIRUBIN===	NEG.	BLOOD=====	NEG.

MICROSCOPIC:

WBC/HPF=====	0-2	RBC/HPF=====	0
EPITH. CELLS/HPF=====	0	MUCUS=====	SLIGHT

CHEMISTRY:

URIC ACID=====	7.8	MG/DL	(3.5=8.5)
CREATININE=====	1.2	MG/DL	(0.7=1.4)
CHOLESTEROL=====	225	MG/DL	(150=300)
BUN=====	14	MG/DL	(10=20)
GLUCOSE=====	91	MG/DL	(65=110)
*TRIGLYCERIDE=====	196	MG/DL	(74=172)

IMMUNOLOGY:

RAPID PLASMA REAGIN (SCREEN)===== NON-REACTIVE

SIGNATURE

Handwritten signature

(COMPLETED)

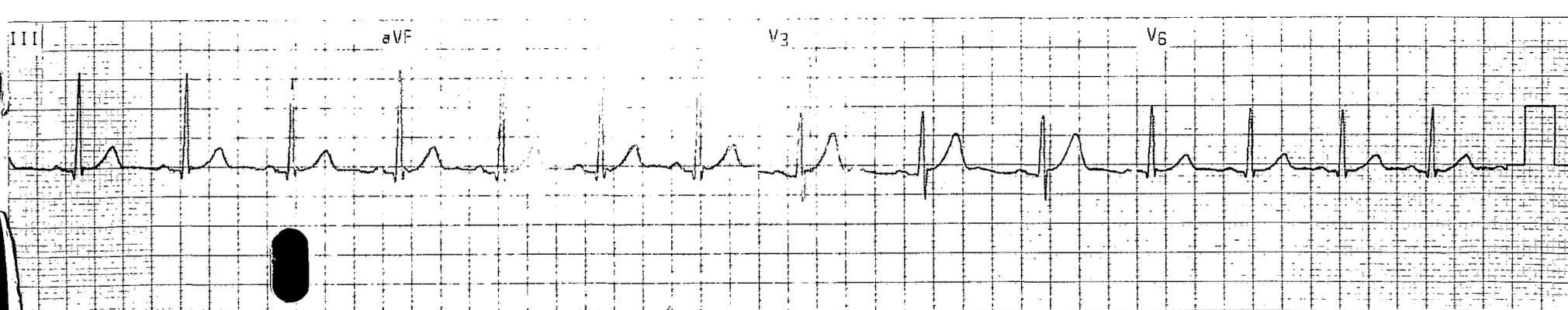
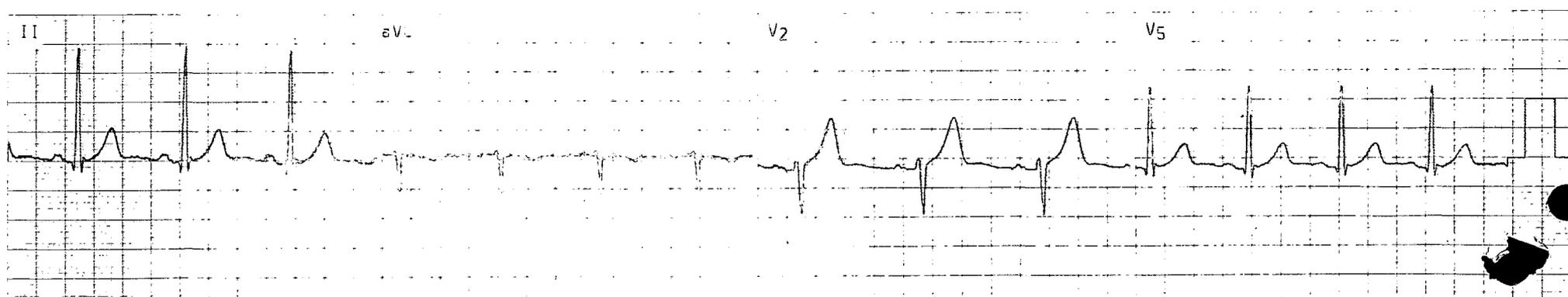
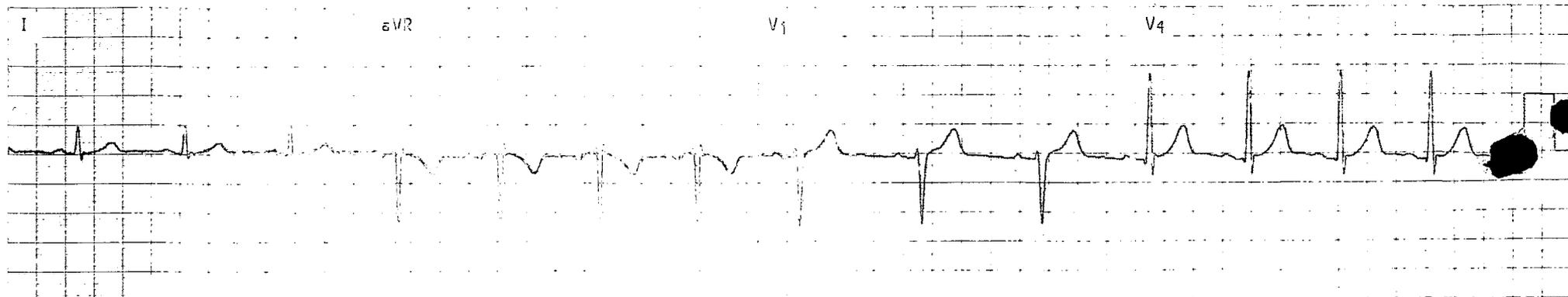
10/19/82
 DATE REPORTED

J O'NEIL

FBI

11-22-85

1.2 Lead ST Level +1.0 Gain x1
Resting ST Slope +0 HR 58 25 mm/sec



Memorandum



To : Director, FBI

Date 4/22/87

Jag
SAC, BALTIMORE

Attention: Personnel Section
HEALTH SERVICES UNIT

Subject: JOHN P. O'NEILL
SUPERVISORY SPECIAL AGENT
PHYSICAL EXAMINATION MATTER

- Remylet _____
 ReBulet _____
- Re physical examination _____ 2/24/87 _____
- Dental work was completed on _____
- Vision has been corrected to _____ Employee specifically instructed _____ (date) by _____ (name of person giving instruction) that he/she can operate a Bureau car only when wearing the necessary glasses.
- Results of chest X ray patch test urinalysis serology were negative.
- Enclosed physician's statement indicates employee is: Qualified for strenuous physical exertion and use of firearms; Qualified for firearms, exclusive of defensive tactics. SAC concurs, Yes No: If answered no, explain under remarks.
- Future participation in firearms is remote and weapon will be returned to the Bureau.
- Enclosed are paid unpaid medical bills.
- Attached are Bureau of Employees' Compensation forms _____
-
- Time and attendance (T&A) records checked and showed employee was on _____ hours (check one: Continuation of Pay Annual Leave Sick Leave Leave Without Pay) at time employee sustained injury. (THIS MUST AGREE WITH CA-1). Enclosed is copy of T&A record.
- Physical examination reports are enclosed.
- Employee is scheduled for physical examination on _____
- Physical examination report has been reviewed and initialed.
- Employee returned to active duty _____
- Employee's physical condition is _____
- UACB he/she is being removed from limited duty.
- UACB he/she is being placed on limited duty.

If employee is a Resident Agent, is there a sufficient amount of nonarduous work available to keep him/her fully occupied and are sufficient agents available to handle emergency assignments. Yes No If answer is no, separately and immediately submit your recommendation for the return of this agent to headquarters city.

Remarks:

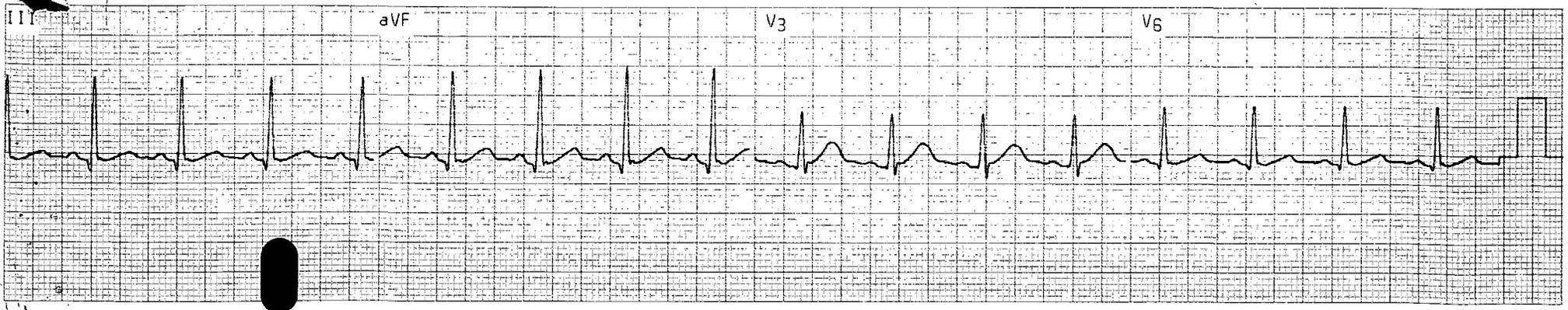
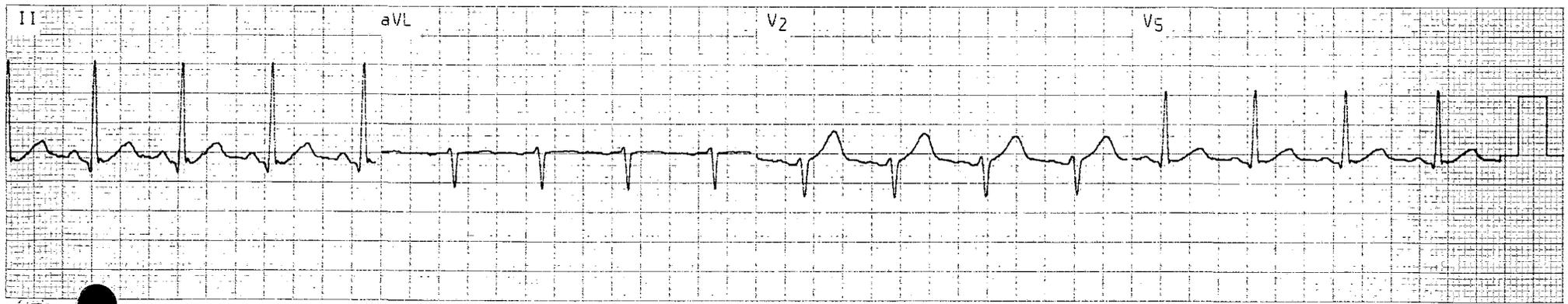
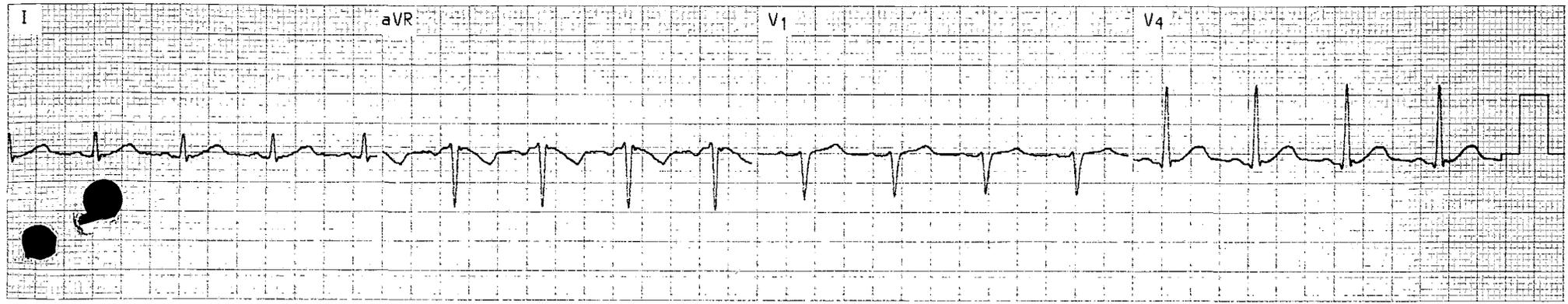
Also enclosed are results of employee's treadmill stress test and pulmonary function test.

Employee transferred to FBIHQ on 4/6/87 and has not reviewed results of his physical. He should be afforded an opportunity to review the results.

① - Bureau
1 - Baltimore
Enclosure
DAB:jag
(2)

12 Lead ST Level +0.4 filter on Gain x1
Resting ST Slope +0 HR 97 25 mm/sec

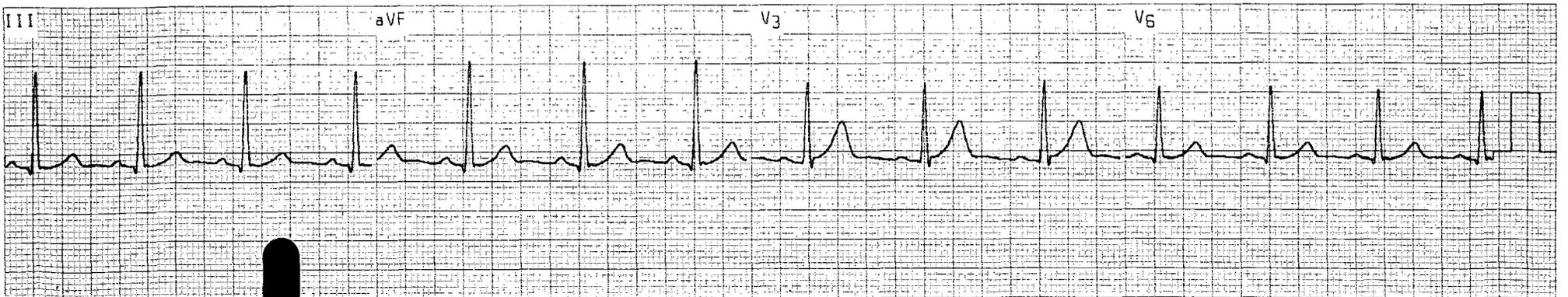
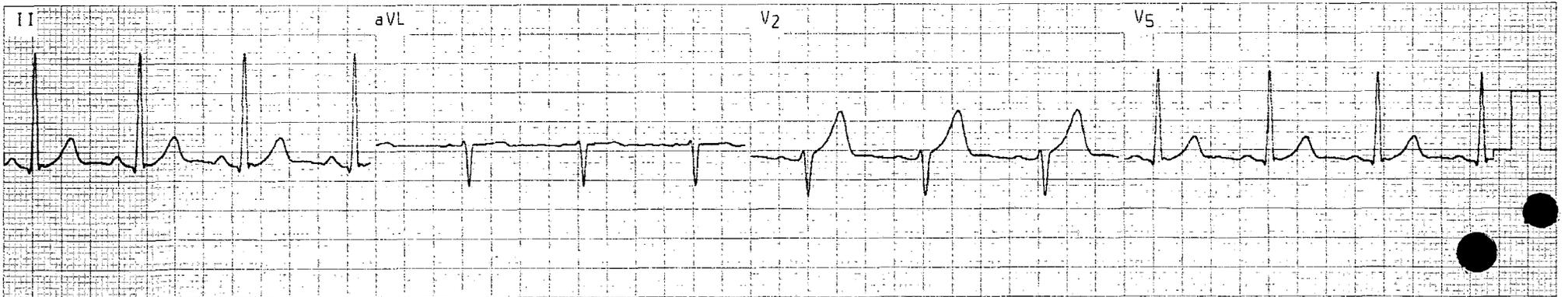
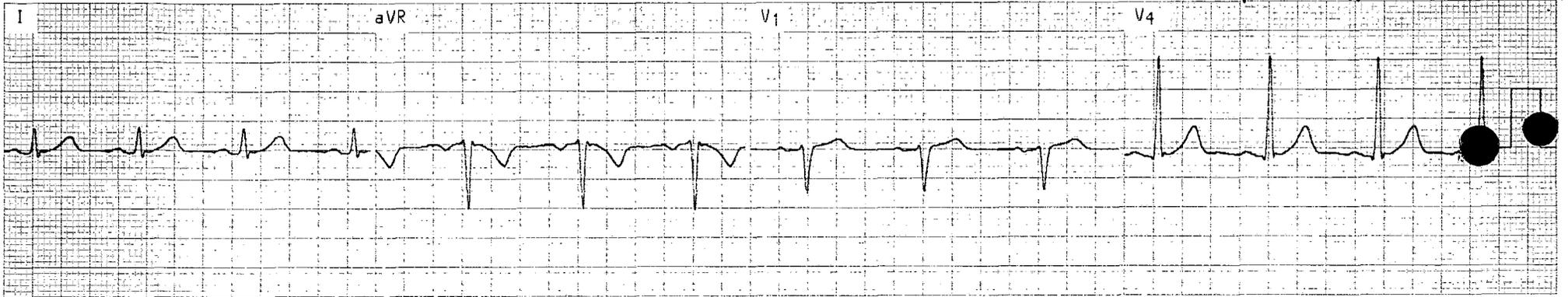
J. O'Neill
2-24-87
30 sec. Hypervent



12 Lead ST Level +0.8 filter on Gain x1
Resting ST Slope +0 HR 78 25 mm/sec

J. O'Neill
2-24-87
~~supine~~ supine

WHR
Full Range



12 Lead

ST Level +1.1 filter on Gain x1

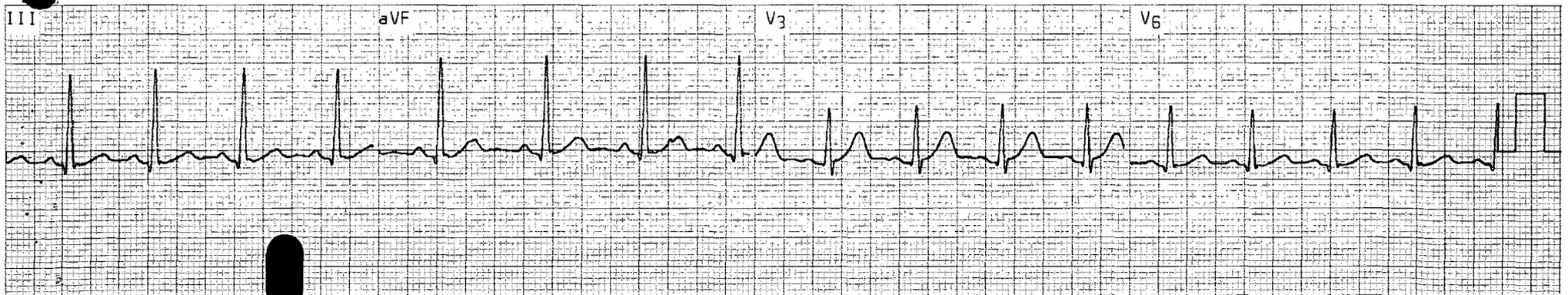
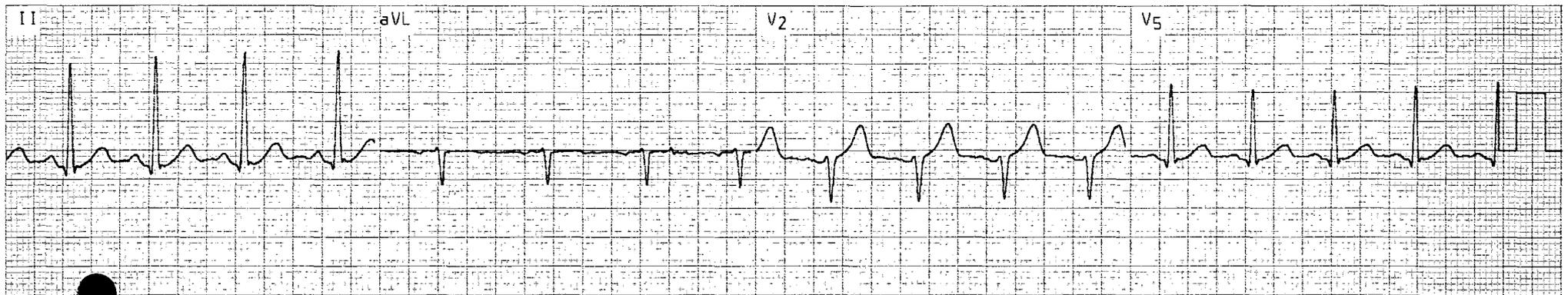
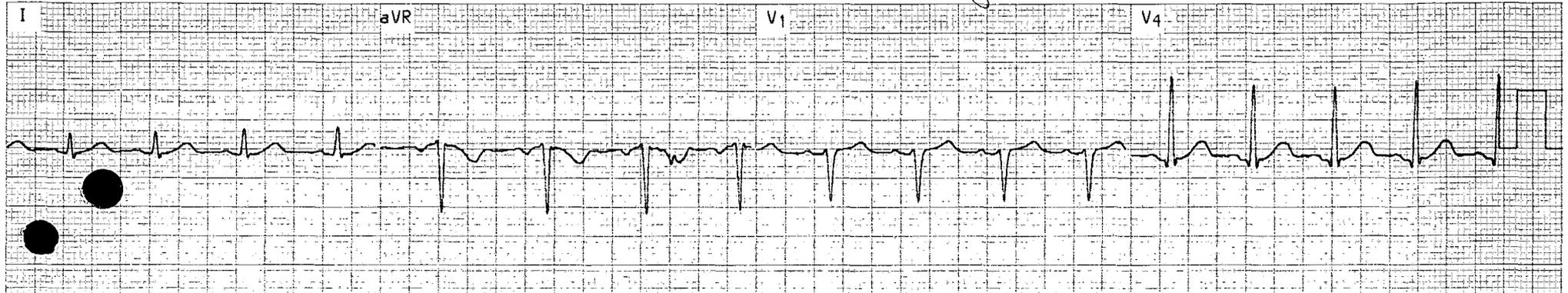
Resting

ST Slope +1 HR 92 25 mm/sec

J. O'Neill

2-24-87

Standing

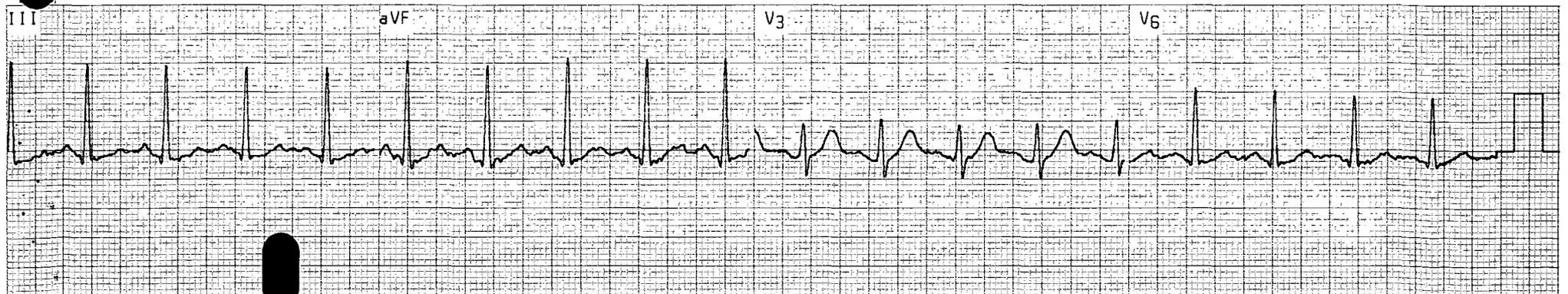
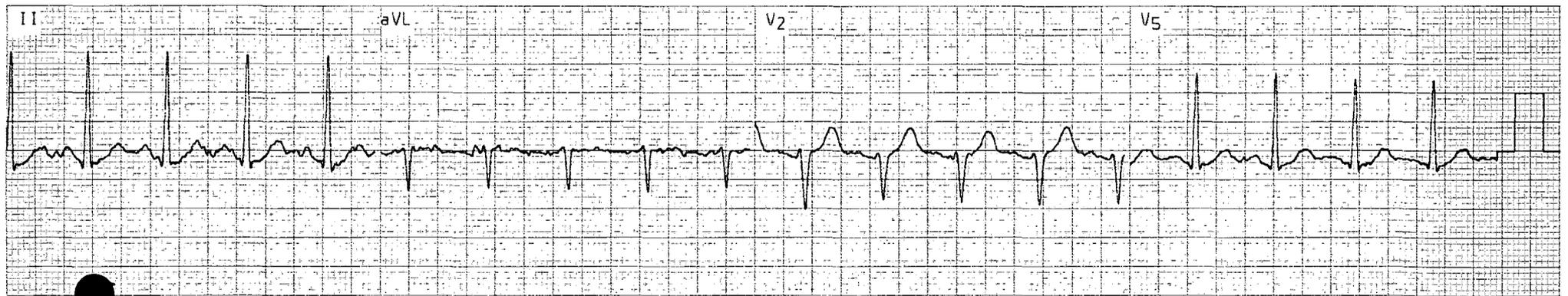
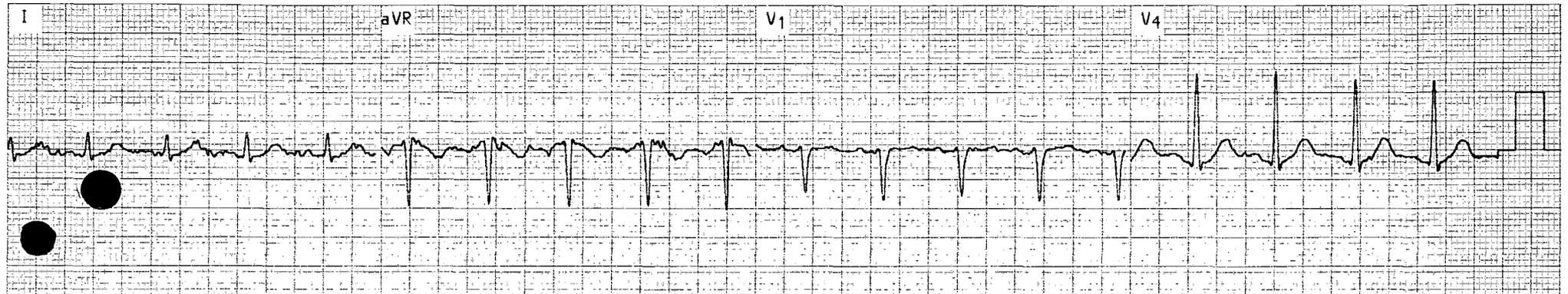


12 Lead ST Level +0.2 filter on Gain x1

Stage 1 1:50 ST Slope +6 HR 111 25 mm/sec

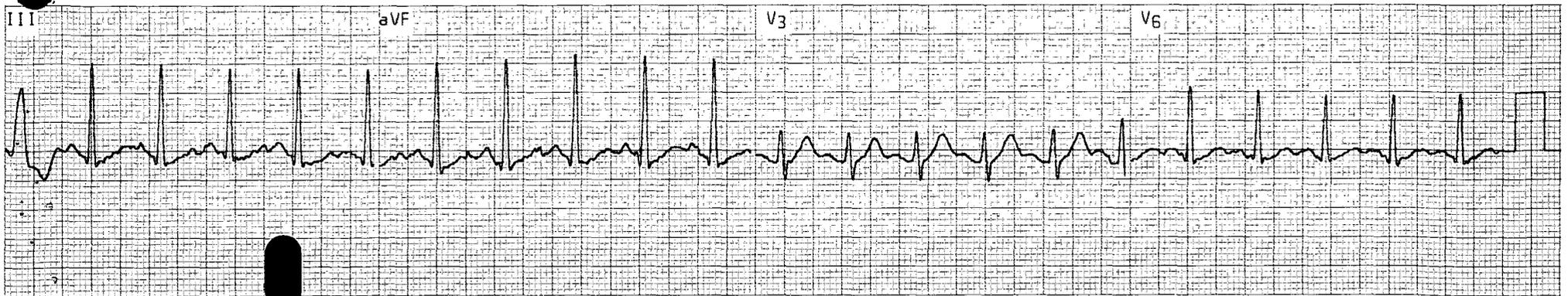
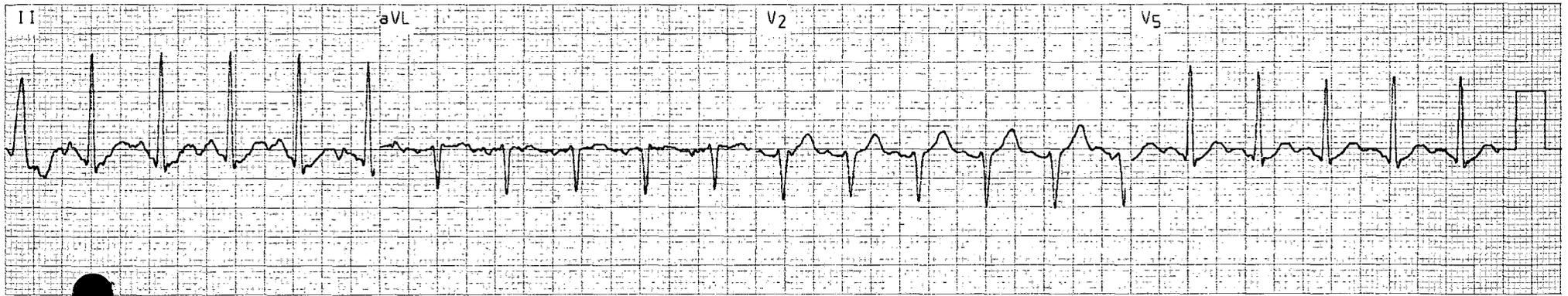
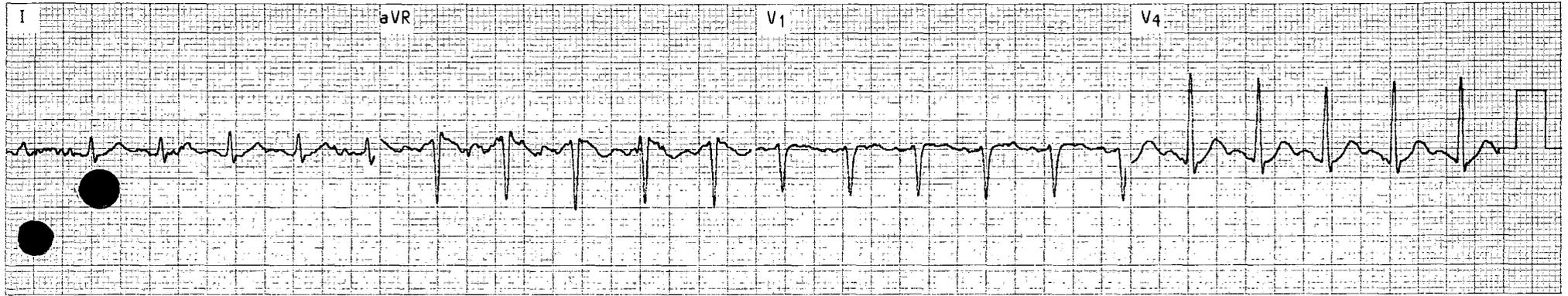
D. O'Neill

2-24-87



12 Lead ST Level +0.0 filter on Gain x1
Stage 2 1:50 ST Slope +5 HR 127 25 mm/sec

J. O'Neill
2-24-87

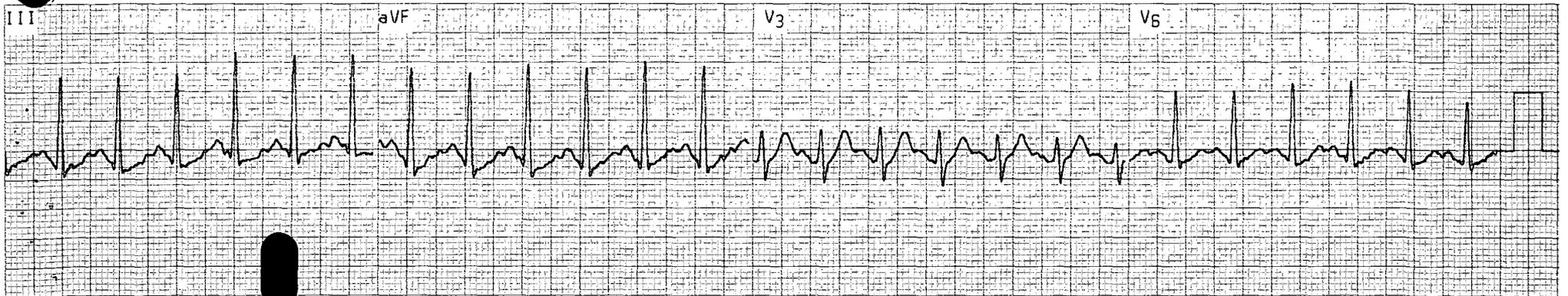
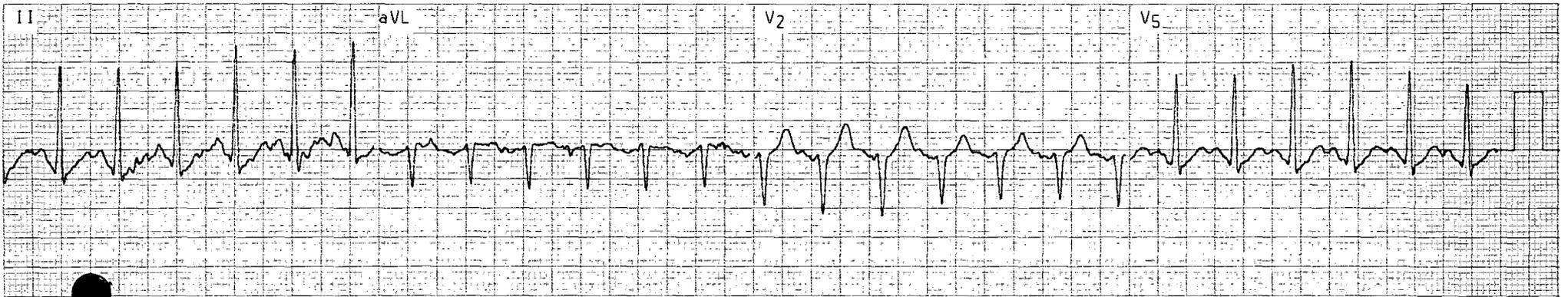
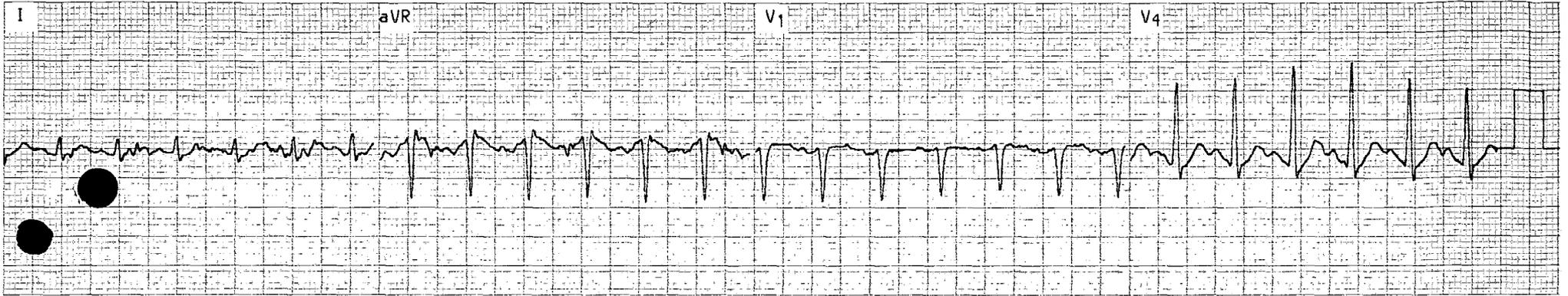


12 Lead ST Level -0.1 filter on Gain x1

Stage 3 1:50 ST Slope +15 HR 148 25 mm/sec

J. O'Neill

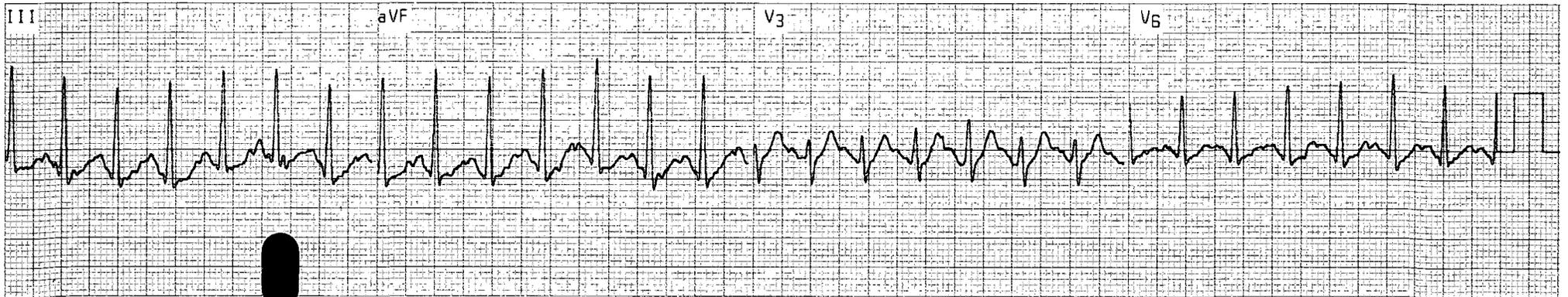
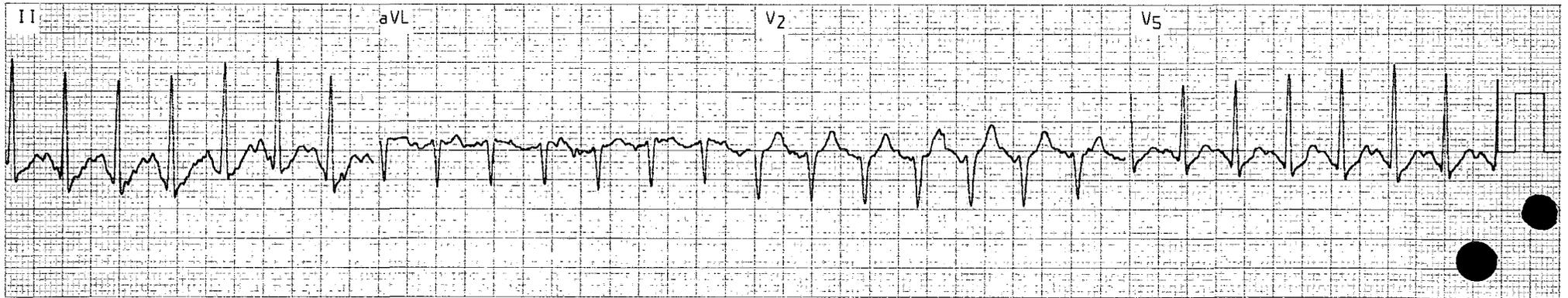
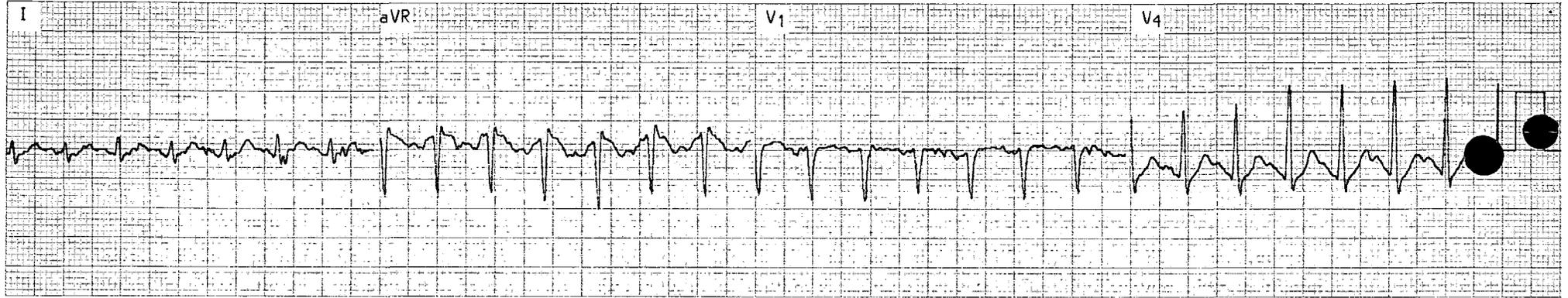
2-24-87



12 Lead ST Level +0.3 filter on Gain x1
Stage 4 1:50 ST Slope +20 HR 162 25 mm/sec

J. O'Neill

2-24-87

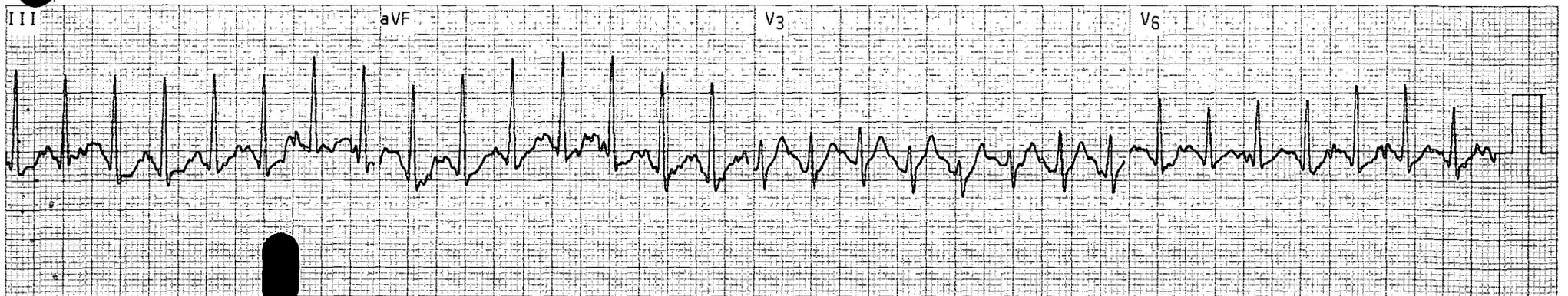
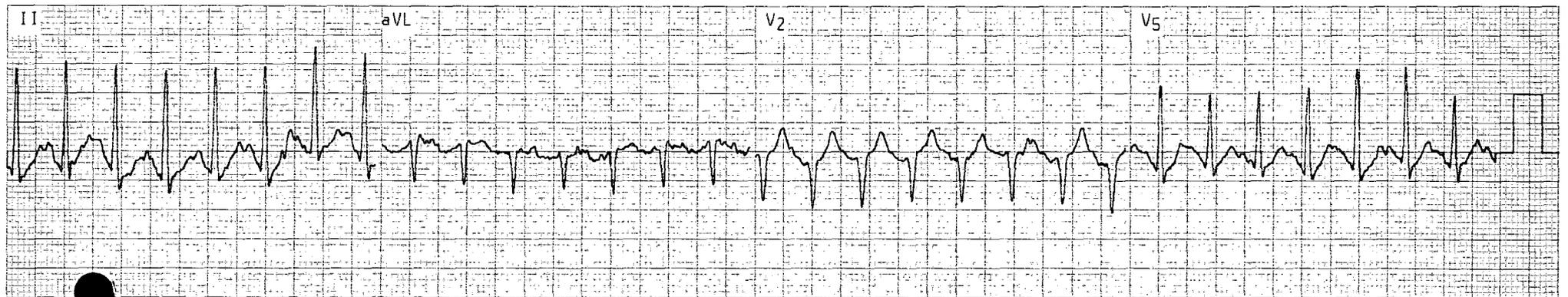
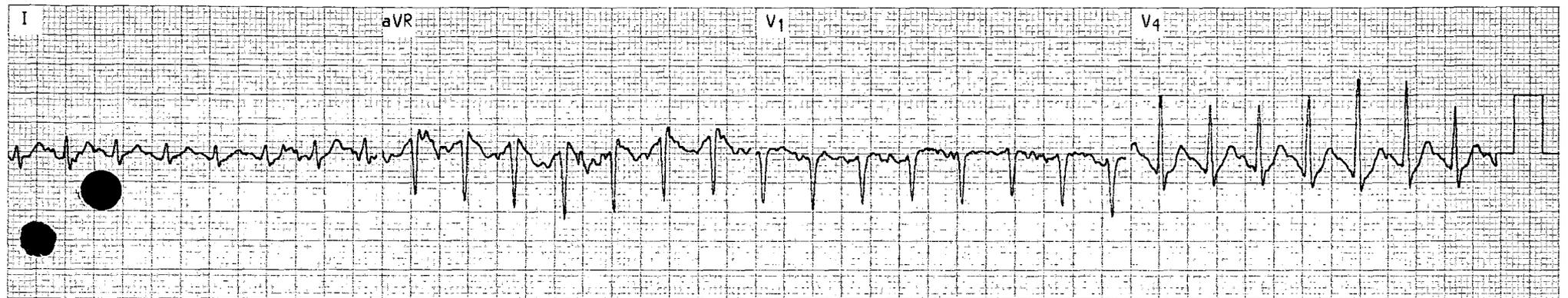


12 Lead ST Level +0.2 filter on Gain x1

Stage 5 1:50 ST Slope +23 HR 175 25 mm/sec

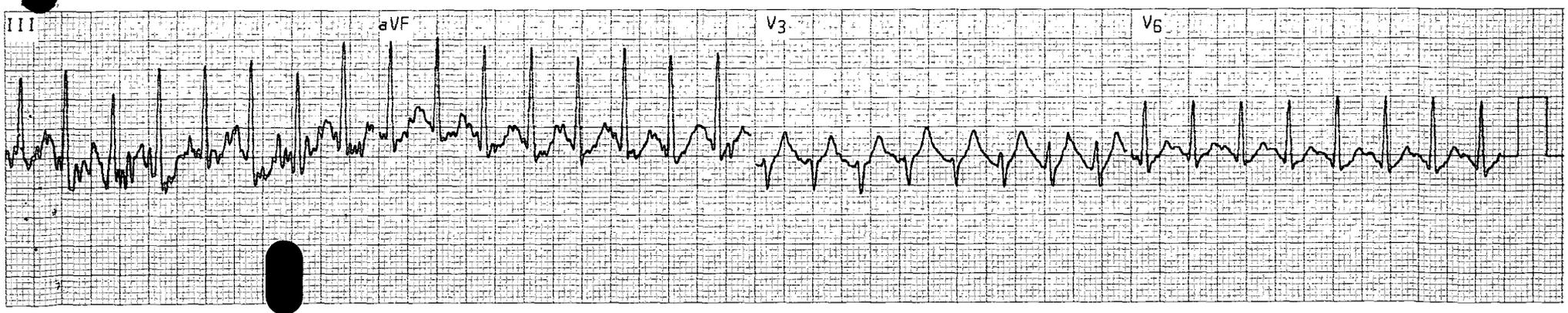
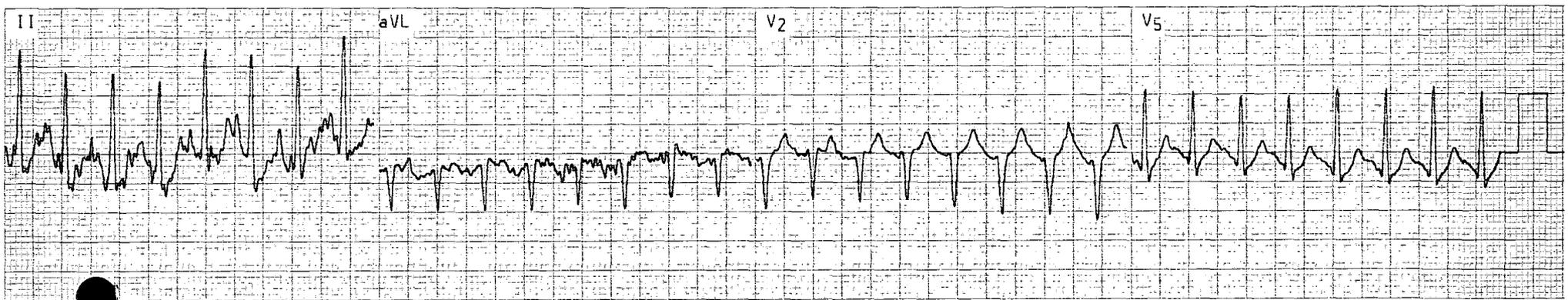
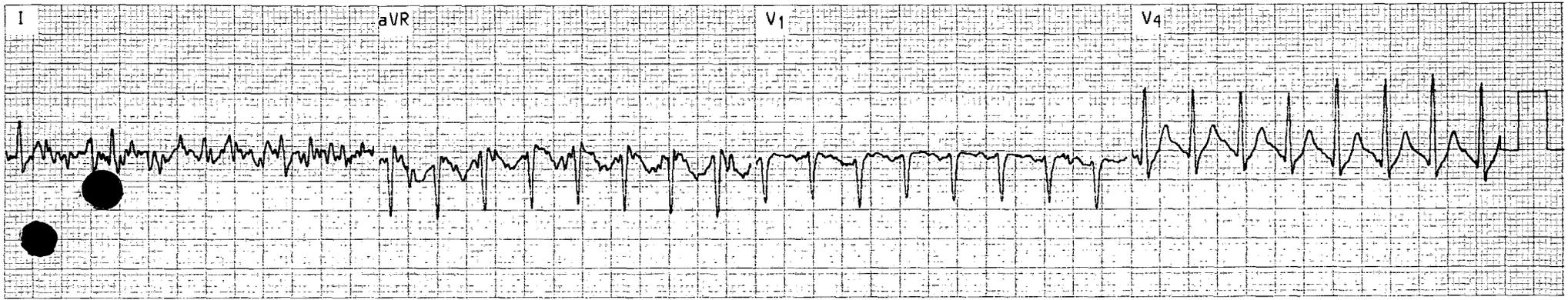
J. O'Neill

2-24-87



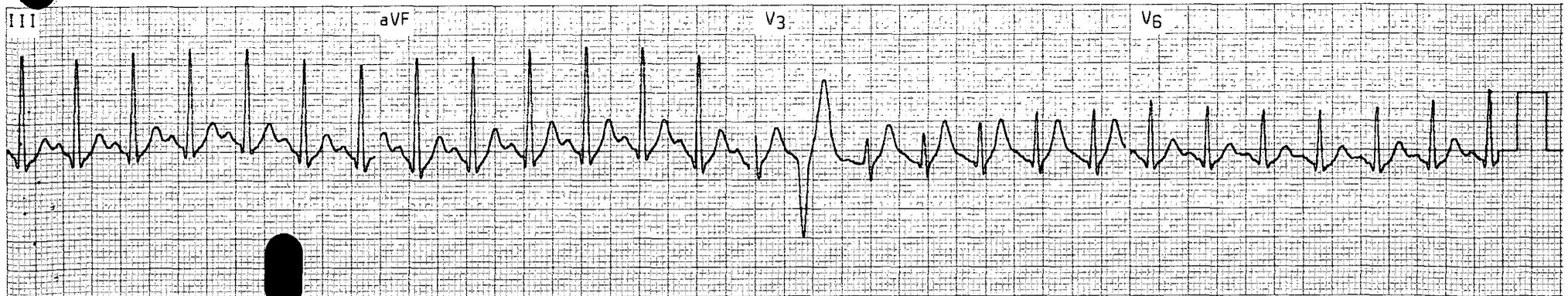
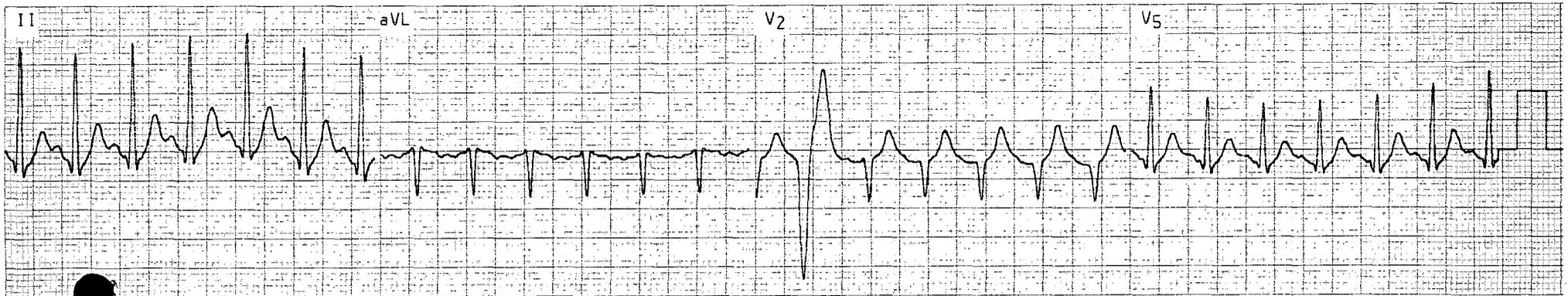
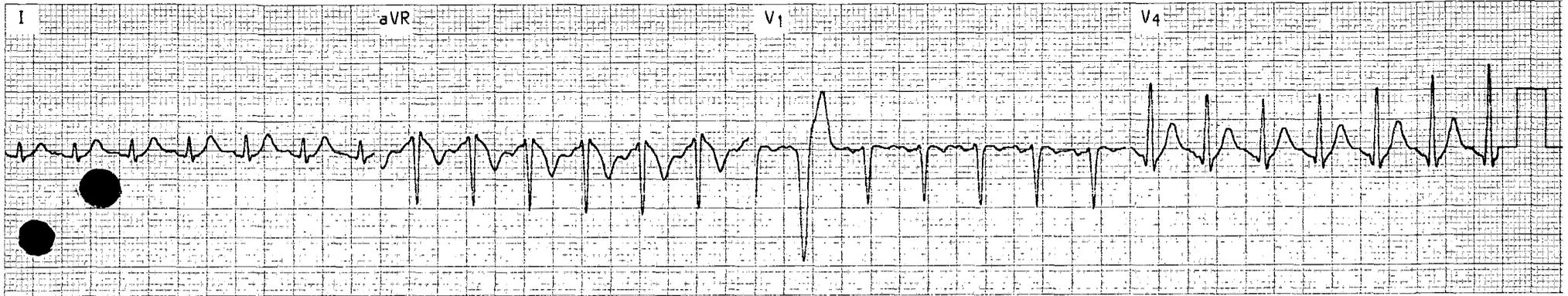
12 Lead ST Level -0.3 filter on Gain x1
Recovery 0:00 ST Slope +21 HR 186 25 mm/sec

J. O'Neill
2-24-87



12 Lead ST Level +2.8 filter on Gain x1
Recovery 1:00 ST Slope +45 HR 157 25 mm/sec

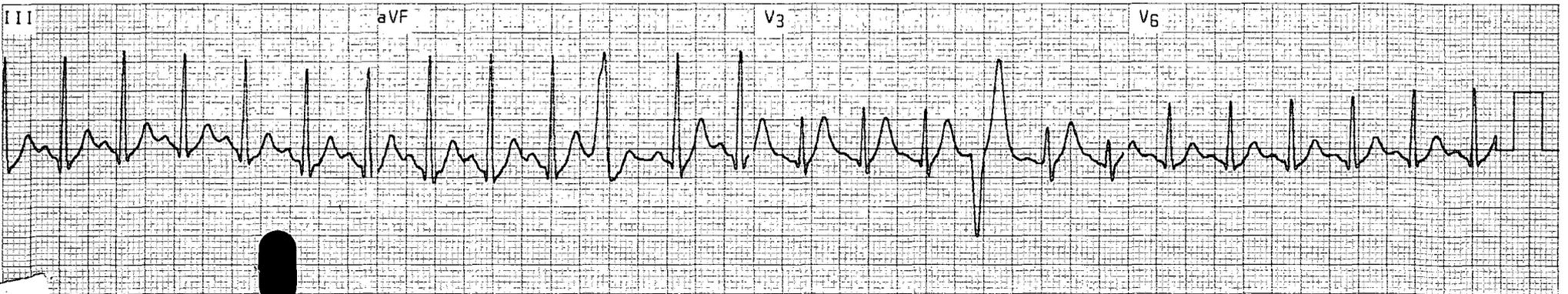
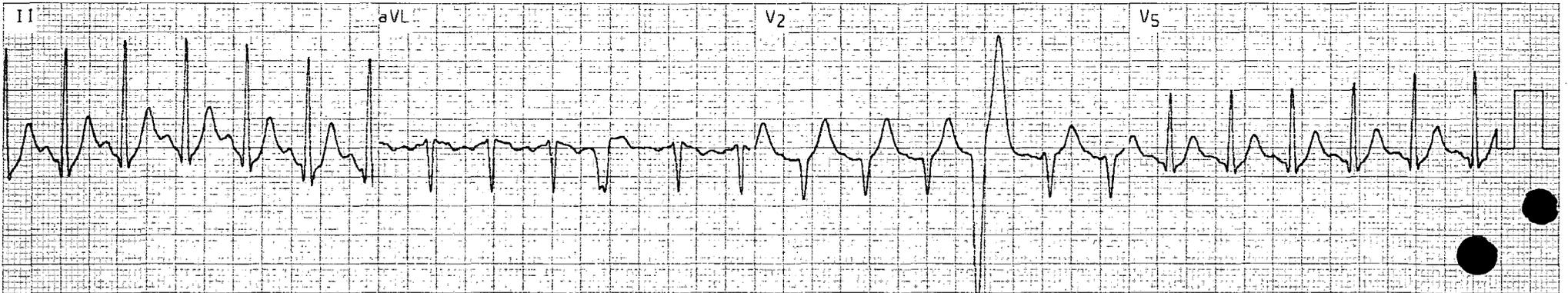
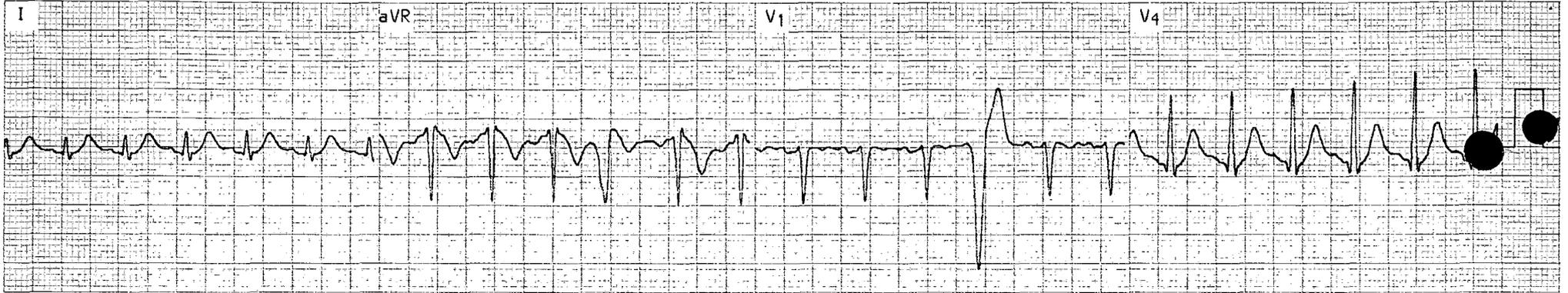
J. O'Neill
2-24-87



12 Lead ST Level +3.2 filter on Gain x1

Recovery 2:00 ST Slope +38 HR 149 25 mm/sec

J. O'Neill
2-24-87

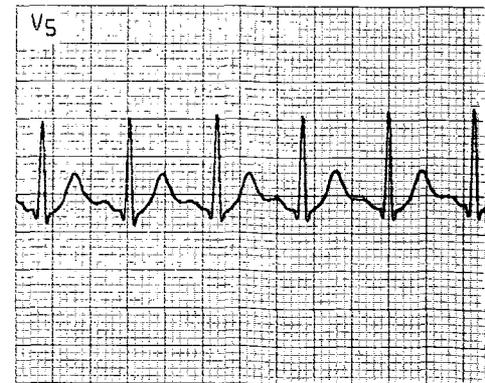
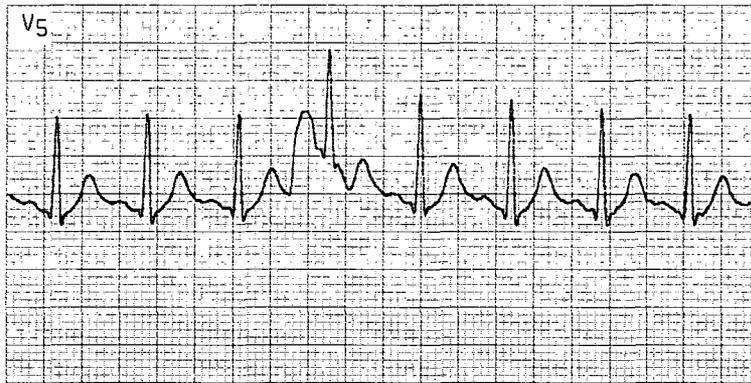
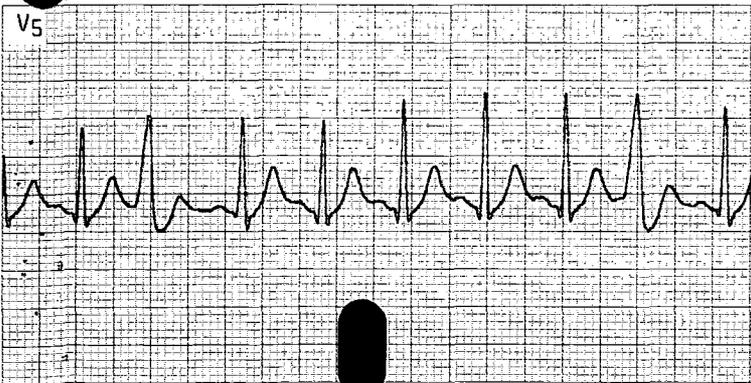
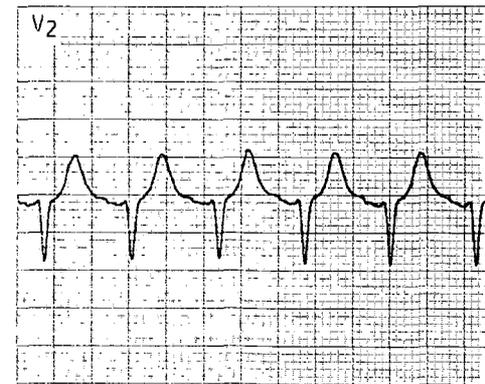
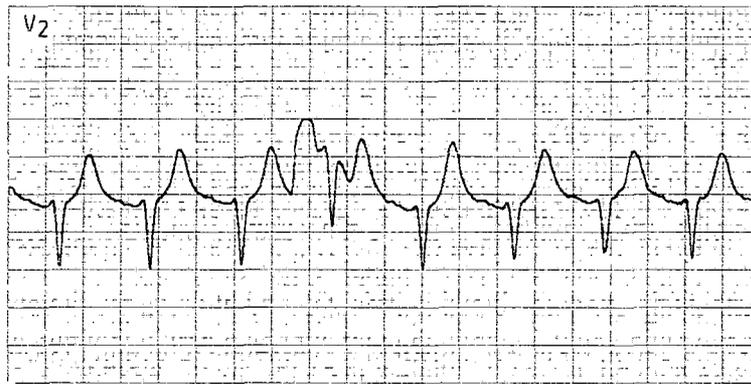
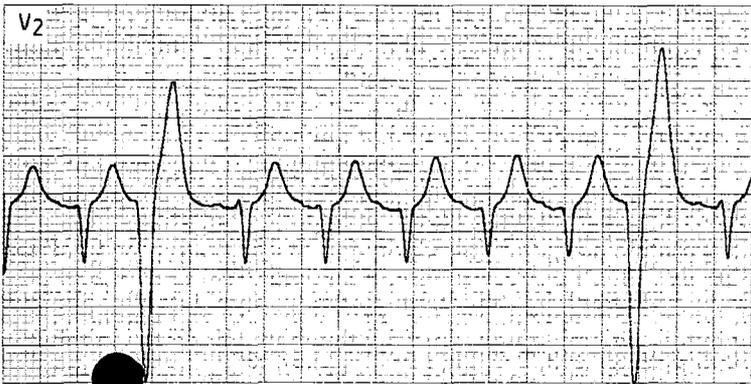
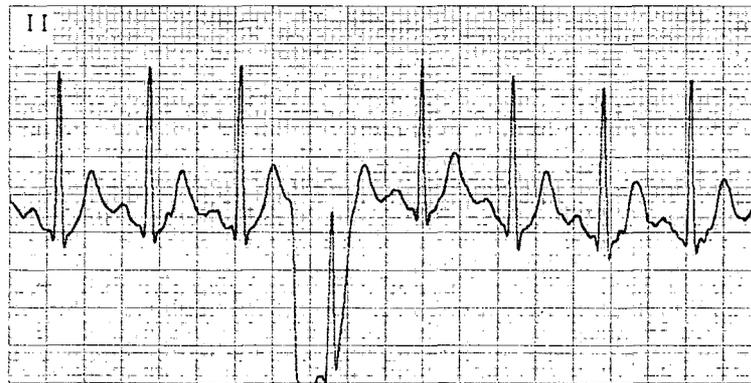
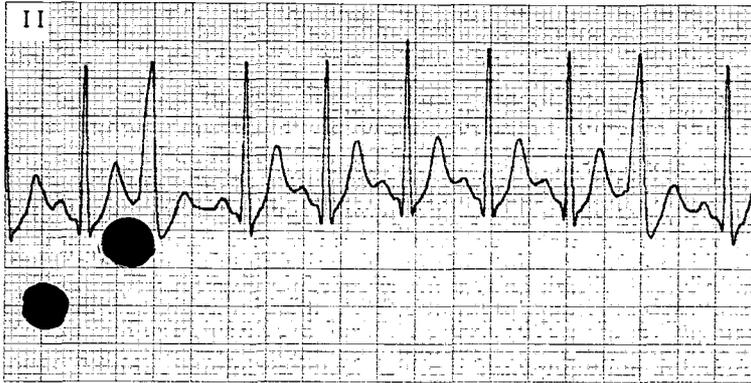


Write Screen ST Level +3.2 filter on Gain x1
Recovery 2:04 ST Slope +38 HR 147 25 mm/sec

Write Screen ST Level +2.4 filter on Gain x1
Recovery 3:40 ST Slope +33 HR 127 25 mm/sec

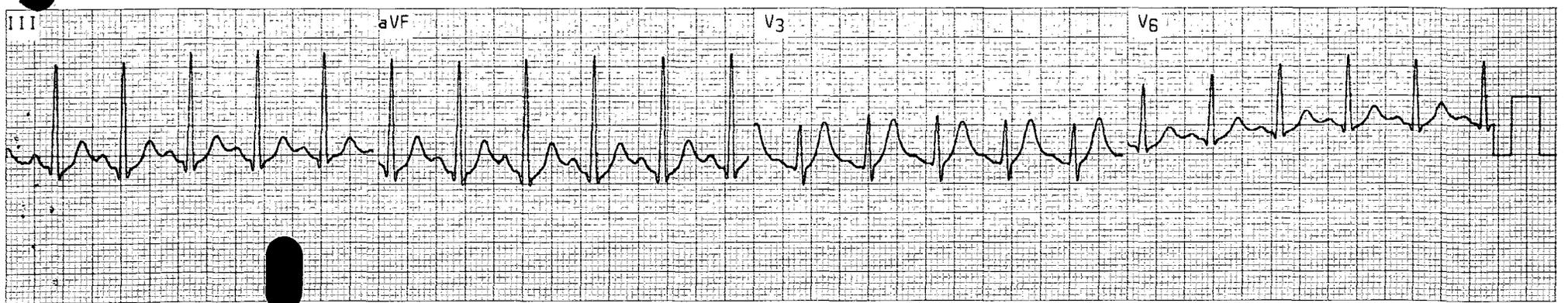
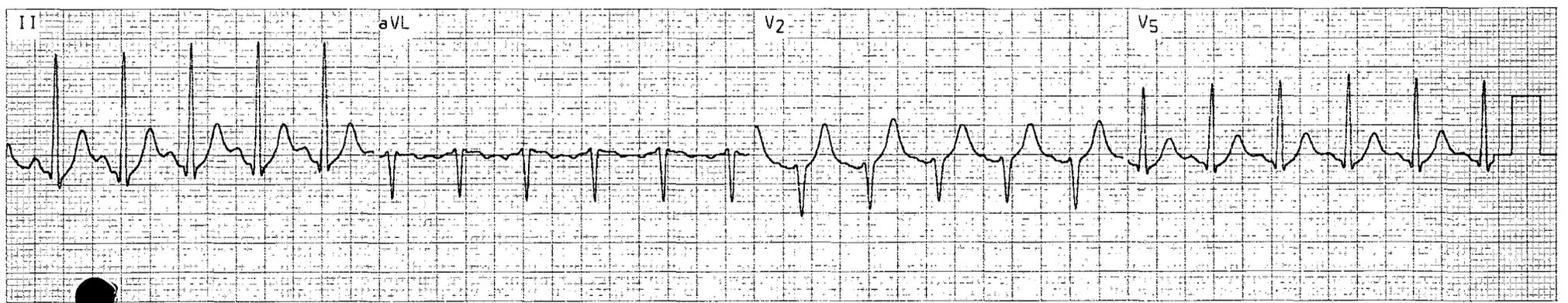
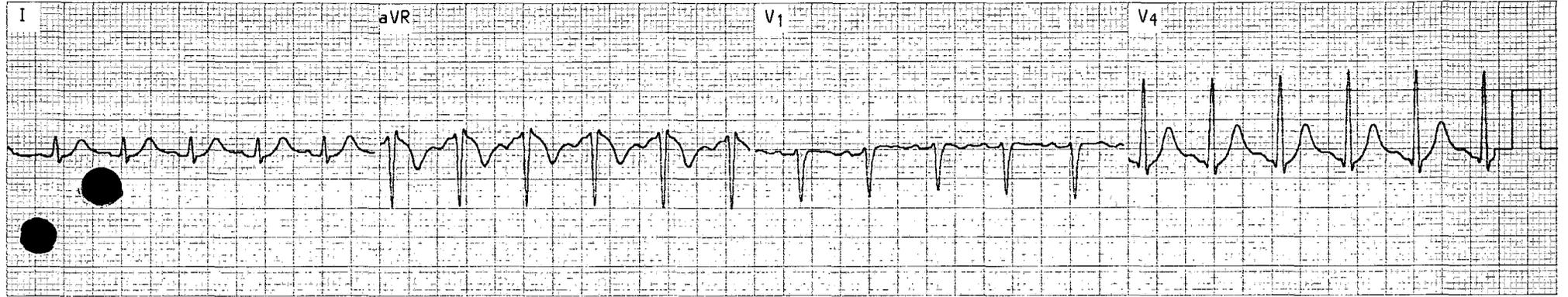
Write Screen ST Level +2.4 fi
Recovery 3:45 ST Slope +33 HR 126

J. O'neil 2-24-87



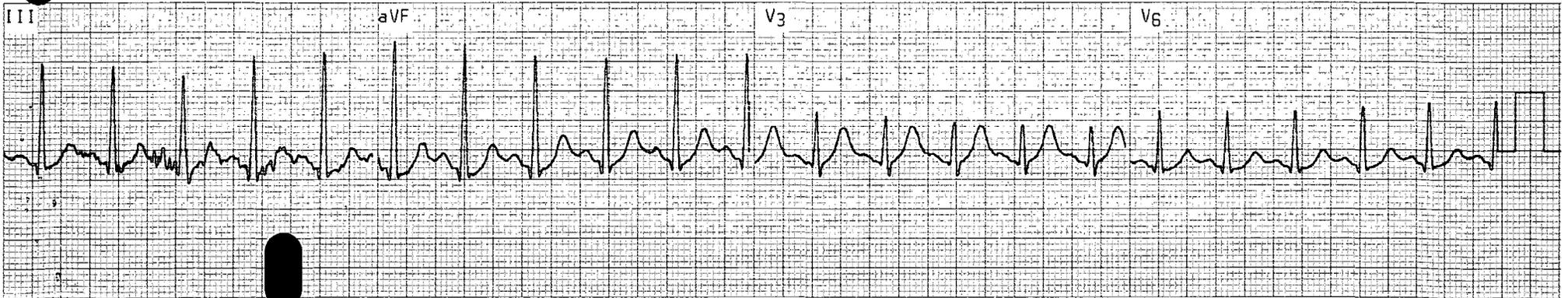
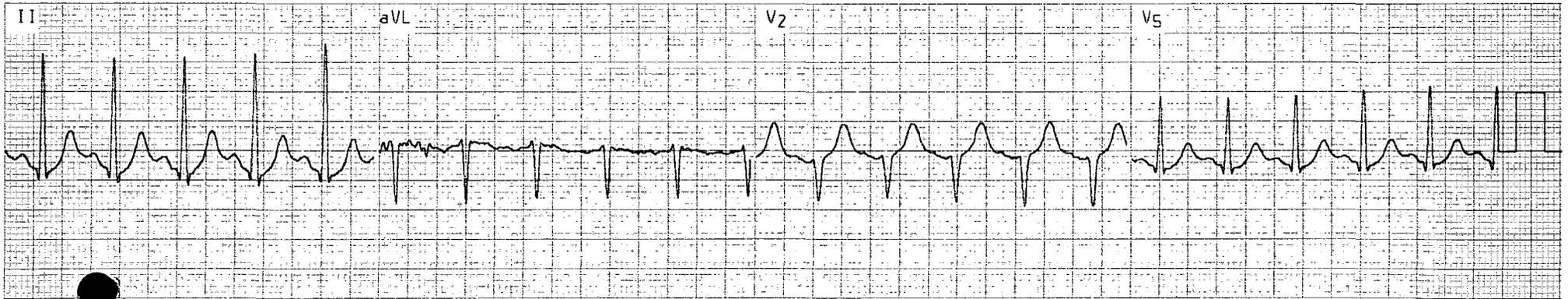
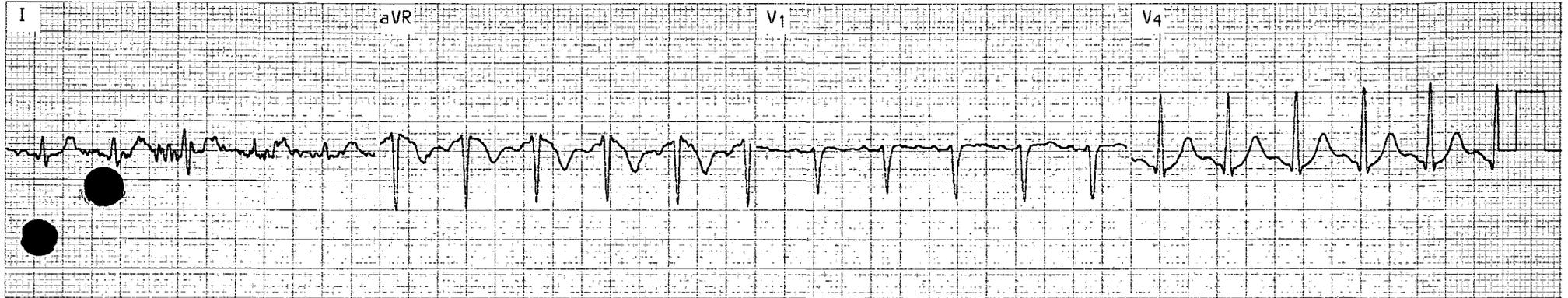
12 Lead ST Level +2.4 filter on Gain x1
Recovery 4:00 ST Slope +31 HR 133 25 mm/sec

J. O'neill
2-24-87



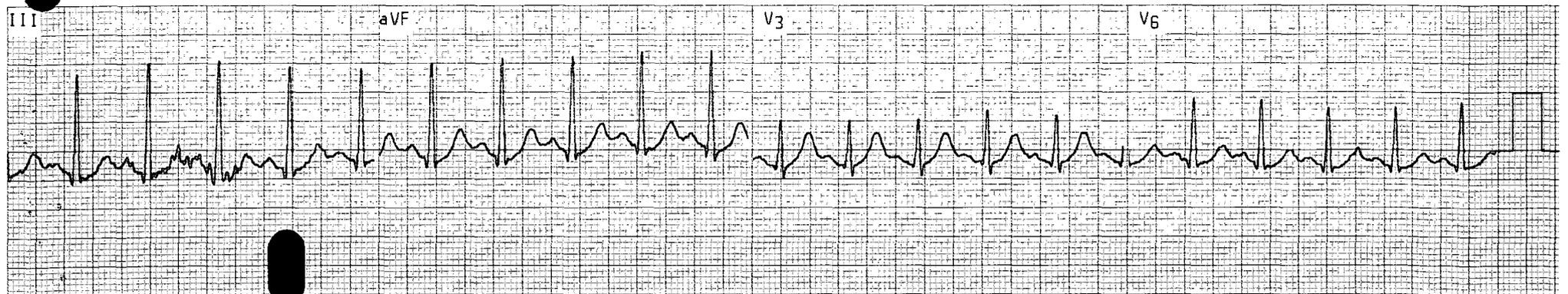
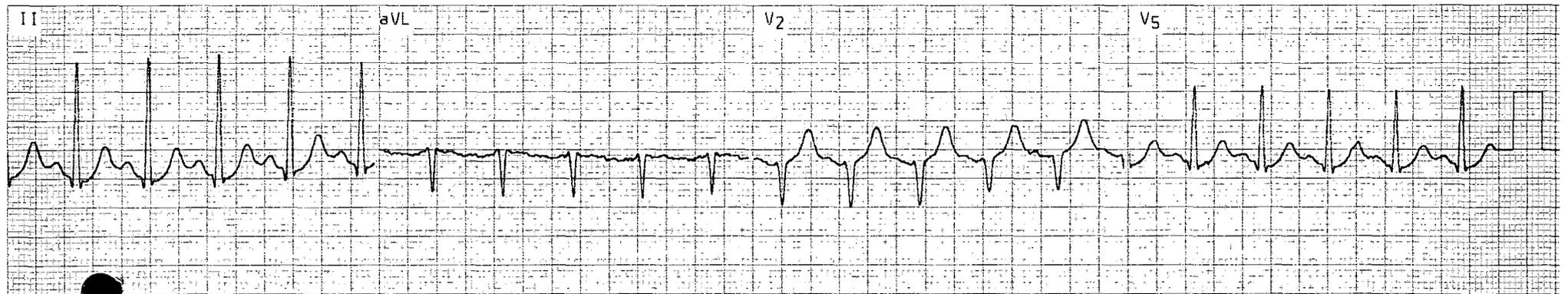
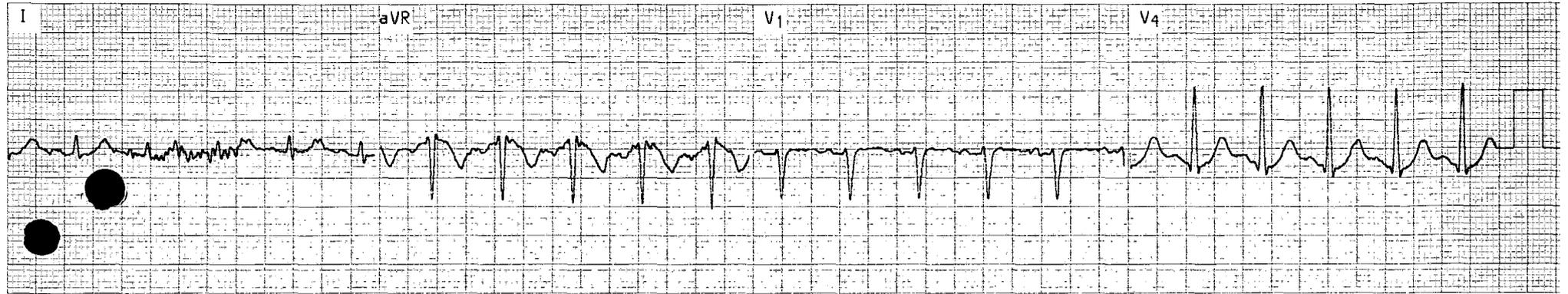
12 Lead ST Level +1.0 filter on Gain x1
Recovery 6:00 ST Slope +16 HR 120 25 mm/sec

J. O'Neill
2-24-87



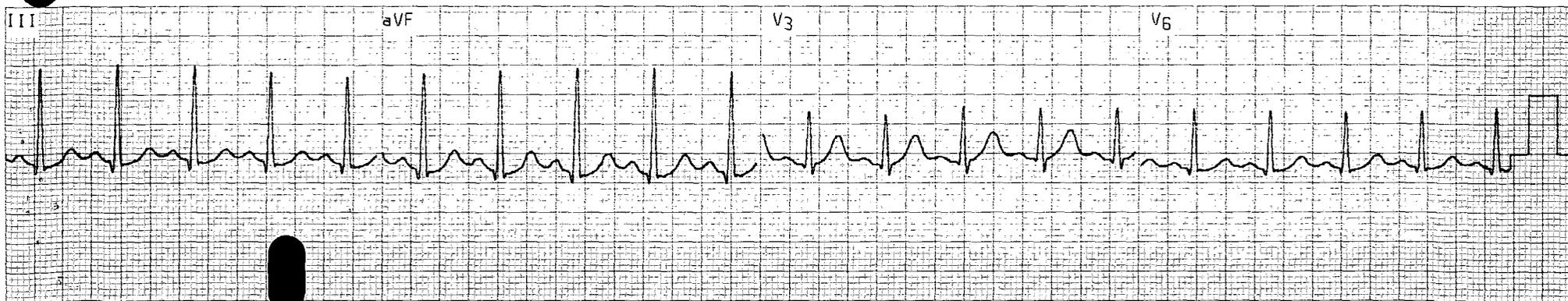
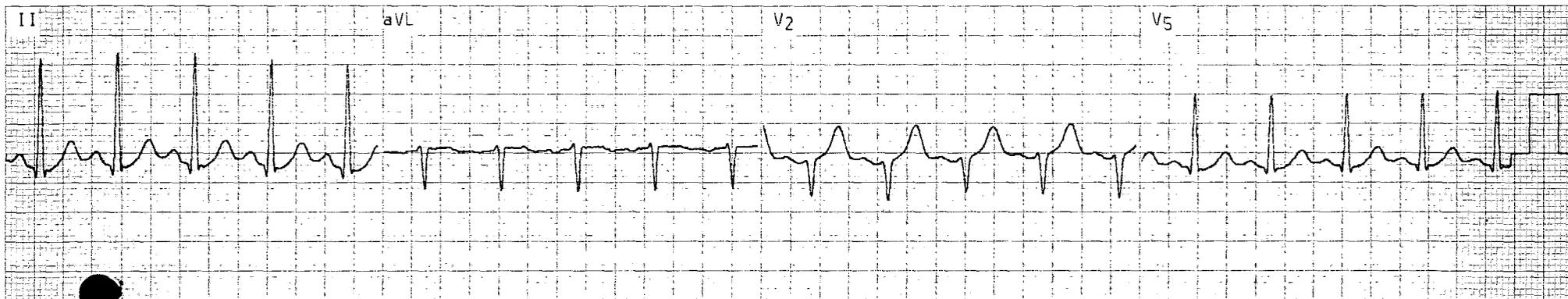
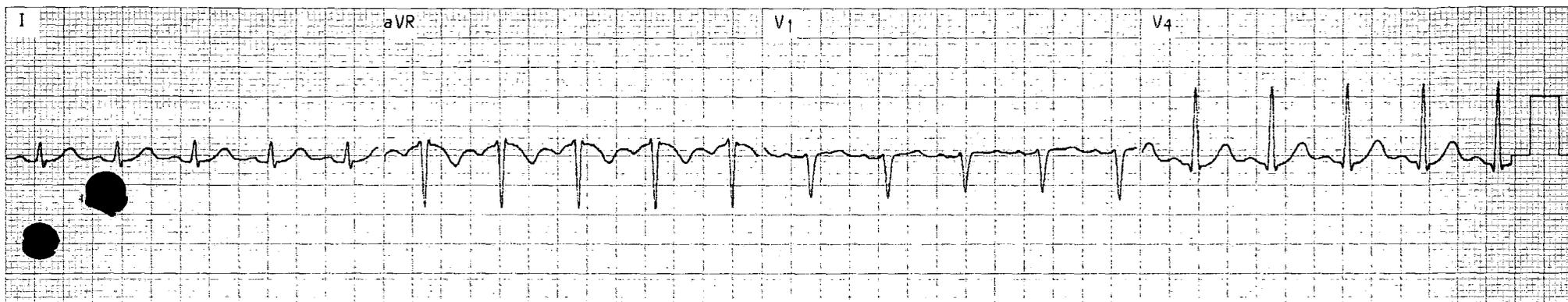
12 Lead ST Level +0.6 filter on Gain x1
Recovery 8:00 ST Slope +13 HR 118 25 mm/sec

J. O'Neill
2-24-87



12 Lead ST Level +0.3 filter on Gain x1
Recovery 14:13 ST Slope +5 HR 114 25 mm/sec

J. O'Neill
2-24-87



Q3000 FINAL REPORT

Patient: _____ Physician: _____ Date: _____
 Address: _____ Phone: _____
 Patient ID: _____ Height: _____ Weight: _____ Age: _____ Sex: M F

Brief History:

Medications: _____ Target HR: _____
 Protocol: V ADVANCED II ST Level at J + 80ms II ST Slope from J + 0ms to J + 60ms

Event	Speed (MPH)	Grade (%)	HR (BPM)	ST Level (mm)	ST Slope (mm/sec)	Comments
rest	1		102	+0.8	+1	
stage 1	3.0	0.0	111	+0.2	+6	
stage 2	3.0	7.5	128	+0.0	+5	
stage 3	3.0	15.0	150	-0.1	+15	
stage 4	3.2	20.0	165	+0.3	+20	
stage 5	3.4	25.0	176	+0.2	+23	
stop exercise @	11:00		186	-0.3	+21	
recovery @	2:00		149	+3.2	+36	
recovery @	4:00		133	+2.4	+31	
recovery @	6:00		120	+1.0	+16	
recovery @	8:00		118	+0.6	+13	
recovery @	10:00		116	+0.2	+8	

Interpretation: _____ METS achieved: 17.8

x _____

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT
✓		15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.
✓		B. Inability to perform certain motions.
✓		C. Inability to assume certain positions.
✓		D. Other medical reasons (If yes, give reasons.)
✓		16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)
✓		17. Have you ever been denied life insurance? (If yes, state reason and give details.)
✓		18. Have you had, or have you been advised to have, any operations? (If yes, describe and give ago at which occurred.)
✓		19. Have you ever been a patient in any type of hospitals? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)
✓		20. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)
✓		21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)
✓		22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)
✓		23. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)
✓		24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)

⑧ Mole Removed by surgery from Right Shoulder Blade area of back-age 6-1958
 Tonsillectomy - age 8-1960
 Appendectomy - age 11-1963
 ⑨ Hospitalized for above Surgery only:
 1958 - De Hildebrandt's Hospital Ventnor, N.J.
 1960 - Same as 1958
 1963 Atlantic City Medical Center Atlantic City N.J.

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE <i>John P. O'Neill</i>	SIGNATURE <i>J. P. O'Neill</i>
---	-----------------------------------

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."
 25. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

TYPED OR PRINTED NAME OF EXAMINER	DATE <i>2/24/67</i>	NUMBER OF ATTACHED SHEETS
-----------------------------------	------------------------	---------------------------

**Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner**

Name of Examinee O'NEILL JOHN P.
(Type or print) Last First Middle

The following portions of the attached examination report form need not be completed:

3	9	17	67	76
4	11	62	68	
8	14	65	72	

- 45, 46, 47 and 49; required for all Special Agent and FBI National Academy applicants but not for any other applicant unless the examining physician deems one, two, three or all four of the examinations necessary. 45, 46 and 47 are required in examination of any current employee.
- 48. Required for (1) all Special Agent applicants; (2) all FBI National Academy applicants; (3) all examinees over 35 years of age; (4) any other where examination indicates such as desirable.
- 69. Required for all examinees over 40 years of age.
- 71. Audiometer examinations must be afforded for all Special Agent applicants and Special Agents and decibel readings must be recorded at 500, 1000, 2000, 3000 and 4000 Hertz. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 25 decibel average (ANSI) in either ear in the frequency range 1000, 2000, and 3000 Hertz. No single reading in that range may exceed 35 decibels and no applicant will be accepted if found to have a hearing loss exceeding 35 decibels at 500 or 45 decibels at 4000 Hertz.

For All Examinees, Whether Clerical or Special Agent Applicants, National Academy Applicants, or Employees:

The medical examiner should answer the following question:

Examinee is is not qualified for strenuous physical exertion.

To be Answered in the Case of All Special Agents, Special Agent Applicants, and National Academy Applicants:

- 1. Does examinee have any defects restricting or prohibiting his/her participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

No Yes If "yes" please specify defects. _____

To be Answered in the Case of All Special Agents, Special Agent Applicants, and other Employees who drive Bureau vehicles:

- 1. Does examinee have any defects prohibiting safe operation of motor vehicles?

No Yes If "yes" please specify defects. _____

- 2. For safe driving of motor vehicles, Office of Personnel Management requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? Yes No

If recommendation is based on a factor other than above standard, indicate basis _____

DESIRABLE WEIGHT RANGES

MALES				FEMALES			
Height	Small Frame	Medium Frame	Large Frame	Height	Small Frame	Medium Frame	Large Frame
5'4"	117 - 138	123 - 149	131 - 163	5'0"	96 - 114	101 - 124	109 - 138
5'5"	120 - 142	126 - 153	134 - 167	5'1"	99 - 118	104 - 128	112 - 141
5'6"	124 - 146	130 - 157	138 - 173	5'2"	102 - 121	107 - 131	115 - 144
5'7"	128 - 151	134 - 163	143 - 178	5'3"	105 - 124	110 - 135	118 - 149
5'8"	132 - 155	138 - 167	147 - 183	5'4"	108 - 128	113 - 139	121 - 152
5'9"	136 - 161	142 - 172	151 - 187	5'5"	111 - 132	117 - 144	125 - 156
5'10"	140 - 165	146 - 177	155 - 193	5'6"	114 - 135	120 - 149	129 - 161
5'11"	144 - 169	150 - 183	160 - 198	5'7"	118 - 140	124 - 153	133 - 165
6'	148 - 174	154 - 188	164 - 204	5'8"	122 - 144	128 - 157	137 - 169
6'1"	152 - 179	158 - 194	169 - 209	5'9"	126 - 149	132 - 162	141 - 174
6'2"	156 - 184	163 - 199	174 - 215	5'10"	130 - 154	136 - 166	145 - 179
6'3"	160 - 188	168 - 205	178 - 220	5'11"	134 - 158	140 - 171	149 - 185
6'4"	169 - 198	178 - 216	188 - 231	6'0"	138 - 163	144 - 175	153 - 190
6'5"	174 - 204	182 - 222	192 - 238				

4. Examinee's frame is small medium large

5. Considering the above weight table, the examinee's frame, and other individual physical characteristics, I consider his/her present weight Satisfactory Excessive Deficient

6. Under proper medical supervision, employee should lose _____ pounds
 gain _____ pounds

Remarks: _____

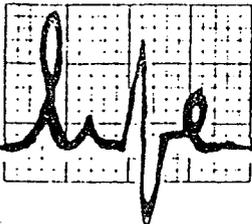
2/24/87
Date

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NORTH ARUNDEL CARDIAC FITNESS AND REHABILITATION CENTER
PRE-STRESS TEST INTERVIEW

Name John P. O'Neill Age 35 Ht. 6'0" Wt. 204 Date 12/1/80

1. What Medications do you take? None
2. Did you take your medications this morning? NO
3. Have you had anything to eat or drink this morning? NO If yes, what and when? _____
4. Do you smoke cigarettes? NO If yes, how many per day? _____
When was your last cigarette? _____
5. Have you had any unusual problems lately (chest pain, SOB, joint problems, etc.)? NO If yes, explain _____
6. Have you been doing any regular exercise? yes If yes, what kind? RACKETBALL How much and how often? 2 times a week
7. Do you ever have any problems while exercising? NO
If yes, explain _____
8. Do you have any orthopedic (Bone or joint) problems? NO
If yes, explain _____ Have you ever had any orthopedic surgery? _____ What kind and when? _____
9. Have you been sick recently? NO If yes, explain _____
10. Is there anything you would like to tell or ask the doctor about the stress test or your exercising? NO



LIFE RESOURCES INC.

Preventive Health Management
Health Information Processing
Health Care Cost Containment

INFORMED CONSENT FOR EXERCISE STRESS TEST & LABORATORY EVALUATION

(Pulmonary)

1. Explanation of Tests and Benefits to be Expected:

In order to determine an appropriate plan of medical management, I hereby consent to voluntarily engage in an exercise test to determine the state of my heart and circulation. I also consent to have a blood sample drawn for blood chemistry analysis and to the performance of a lung function test and a body fat analysis. The information thus obtained will help my physician in advising me as to the activities in which I may engage.

Before I undergo the test, I will be interviewed and my records will be reviewed to determine if any condition exists that would contra-indicate the performance of the test. The test which I will undergo will be performed on a Quinton Treadmill with the amount of effort increasing gradually. This increase in effort will continue until symptoms such as fatigue, shortness of breath, or chest discomfort may appear, or the doctor determines that the test should be stopped.

During the test, pulse, blood pressure and electrocardiogram will be monitored. Additionally, a special device will be attached to your ear to monitor the oxygen content of your blood.

2. Risks:

There exists the possibility of adverse changes occurring during the test. These could include abnormal blood pressure, fainting, disorders of heart rhythm, and very rare instances of heart attack. Every effort will be made to minimize these by preliminary examination and by observations during the test. Emergency equipment and trained personnel are available to deal with the unusual situations which may arise.

3. Confidentiality and Uses of Information:

The information which is obtained in this test will be treated as privileged and confidential and will not be released or revealed to any person without my express written consent. I further understand that any information about my participation in the exercise program or about my future health or work status will also be treated as privileged and confidential.

NORTH ARUNDEL CARDIAC FITNESS AND REHABILITATION CENTER

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EXERCISE STRESS TEST SUMMARY

NAME John O'Neill AGE 35 M.D. DATE 2-24-87

MEDICATIONS N/A

CLINICAL INFORMATION

RESTING EKG: Norm Bdline Abnorm Interpretation: _____

Supine HR 78 Supine BP 120/84 Standing HR 92 Standing BP 120/84

EXERCISE 184-190 ^{Pre} Protocol V Fitness

Stage	METS	Speed	Grade	Min.	HR	BP	RPE	Signs-Symptoms	EKG Changes
I	3.3	3.0	0	2	111	140/80	9		
II	6.4	3.0	7.5	4	127	144/88	11		
III	9.5	3.0	15.0	6	148	160/90	12		
IV	12.2	3.2	20.0	8	162	165/80	13		
V	15.3	3.4	25.0	10	175	170/70	15	leg pain - Fatigue	
VI	17.8	6.0	19.0	12	186	stopped		(11:00 min) Reached max	
VII									
VIII									
IX									
X									

POST EXERCISE

Time	HR	BP	Signs-Symptoms	EKG Changes	Remarks
IPE	186	130/70			Termination criteria:
1 Min	157	140/68	1 PUC		
2 Min	149	138/70	III		
4 Min	133	144/80	IIII		
6 Min	120	138/80	II		
8 Min	118	130/80	III 14mm - 114		

Exercise EKG: Norm Bdline Abnorm Interpretation: _____

Post-Exercise EKG Interpretation: _____

MET Level Acheived _____ Prescribed Exercise HR Range _____

CONCLUSIONS: Normal Exercise tolerance test
No evidence of ischemia
Satisfactory fitness level

M.D. Sig

FIR25-75% (L/s) 0.11 0.27
 INSP Test Time (s) 18.56 5.88

Comments:

MVV

(No Pre-MVV performed)

Function	Pred	Meas	%Pred
MVV (L/min)	151.58		
MVV (L/s)	2.53		
Test time (sec)			
VE (L)			
RR (brths/min)			

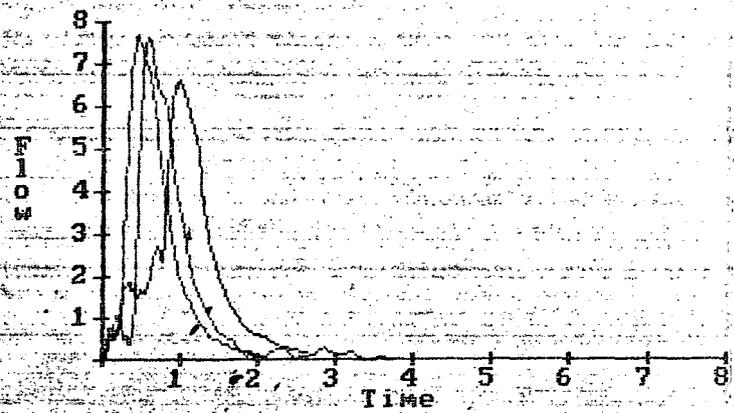
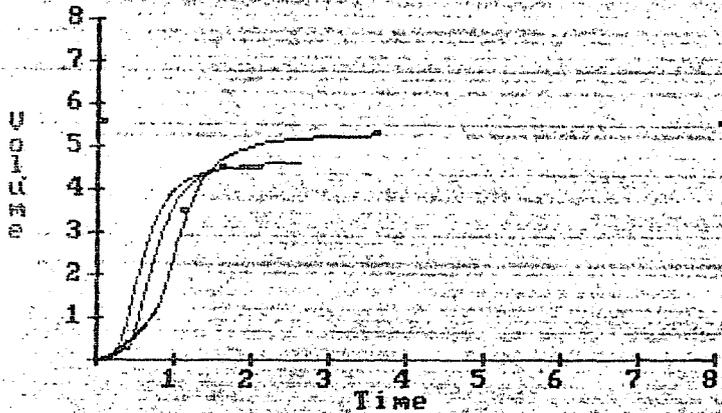
NORTH ARUNDEL CARDIAC FITNESS AND REHABILITATION CENTER
 200 HOSPITAL DRIVE LL 10
 GLEN BURNIE, MARYLAND 21061 301/768-6644

PULMONARY FUNCTION REPORT
 (Pre-Summary)

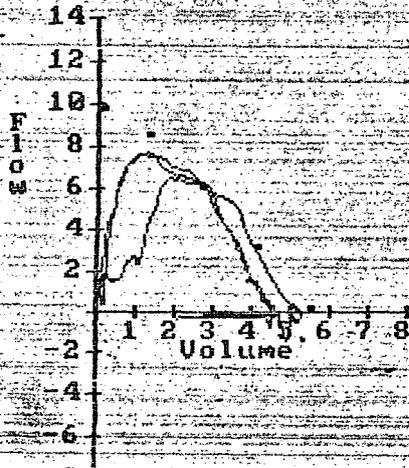
Name: JOHN O'NEILL

ID #: 147421004

Best ---
 Pred ...



Best ---
 Pred ...



NORTH ARUNDEL CARDIAC FITNESS AND REHABILITATION CENTER

200 HOSPITAL DRIVE LL 10

GLEN BURNIE, MARYLAND 21061

301/768-6644

PULMONARY FUNCTION REPORT

Page 1

(Pre-Summary)

Name: JOHN O'NEILL ID #: 147421004
 Age: 35 Sex: M Height: 72 in. Weight: 204 lb.
 Smoking history: 0 pack-years Race: CAUC
 Doctor: [REDACTED] Tech: [REDACTED]
 Predicted: Crapo File: J00240E8 Report #: 1 DEMO STANDARD REPORT
 Comments:

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~~~~~ Interpretation ~~~~~

Spirometry within normal limits  
 (Subject to physician's review)

~~~~~ Exp/Insp ~~~~~

(Pre: 02-24-1987 12:18:17)

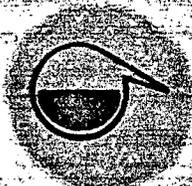
| Function | Pred | Best | | Incn | | Incn | |
|-----------------------------|------|-------|------|------|------|------|------|
| | | Meas | %Prd | Meas | %Prd | Meas | %Prd |
| FVC (L) | 5.57 | 5.29 | 95% | 4.62 | 83% | 4.52 | 81% |
| FEV1 (L) | 4.53 | 4.70 | 104% | 4.36 | 96% | 4.32 | 95% |
| FEV1/FVC | 0.81 | 0.89 | 109% | 0.94 | 115% | 0.96 | 118% |
| PEFR (L/s) | 9.75 | 6.63 | 68% | 7.66 | 79% | 7.69 | 79% |
| FEF _{2-1.2} (L/s) | | 2.06 | | 4.09 | | 6.05 | |
| FEF _{50%} (L/s) | 6.03 | 6.33 | 105% | 6.32 | 105% | 6.85 | 114% |
| FEF _{25-75%} (L/s) | 4.53 | 5.62 | 124% | 6.00 | 132% | 6.33 | 140% |
| EXP Test Time(s) | | 3.72 | | 2.69 | | 2.25 | |
| FIVC (L) | | 2.48 | | 2.50 | | | |
| FIV1 (L) | | 0.59 | | 0.45 | | | |
| FIV1/FIVC | | 0.24 | | 0.18 | | | |
| PIFR (L/s) | | 1.43 | | 0.71 | | | |
| FIF _{2-1.2} (L/s) | | 0.15 | | 0.28 | | | |
| FIF _{25-75%} (L/s) | | 0.11 | | 0.27 | | | |
| INSP Test Time(s) | | 18.56 | | 8.88 | | | |

Comments:

~~~~~ MVV ~~~~~

(No Pre-MVV performed)

| Function        | Pred   | Meas | %Prd |
|-----------------|--------|------|------|
| MVV (L/min)     | 151.58 |      |      |
| MVV (L/s)       | 2.53   |      |      |
| Test time (sec) |        |      |      |
| Vt (L)          |        |      |      |
| RR (brths/min)  |        |      |      |



# MARYLAND MEDICAL LABORATORY, INC.

Main Office: Pathology Building  
1901 Sulphur Spring Road, P. O. Box 24080  
Baltimore, Maryland 21227-0580

BALTO. AREA (301) 247-9100/WASH. AREA (301) 596-0560

PATHOLOGISTS  
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DIRECTOR OF LABORATORIES

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KENNETH L. MUMBERT, M.D.  
WILLIAM R. WEISBURGER, M.D.  
ROBERT R. L. SMITH, M.D.

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DAVID L. BLACK, Ph.D.

VIROLOGIST/IMMUNOLOGIST:  
WILLIAM A. MEYER, III, Ph.D.  
HELENE M. PARTON, M.A., M.T. (ASCP)

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PHYSICIAN

[Redacted]  
FITNESS & CARDIAC REHAB.  
CENTER  
200 HOSPITAL DRIVE  
GLEN BURNIE MD 21061 (C-1)

PATIENT

ONEILL, JOHN P.  
7142 AMBASSADOR RD  
BALTIMORE MD 21207

SPECIMEN COLLECTED: 2/20/87 12:05PM

| PATIENT NAME    | DATE     | AGE | SEX | LAB NUMBER | LABORATORY REPORT |
|-----------------|----------|-----|-----|------------|-------------------|
| ONEILL, JOHN P. | 02/20/87 | 35  | M   | A87145274  |                   |

## CONTINUATION OF REPORT

HDL-CHOLESTEROL ----- 38 MG/DL ( 29-62 )  
 % HDL-CHOLESTEROL ----- 18.9 % ( 15-75 )  
 C-TOTAL/C-HDL RATIO ----- 5.13

| C-TOTAL/C-HDL (RATIO) | RELATIVE RISK * |
|-----------------------|-----------------|
| ( LESS THAN 3.43 )    | LOW             |
| ( 3.43 - 4.96 )       | BELOW AVERAGE   |
| ( 4.97 )              | AVERAGE         |
| ( 4.98 - 9.55 )       | ABOVE AVERAGE   |
| ( GREATER THAN 9.55 ) | HIGH            |

( \* IN ORDER TO DETERMINE THE RELATIVE RISK OF DEVELOPING CORONARY ARTERY DISEASE, TAKE THE VALUE FOR C-TOTAL/C-HDL RATIO AND DETERMINE WHERE THE VALUE FITS INTO THE ABOVE TABLE. )

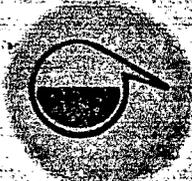
## IMMUNOLOGY:

RAPID PLASMA REAGIN (SCREEN)---- NON-REACTIVE  
 ( NORMAL: NON-REACTIVE )  
 ( SIGNIFICANT: REACTIVE )



(COMPLETED)

02/21/87  
DATE REPORTED



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b6  
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PHYSICIAN

FITNESS & CARDIAC REHAB.  
CENTER  
200 HOSPITAL DRIVE  
GLEN BURNIE MD 21061 (C-1)

PATIENT

ONEILL, JOHN P  
7142 AMBASSADOR RD  
BALTIMORE MD 21207

SPECIMEN COLLECTED: 2/20/87 12:05PM

| PATIENT NAME   | DATE     | AGE | SEX | LAB NUMBER | LABORATORY REPORT |
|----------------|----------|-----|-----|------------|-------------------|
| ONEILL, JOHN P | 02/20/87 | 35  | M   | A87145274  |                   |

### HEMATOLOGY:

|      |      |                   |            |     |                  |
|------|------|-------------------|------------|-----|------------------|
| RBC  | 4.86 | MEGA. (4.4-6.0)   | WBC        | 6.1 | KILO. (4.3-10.5) |
| HGB  | 16.1 | GM/DL (13.5-17.5) | BANDS      | 6   | % (0-8)          |
| HCT  | 46.7 | % (40-53)         | POLYS      | 52  | % (40-80)        |
| MCV  | 96   | CUU. (80-100)     | LYMPHS     | 35  | % (10-49)        |
| *MCH | 33.1 | UUG. (26-33)      | MONOS      | 3   | % (1-12)         |
| MCHC | 34.5 | % (32-36)         | EOSIN      | 3   | % (0-7)          |
|      |      |                   | BASOS      | 1   | % (0-2)          |
|      |      |                   | ATYP LYMPH | 0   | % (0-2)          |

### COMMENT:

PLATELETS----- ADEQUATE

### CLINICAL MICROSCOPY:

COLOR----- AMBER-MILD TURBIDITY  
PH----- 5.0  
GLUCOSE----- NEG.  
BILIRUBIN--- NEG.  
LEUK. EST.-- NEG.

SP. GRAV.--- 1.024  
PROTEIN----- NEG.  
ACETONE----- NEG.  
BLOOD----- NEG.

### MICROSCOPIC:

WBC/HPF----- 0  
EPITH. CELLS/HPF----- 0  
MUCUS----- MARKED  
RBC/HPF----- 0  
BACTERIA----- SLIGHT

### CHEMISTRY:

|              |      |                 |              |      |                  |
|--------------|------|-----------------|--------------|------|------------------|
| LDH-----     | 131  | IU/L (70-200)   | GLUCOSE----  | 92   | MG/DL (65-115)   |
| SGOT-----    | 24   | IU/L (0-50)     | BUN-----     | 16   | MG/DL (8-22)     |
| SGPT-----    | 36   | IU/L (0-50)     | CREATININE-- | 1.0  | MG/DL (0.9-1.4)  |
| ALK PHOS---  | 116  | IU/L (35-130)   | BU/CR RATIO  | 16.0 | (10-25)          |
| TOT. BILI--  | 0.9  | MG/DL (0.2-1.4) | URIC ACID--  | 7.4  | MG/DL (3.5-8.4)  |
| DIR. BILI--  | 0.1  | MG/DL (0.0-0.4) | CALCIUM----  | 10.3 | MG/DL (8.7-10.6) |
| IND. BILI--  | 0.8  | MG/DL (0.1-1.0) | PHOSPHATES-- | 3.7  | MG/DL (2.7-4.6)  |
| TOT. PROT.-- | 7.7  | GM/DL (6.3-8.2) | SODIUM-----  | 139  | MEQ/L (137-147)  |
| ALBUMIN---   | 4.9  | GM/DL (3.7-5.5) | POTASSIUM--  | 4.1  | MEQ/L (3.7-5.3)  |
| GLOBULIN---  | 2.8  | GM/DL (1.8-3.5) | CHLORIDE---  | 107  | MEQ/L (97-110)   |
| A/G RATIO--  | 1.75 | (1.10-2.60)     | CO/2-----    | 27   | MEQ/L (22-32)    |

CHOLESTEROL----- 201 MG/DL (MODERATE RISK-OVER 220)  
(HIGH RISK-----OVER 240)  
TRIGLYCERIDE----- 117 MG/DL (58-250)



DATE REPORTED

*DIV-6*

REPORT OF MEDICAL EXAMINATION

|                                                                                                                                           |                             |                                                                    |                                                                  |            |                                             |                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|--------------------------------------------------------------------|------------------------------------------------------------------|------------|---------------------------------------------|----------------------------------------------------|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME<br><b>O'NEILL, JOHN P.</b>                                                                            |                             |                                                                    | 2. GRADE AND COMPONENT OR POSITION<br><b>SUPV. SPECIAL AGENT</b> |            | 3. IDENTIFICATION NO.<br><b>147-42-1004</b> |                                                    |
| 4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)<br><b>n/a</b>                                                   |                             |                                                                    | 5. PURPOSE OF EXAMINATION<br><b>FITNESS FOR DUTY</b>             |            | 6. DATE OF EXAMINATION<br><b>2/24/87</b>    |                                                    |
| 7. SEX<br><b>M</b>                                                                                                                        | 8. RACE<br><b>Caucasian</b> | 9. TOTAL YEARS GOVERNMENT SERVICE<br>MILITARY _____ CIVILIAN _____ |                                                                  | 10. AGENCY | 11. ORGANIZATION UNIT                       |                                                    |
| 12. DATE OF BIRTH<br><b>2/6/52</b> (35)                                                                                                   |                             |                                                                    | 13. PLACE OF BIRTH                                               |            |                                             | 14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN |
| 15. EXAMINING FACILITY OR EXAMINER AND ADDRESS<br><b>North Arundel Cardiac Fitness Center<br/>200 Hospital Dr., Glen Burnie, MD 21061</b> |                             |                                                                    | 16. OTHER INFORMATION                                            |            |                                             |                                                    |
| 17. RATING OR SPECIALTY                                                                                                                   |                             |                                                                    | TIME IN THIS CAPACITY (Total)                                    |            | LAST SIX MONTHS                             |                                                    |

CLINICAL EVALUATION

| NOR-MAL                             | (Check each item in appropriate column; enter "NE" if not evaluated)                                        | ABNOR-MAL |
|-------------------------------------|-------------------------------------------------------------------------------------------------------------|-----------|
| <input checked="" type="checkbox"/> | 18. HEAD, FACE, NECK AND SCALP                                                                              |           |
| <input checked="" type="checkbox"/> | 19. NOSE                                                                                                    |           |
| <input checked="" type="checkbox"/> | 20. SINUSES                                                                                                 |           |
| <input checked="" type="checkbox"/> | 21. MOUTH AND THROAT                                                                                        |           |
| <input checked="" type="checkbox"/> | 22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)                               |           |
| <input checked="" type="checkbox"/> | 23. DRUMS (Perforation)                                                                                     |           |
| <input checked="" type="checkbox"/> | 24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 65)                                   |           |
| <input checked="" type="checkbox"/> | 25. OPHTHALMOSCOPIC                                                                                         |           |
| <input checked="" type="checkbox"/> | 26. PUPILS (Equality and reaction)                                                                          |           |
| <input checked="" type="checkbox"/> | 27. OCULAR MOTILITY (Associated parallel movements, nystagmus)                                              |           |
| <input checked="" type="checkbox"/> | 28. LUNGS AND CHEST (Include breasts)                                                                       |           |
| <input checked="" type="checkbox"/> | 29. HEART (Thrust, size, rhythm, sounds)                                                                    |           |
| <input checked="" type="checkbox"/> | 30. VASCULAR SYSTEM (Varicosities, etc.)                                                                    |           |
| <input checked="" type="checkbox"/> | 31. ABDOMEN AND VISCERA (Include hernia)                                                                    |           |
| <input checked="" type="checkbox"/> | 32. ANUS AND RECTUM (Hemorrhoids, fistula) (Prostate, if indicated)                                         |           |
| <input checked="" type="checkbox"/> | 33. ENDOCRINE SYSTEM                                                                                        |           |
| <input checked="" type="checkbox"/> | 34. G-U SYSTEM                                                                                              |           |
| <input checked="" type="checkbox"/> | 35. UPPER EXTREMITIES (Strength, range of motion)                                                           |           |
| <input checked="" type="checkbox"/> | 36. FEET                                                                                                    |           |
| <input checked="" type="checkbox"/> | 37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)                                             |           |
| <input checked="" type="checkbox"/> | 38. SPINE, OTHER MUSCULOSKELETAL                                                                            |           |
| <input checked="" type="checkbox"/> | 39. IDENTIFYING BODY MARKS, SCARS, TATTOOS                                                                  |           |
| <input checked="" type="checkbox"/> | 40. SKIN, LYMPHATICS                                                                                        |           |
| <input checked="" type="checkbox"/> | 41. NEUROLOGIC (Equilibrium tests under item 72)                                                            |           |
| <input checked="" type="checkbox"/> | 42. PSYCHIATRIC (Specify any personality deviation)                                                         |           |
| <input checked="" type="checkbox"/> | 43. PELVIC (Females only) (Check how done)<br>ANAL <input type="checkbox"/> RECTAL <input type="checkbox"/> |           |

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

*5/4/87 Annual physical and Cardiac stress test, WNL.*



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*Refer home. Sta reg.*

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

| Restorable teeth |   |   | Non-restorable teeth |   |   | Missing teeth |   |   | Replaced by dentures |   |   | Fixed Partial dentures |   |   |
|------------------|---|---|----------------------|---|---|---------------|---|---|----------------------|---|---|------------------------|---|---|
| 1                | 2 | 3 | 1                    | 2 | 3 | 1             | 2 | 3 | 1                    | 2 | 3 | 1                      | 2 | 3 |
| R                |   |   |                      |   |   |               |   |   |                      |   |   |                        |   |   |
| I                |   |   |                      |   |   |               |   |   |                      |   |   |                        |   |   |
| G                |   |   |                      |   |   |               |   |   |                      |   |   |                        |   |   |
| H                |   |   |                      |   |   |               |   |   |                      |   |   |                        |   |   |
| T                |   |   |                      |   |   |               |   |   |                      |   |   |                        |   |   |

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

*Class T*

LABORATORY FINDINGS

|                                                   |                                          |                                                                    |                                      |
|---------------------------------------------------|------------------------------------------|--------------------------------------------------------------------|--------------------------------------|
| 45. URINALYSIS: A. SPECIFIC GRAVITY. <b>1.024</b> |                                          | 46. CHEST X-RAY (Place, date, film number and result)<br><b>NA</b> |                                      |
| B. ALBUMIN <b>ONE</b>                             | D. MICROSCOPIC <b>Microscopic method</b> |                                                                    |                                      |
| C. SUGAR <b>ONE</b>                               | 48. EKG <b>WNL</b>                       | 49. BLOOD TYPE AND RH FACTOR <b>NA</b>                             | 50. OTHER TESTS <b>Stem Test WNL</b> |

**MEASUREMENTS AND OTHER FINDINGS**

|                                         |     |                                     |  |                                              |  |                                |            |                                                                                                                                                         |              |                                                          |                         |                         |                          |              |
|-----------------------------------------|-----|-------------------------------------|--|----------------------------------------------|--|--------------------------------|------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|----------------------------------------------------------|-------------------------|-------------------------|--------------------------|--------------|
| 51. HEIGHT<br>6'0"                      |     | 52. WEIGHT<br>204                   |  | 53. COLOR HAIR<br>Brown                      |  | 54. COLOR EYES<br>Hazel        |            | 55. BUILD:<br><input type="checkbox"/> SLENDER <input checked="" type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE |              |                                                          | 56. TEMPERATURE<br>97.9 |                         |                          |              |
| 57. BLOOD PRESSURE (Arm at heart level) |     |                                     |  |                                              |  | 58. PULSE (Arm at heart level) |            |                                                                                                                                                         |              |                                                          |                         |                         |                          |              |
| A. SITTING<br>SYS. 122<br>DIAS. 82      |     | B. RECUMBENT<br>SYS. 26<br>DIAS. 80 |  | C. STANDING (3 min.)<br>SYS. 119<br>DIAS. 78 |  | A. SITTING<br>66               |            | B. AFTER EXERCISE<br>104                                                                                                                                |              | C. 2 MIN. AFTER<br>84                                    |                         | D. RECUMBENT<br>72      | E. AFTER STANDING 3 MIN. |              |
| 59. DISTANT VISION                      |     |                                     |  | 60. REFRACTION                               |  |                                |            | 61. NEAR VISION                                                                                                                                         |              |                                                          |                         |                         |                          |              |
| RIGHT 20/50                             |     | CORR. TO 20/20                      |  | BY S.                                        |  | CX                             |            | 20/25                                                                                                                                                   |              | CORR. TO                                                 |                         | BY                      |                          |              |
| LEFT 20/30                              |     | CORR. TO 20/15                      |  | BY S.                                        |  | CX                             |            | 20/30                                                                                                                                                   |              | CORR. TO                                                 |                         | BY                      |                          |              |
| 62. HETEROPHORIA (Specify distance)     |     |                                     |  |                                              |  |                                |            |                                                                                                                                                         |              |                                                          |                         |                         |                          |              |
| ES°                                     | EX° | R. H.                               |  | L. H.                                        |  | PRISM DIV.                     |            | PRISM CONV. CT                                                                                                                                          |              | PC                                                       |                         | PD                      |                          |              |
| 63. ACCOMMODATION                       |     |                                     |  | 64. COLOR VISION (Test used and result)      |  |                                |            | 65. DEPTH PERCEPTION (Test used and score)                                                                                                              |              |                                                          |                         | UNCORRECTED             |                          |              |
| RIGHT                                   |     | LEFT                                |  | Disturbed: WNL                               |  |                                |            |                                                                                                                                                         |              |                                                          |                         | CORRECTED               |                          |              |
| 66. FIELD OF VISION                     |     |                                     |  | 67. NIGHT VISION (Test used and score)       |  |                                |            | 68. RED LENS TEST                                                                                                                                       |              |                                                          |                         | 69. INTRAOCULAR TENSION |                          |              |
| 70. HEARING                             |     |                                     |  | 71. AUDIOMETER                               |  |                                |            |                                                                                                                                                         |              | 72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score) |                         |                         |                          |              |
| RIGHT WV                                |     | /15 SV                              |  | /15                                          |  |                                | 250<br>256 | 500<br>512                                                                                                                                              | 1000<br>1024 | 2000<br>2048                                             | 3000<br>2986            | 4000<br>4096            | 6000<br>6144             | 8000<br>8192 |
| LEFT WV                                 |     | /15 SV                              |  | /15                                          |  | RIGHT                          | 25         | 20                                                                                                                                                      | 0            | 10                                                       | 10                      | 10                      |                          |              |
|                                         |     |                                     |  |                                              |  | LEFT                           | 25         | 20                                                                                                                                                      | 5            | 5                                                        | 15                      | 20                      |                          |              |

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets if necessary)

|                                                                         |  |  |  |  |  |                         |   |   |   |                           |   |
|-------------------------------------------------------------------------|--|--|--|--|--|-------------------------|---|---|---|---------------------------|---|
| 74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers) |  |  |  |  |  |                         |   |   |   |                           |   |
| 75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify) |  |  |  |  |  | 76. A. PHYSICAL PROFILE |   |   |   |                           |   |
|                                                                         |  |  |  |  |  | P                       | U | L | H | E                         | S |
|                                                                         |  |  |  |  |  |                         |   |   |   |                           |   |
| 77. EXAMINEE (Check)                                                    |  |  |  |  |  | B. PHYSICAL CATEGORY    |   |   |   |                           |   |
| A. <input checked="" type="checkbox"/> IS QUALIFIED FOR                 |  |  |  |  |  |                         |   |   |   |                           |   |
| B. <input type="checkbox"/> IS NOT QUALIFIED FOR                        |  |  |  |  |  | A                       |   |   |   |                           |   |
| 78. IF NOT QUALIFIED. LIST DISQUALIFYING DEFECTS BY ITEM NUMBER         |  |  |  |  |  | B                       | C | E |   |                           |   |
| 79. TYPED OR PRINTED NAME OF PHYSICIAN                                  |  |  |  |  |  | SIGNATURE               |   |   |   |                           |   |
| 80. TYPED OR PRINTED NAME OF PHYSICIAN                                  |  |  |  |  |  | [Signature Box]         |   |   |   |                           |   |
| 81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)      |  |  |  |  |  |                         |   |   |   |                           |   |
| 82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY   |  |  |  |  |  | SIGNATURE               |   |   |   | NUMBER OF ATTACHED SHEETS |   |

b6  
b7c

Interpretation of Exercise EKG

1. \_\_\_\_\_ Normal EKG at maximal effort: heart rate \_\_\_\_\_
2. \_\_\_\_\_ Normal EKG at submaximal (90% predicted) heart rate
3. \_\_\_\_\_ Normal EKG at submaximal heart rate of \_\_\_\_\_
4. \_\_\_\_\_ Abnormal ST junction and segment shift (3 consecutive beats)
  - a. Junction elevated \_\_\_\_\_ mm
  - b. Junction depressed \_\_\_\_\_ mm
  - c. ST segment (from J point to at least .08 seconds):  
\_\_\_\_\_ downsloping  
\_\_\_\_\_ flat  
\_\_\_\_\_ slowly rising
  - d. Leads where changes seen \_\_\_\_\_

---

5. \_\_\_\_\_ ST junction depression but segment normal (probably a normal response)
6. \_\_\_\_\_ Tracing technically inadequate for interpretation
7. \_\_\_\_\_ Other \_\_\_\_\_

Conclusions

1. \_\_\_\_\_ Negative exercise stress test
2. \_\_\_\_\_ Positive exercise stress test due to \_\_\_\_\_

---

3. \_\_\_\_\_ Borderline pos. exercise stress test
4. \_\_\_\_\_ Uninterpretable exercise stress test
5. \_\_\_\_\_ Negative exercise stress test with hypertensive response to exercise

Recommendations

1. \_\_\_\_\_ O.K. to begin exercise: \_\_\_\_\_ Program
2. \_\_\_\_\_ Refer back to private physician
3. \_\_\_\_\_ Further tests or treatment recommended: \_\_\_\_\_

\_\_\_\_\_  
M.D. Signature

NORTH ARUNDEL CARDIAC FITNESS AND REHABILITATION CENTER  
 200 HOSPITAL DRIVE LL 10  
 GLEN BURNIE, MARYLAND 21061 301/768-6644

PULMONARY FUNCTION REPORT  
 (Pre- Summary)

Page 1

Name: JOHN O'NEILL ID #: 147421004  
 Age: 35 Sex: M Height: 72 in. Weight: 204 lb. b6  
 Smoking history: 0 pack-years Race: CAUC b7c  
 Doctor: [redacted] Tech: [redacted]  
 Predicteds: Crapo File: J00Z40E8 Report #: 1 DEMO STANDARD REPORT  
 Comments:

~~~~~ Interpretation ~~~~~

Spirometry within normal limits.
 (Subject to physician's review)

~~~~~ Exp/Insp ~~~~~  
 (Pre-: 02-24-1987 12:18:17)

| Function         |       | Pred | Best |      |      | Incn |      |      |
|------------------|-------|------|------|------|------|------|------|------|
|                  |       |      | Meas | %Prd |      | Meas | %Prd | Incn |
| FVC              | (L)   | 5.57 | 5.29 | 95%  | 4.62 | 83%  | 4.52 | 81%  |
| FEV1             | (L)   | 4.53 | 4.70 | 104% | 4.36 | 96%  | 4.32 | 95%  |
| FEV1/FVC         |       | 0.81 | 0.89 | 109% | 0.94 | 115% | 0.96 | 118% |
| PEFR             | (L/s) | 9.75 | 6.63 | 68%  | 7.66 | 79%  | 7.69 | 79%  |
| FEF.2-1.2        | (L/s) |      | 2.06 |      | 4.09 |      | 6.05 |      |
| FEF50%           | (L/s) | 6.03 | 6.33 | 105% | 6.32 | 105% | 6.85 | 114% |
| FEF25-75%        | (L/s) | 4.53 | 5.62 | 124% | 6.00 | 132% | 6.33 | 140% |
| EXP Test Time(s) |       |      | 3.72 |      | 2.69 |      | 2.25 |      |
| FIVC             | (L)   |      | 2.48 |      | 2.50 |      |      |      |
| FIV1             | (L)   |      | 0.59 |      | 0.45 |      |      |      |
| FIV1/FIVC        |       |      | 0.24 |      | 0.18 |      |      |      |
| PIFR             | (L/s) |      | 1.43 |      | 0.71 |      |      |      |
| PIEF.2-1.2       | (L/s) |      | 0.15 |      | 0.28 |      |      |      |

Name: JOHN O'NEILL ID #: 147421004  
 Age: 35 Sex: M Height: 72 in. Weight: 204 lb.  
 Smoking history: 0 pack-years Race: CAUC  
 Doctor: [redacted] Tech: [redacted]  
 Predicteds: Crapo File: J00Z40EB Report #: 1 DEMO STANDARD REPORT  
 Comments:

~~~~~ Interpretation ~~~~~

Spirometry within normal limits.
(Subject to physician's review)

~~~~~ Exp/Insp ~~~~~

(Pre-: 02-24-1987 12:18:17)

| Function              |       | Pred | Best  |      | Incn |      | Incn |      |
|-----------------------|-------|------|-------|------|------|------|------|------|
|                       |       |      | Meas  | %Prd | Meas | %Prd | Meas | %Prd |
| FVC                   | (L)   | 5.57 | 5.29  | 95%  | 4.62 | 83%  | 4.52 | 81%  |
| FEV1                  | (L)   | 4.53 | 4.70  | 104% | 4.36 | 96%  | 4.32 | 95%  |
| FEV1/FVC              |       | 0.81 | 0.89  | 109% | 0.94 | 115% | 0.96 | 118% |
| PEFR                  | (L/s) | 9.75 | 6.63  | 68%  | 7.66 | 79%  | 7.69 | 79%  |
| FEF <sub>2-1.2</sub>  | (L/s) |      | 2.06  |      | 4.09 |      | 6.05 |      |
| FEF <sub>50%</sub>    | (L/s) | 6.03 | 6.33  | 105% | 6.32 | 105% | 6.85 | 114% |
| FEF <sub>25-75%</sub> | (L/s) | 4.53 | 5.62  | 124% | 6.00 | 132% | 6.33 | 140% |
| EXP Test Time(s)      |       |      | 3.72  |      | 2.59 |      | 2.25 |      |
| FIVC                  | (L)   |      | 2.48  |      | 2.50 |      |      |      |
| FIV1                  | (L)   |      | 0.59  |      | 0.45 |      |      |      |
| FIV1/FIVC             |       |      | 0.24  |      | 0.18 |      |      |      |
| PIFR                  | (L/s) |      | 1.43  |      | 0.71 |      |      |      |
| FIF <sub>2-1.2</sub>  | (L/s) |      | 0.15  |      | 0.28 |      |      |      |
| FIF <sub>25-75%</sub> | (L/s) |      | 0.11  |      | 0.27 |      |      |      |
| INSP Test Time(s)     |       |      | 18.56 |      | 8.98 |      |      |      |

Comments:

~~~~~ MVV ~~~~~

(No Pre- MVV performed)

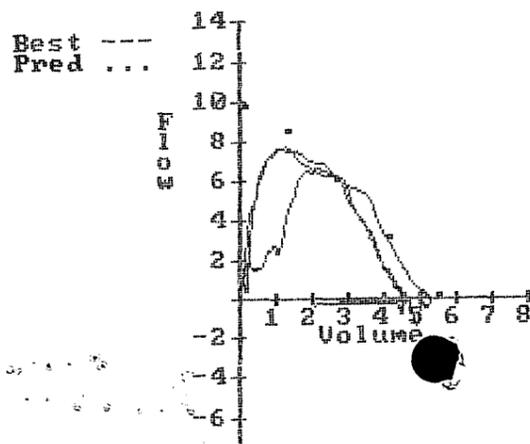
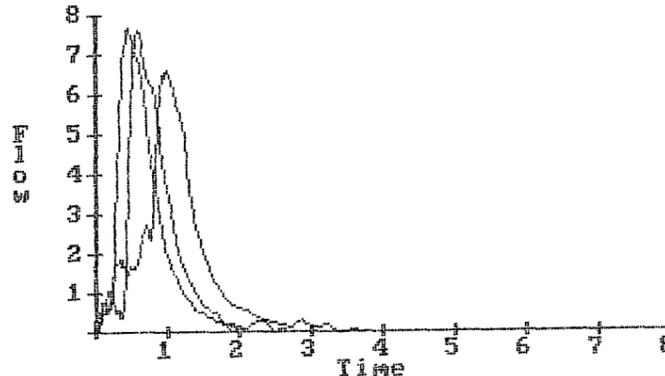
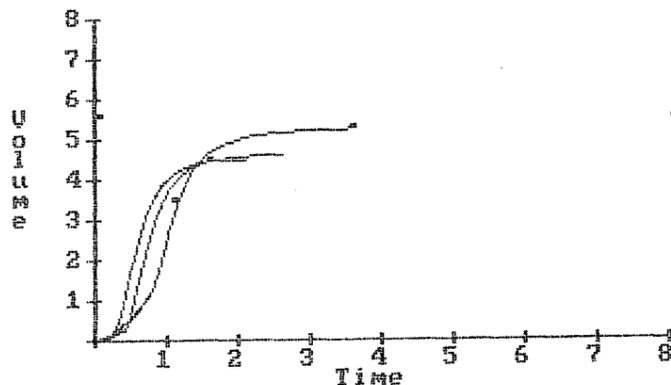
| Function | | Pred | Meas | %Prd |
|-----------|-------------|--------|------|------|
| MVV | (L/min) | 151.58 | | |
| MVV | (L/s) | 2.53 | | |
| Test time | (sec) | | | |
| Vt | (L) | | | |
| RR | (brths/min) | | | |

NORTH ARUNDEL CARDIAC FITNESS AND REHABILITATION CENTER
 200 HOSPITAL DRIVE LL 10
 GLEN BURNIE, MARYLAND 21061 301/768-6644

PULMONARY FUNCTION REPORT
(Pre- Summary)

Name: JOHN O'NEILL ID #: 147421004

Best ---
Pred ...



MEDICAL REPORTS

Personnel File of: O'NEILL, JOHN P.

Personnel File No. _____

[Handwritten signature]

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

| | | | |
|---|---|---|--|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME
<i>O'Neill, JOHN P.</i> | | 2. SOCIAL SECURITY OR IDENTIFICATION NO.
<i>147-42-1004</i> | |
| 3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE)
<i>3102 FURMAN LANE #201
ALEXANDRIA, VA.</i> | | 4. POSITION (City, grade, component)
<i>GS 7
RESEARCH ANALYST</i> | |
| 5. PURPOSE OF EXAMINATION
<i>SPECIAL AGENT
APPLICANT</i> | 6. DATE OF EXAMINATION
<i>4/1/76</i> | 7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code)
<i>Bethesda
NAVAL HOSPITAL</i> | |
| 8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint exists)
<i>Excellent Health, no medications used</i> | | | |

| 9. HAVE YOU EVER (Please check each item) | | | 10. DO YOU (Please check each item) | | |
|---|-------------------------------------|---|-------------------------------------|-------------------------------------|--------------------------------|
| YES | NO | (Check each item) | YES | NO | (Check each item) |
| | <input checked="" type="checkbox"/> | Lived with anyone who had tuberculosis | <input checked="" type="checkbox"/> | | Wear glasses or contact lenses |
| | <input checked="" type="checkbox"/> | Coughed up blood | <input checked="" type="checkbox"/> | | Have vision in both eyes |
| | <input checked="" type="checkbox"/> | Bled excessively after injury or tooth extraction | | <input checked="" type="checkbox"/> | Wear a hearing aid |
| | <input checked="" type="checkbox"/> | Attempted suicide | | <input checked="" type="checkbox"/> | Stutter or stammer habitually |
| | <input checked="" type="checkbox"/> | Been a sleepwalker | | <input checked="" type="checkbox"/> | Wear a brace or back support |

| 11. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item) | | | | | | | | | | | |
|---|-------------------------------------|------------|-------------------------------|-----|-------------------------------------|------------|--|-----|-------------------------------------|------------|---------------------------------|
| YES | NO | DON'T KNOW | (Check each item) | YES | NO | DON'T KNOW | (Check each item) | YES | NO | DON'T KNOW | (Check each item) |
| | <input checked="" type="checkbox"/> | | Scarlet fever, erysipelas | | <input checked="" type="checkbox"/> | | Cramps in your legs | | <input checked="" type="checkbox"/> | | "Trick" or locked knee |
| | <input checked="" type="checkbox"/> | | Rheumatic fever | | <input checked="" type="checkbox"/> | | Frequent indigestion | | <input checked="" type="checkbox"/> | | Foot trouble |
| | <input checked="" type="checkbox"/> | | Swollen or painful joints | | <input checked="" type="checkbox"/> | | Stomach, liver, or intestinal trouble | | <input checked="" type="checkbox"/> | | Neuritis |
| | <input checked="" type="checkbox"/> | | Frequent or severe headache | | <input checked="" type="checkbox"/> | | Gall bladder trouble or gallstones | | <input checked="" type="checkbox"/> | | Paralysis (include infantile) |
| | <input checked="" type="checkbox"/> | | Dizziness or fainting spells | | <input checked="" type="checkbox"/> | | Jaundice or hepatitis | | <input checked="" type="checkbox"/> | | Epilepsy or fits |
| | <input checked="" type="checkbox"/> | | Eye trouble | | <input checked="" type="checkbox"/> | | Adverse reaction to serum, drug, or medicine | | <input checked="" type="checkbox"/> | | Car, train, sea or air sickness |
| | <input checked="" type="checkbox"/> | | Ear, nose, or throat trouble | | <input checked="" type="checkbox"/> | | Broken bones | | <input checked="" type="checkbox"/> | | Frequent trouble sleeping |
| | <input checked="" type="checkbox"/> | | Hearing loss | | <input checked="" type="checkbox"/> | | Tumor, growth, cyst, cancer | | <input checked="" type="checkbox"/> | | Depression or excessive worry |
| | <input checked="" type="checkbox"/> | | Chronic or frequent colds | | <input checked="" type="checkbox"/> | | Rupture/hernia | | <input checked="" type="checkbox"/> | | Loss of memory or amnesia |
| | <input checked="" type="checkbox"/> | | Severe tooth or gum trouble | | <input checked="" type="checkbox"/> | | Piles or rectal disease | | <input checked="" type="checkbox"/> | | Nervous trouble of any sort |
| | <input checked="" type="checkbox"/> | | Sinusitis | | <input checked="" type="checkbox"/> | | Frequent or painful urination | | <input checked="" type="checkbox"/> | | Periods of unconsciousness |
| | <input checked="" type="checkbox"/> | | Hay Fever | | <input checked="" type="checkbox"/> | | Bed wetting since age 12 | | | | |
| | <input checked="" type="checkbox"/> | | Head injury | | <input checked="" type="checkbox"/> | | Kidney stone or blood in urine | | | | |
| | <input checked="" type="checkbox"/> | | Skin diseases | | <input checked="" type="checkbox"/> | | Sugar or albumin in urine | | | | |
| | <input checked="" type="checkbox"/> | | Thyroid trouble | | <input checked="" type="checkbox"/> | | VD—Syphilis, gonorrhoea, etc. | | | | |
| | <input checked="" type="checkbox"/> | | Tuberculosis | | <input checked="" type="checkbox"/> | | Recent gain or loss of weight | | | | |
| | <input checked="" type="checkbox"/> | | Asthma | | <input checked="" type="checkbox"/> | | Arthritis, Rheumatism, or Bursitis | | | | |
| | <input checked="" type="checkbox"/> | | Shortness of breath | | <input checked="" type="checkbox"/> | | Bone, joint or other deformity | | | | |
| | <input checked="" type="checkbox"/> | | Pain or pressure in chest | | <input checked="" type="checkbox"/> | | Lameness | | | | |
| | <input checked="" type="checkbox"/> | | Chronic cough | | <input checked="" type="checkbox"/> | | Loss of finger or toe | | | | |
| | <input checked="" type="checkbox"/> | | Palpitation or pounding heart | | <input checked="" type="checkbox"/> | | Painful or "trick" shoulder or elbow | | | | |
| | <input checked="" type="checkbox"/> | | Heart trouble | | <input checked="" type="checkbox"/> | | Recurrent back pain | | | | |
| | <input checked="" type="checkbox"/> | | High or low blood pressure | | <input checked="" type="checkbox"/> | | | | | | |

| | |
|--|--|
| 13. WHAT IS YOUR USUAL OCCUPATION?
<i>RESEARCH WORK</i> | 14. ARE YOU (Check one)
<input type="checkbox"/> Right handed <input checked="" type="checkbox"/> Left handed |
|--|--|

| YES | NO | CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT |
|-----|----|---|
| | | 15. Have you been refused employment or been unable to hold a job or stay in school because of:
A. Sensitivity to chemicals, dust, sunlight, etc. |
| ✓ | | B. Inability to perform certain motions. |
| ✓ | | C. Inability to assume certain positions. |
| ✓ | | D. Other medical reasons (If yes, give reasons.) |
| ✓ | | 16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.) |
| ✓ | | 17. Have you ever been denied life insurance? (If yes, state reason and give details.) |
| ✓ | | 18. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.) |
| ✓ | | 19. Have you ever been a patient in any type of hospitals? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) |
| ✓ | | 20. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) |
| ✓ | | 21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) |
| ✓ | | 22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.) |
| ✓ | | 23. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for-unfitness or unsuitability.) |
| ✓ | | 24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.) |

b6
b7c

*Make Removed by surgery FROM Right Shoulder
BLADE AREA OF THE BACK AGE 6-1958
Tonsillectomy 1960 - AGE 8
APPENDIX REMOVE 1963 - AGE 11*

HOSPITALS - FOR ABOVE SURGERY ONLY

*1958 - DeHilderbrants Hospital
VENTNOR, N.J. [REDACTED]
DID NOT STAY OVERNIGHT.*

*1960 - DeHilderbrants Hospital
VENTNOR, N.J. [REDACTED]*

*1963 - ATLANTIC CITY HOSPITAL
ATLANTIC CITY, N.J. [REDACTED]*

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

| | |
|---|-------------------------------------|
| TYPED OR PRINTED NAME OF EXAMINEE
<i>John P. O'Neill</i> | SIGNATURE
<i>John P. O'Neill</i> |
|---|-------------------------------------|

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."
25. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

| | | | |
|--|-----------------------|-------------------------|---------------------------|
| TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER | DATE
<i>4/1/76</i> | SIGNATURE
[REDACTED] | NUMBER OF ATTACHED SHEETS |
|--|-----------------------|-------------------------|---------------------------|

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

| | | | |
|---|--|--|--|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME
O'NEILL JOHN P. | | 2. SOCIAL SECURITY OR IDENTIFICATION NO.
147-42-1004 | |
| 3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE)
7142 AMBASSADOR RD, BA, VA | | 4. POSITION (Title, grade, component)
SPECIAL AGENT, FBI | |
| 5. PURPOSE OF EXAMINATION
FITNESS FOR DUTY | | 6. DATE OF EXAMINATION
8/6/79 | |
| | | 7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code)
KIRK ARMY HOSPITAL
APG, MARYLAND | |

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint exists)
Excellent, no medications used

| 9. HAVE YOU EVER (Please check each item) | | | 10. DO YOU (Please check each item) | | |
|---|-------------------------------------|---|-------------------------------------|-------------------------------------|--------------------------------|
| YES | NO | (Check each item) | YES | NO | (Check each item) |
| | <input checked="" type="checkbox"/> | Lived with anyone who had tuberculosis | <input checked="" type="checkbox"/> | | Wear glasses or contact lenses |
| | <input checked="" type="checkbox"/> | Coughed up blood | <input checked="" type="checkbox"/> | | Have vision in both eyes |
| | <input checked="" type="checkbox"/> | Bled excessively after injury or tooth extraction | | <input checked="" type="checkbox"/> | Wear a hearing aid |
| | <input checked="" type="checkbox"/> | Attempted suicide | | <input checked="" type="checkbox"/> | Stutter or stammer habitually |
| | <input checked="" type="checkbox"/> | Been a sleepwalker | | <input checked="" type="checkbox"/> | Wear a brace or back support |

| 11. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item) | | | | | | | | | | | |
|---|-------------------------------------|------------|-------------------------------|-----|-------------------------------------|------------|--|-----|-------------------------------------|------------|---------------------------------|
| YES | NO | DON'T KNOW | (Check each item) | YES | NO | DON'T KNOW | (Check each item) | YES | NO | DON'T KNOW | (Check each item) |
| | <input checked="" type="checkbox"/> | | Scarlet fever, erysipelas | | <input checked="" type="checkbox"/> | | Cramps in your legs | | <input checked="" type="checkbox"/> | | "Trick" or locked knee |
| | <input checked="" type="checkbox"/> | | Rheumatic fever | | <input checked="" type="checkbox"/> | | Frequent indigestion | | <input checked="" type="checkbox"/> | | Foot trouble |
| | <input checked="" type="checkbox"/> | | Swollen or painful joints | | <input checked="" type="checkbox"/> | | Stomach, liver, or intestinal trouble | | <input checked="" type="checkbox"/> | | Neuritis |
| | <input checked="" type="checkbox"/> | | Frequent or severe headache | | <input checked="" type="checkbox"/> | | Gall bladder trouble or gallstones | | <input checked="" type="checkbox"/> | | Paralysis (include infantile) |
| | <input checked="" type="checkbox"/> | | Dizziness or fainting spells | | <input checked="" type="checkbox"/> | | Jaundice or hepatitis | | <input checked="" type="checkbox"/> | | Epilepsy or fits |
| | <input checked="" type="checkbox"/> | | Eye trouble | | <input checked="" type="checkbox"/> | | Adverse reaction to serum, drug, or medicine | | <input checked="" type="checkbox"/> | | Car, train, sea or air sickness |
| | <input checked="" type="checkbox"/> | | Ear, nose, or throat trouble | | <input checked="" type="checkbox"/> | | Broken bones | | <input checked="" type="checkbox"/> | | Frequent trouble sleeping |
| | <input checked="" type="checkbox"/> | | Hearing loss | | <input checked="" type="checkbox"/> | | Tumor, growth, cyst, cancer | | <input checked="" type="checkbox"/> | | Depression or excessive worry |
| | <input checked="" type="checkbox"/> | | Chronic or frequent colds | | <input checked="" type="checkbox"/> | | Rupture/hernia | | <input checked="" type="checkbox"/> | | Loss of memory or amnesia |
| | <input checked="" type="checkbox"/> | | Severe tooth or gum trouble | | <input checked="" type="checkbox"/> | | Piles or rectal disease | | <input checked="" type="checkbox"/> | | Nervous trouble of any sort |
| | <input checked="" type="checkbox"/> | | Sinusitis | | <input checked="" type="checkbox"/> | | Frequent or painful urination | | <input checked="" type="checkbox"/> | | Periods of unconsciousness |
| | <input checked="" type="checkbox"/> | | Hay Fever | | <input checked="" type="checkbox"/> | | Bed wetting since age 12 | | | | |
| | <input checked="" type="checkbox"/> | | Head injury | | <input checked="" type="checkbox"/> | | Kidney stone or blood in urine | | | | |
| | <input checked="" type="checkbox"/> | | Skin diseases | | <input checked="" type="checkbox"/> | | Sugar or albumin in urine | | | | |
| | <input checked="" type="checkbox"/> | | Thyroid trouble | | <input checked="" type="checkbox"/> | | VD—Syphilis, gonorrhea, etc. | | | | |
| | <input checked="" type="checkbox"/> | | Tuberculosis | | <input checked="" type="checkbox"/> | | Recent gain or loss of weight | | | | |
| | <input checked="" type="checkbox"/> | | Asthma | | <input checked="" type="checkbox"/> | | Arthritis, Rheumatism, or Bursitis | | | | |
| | <input checked="" type="checkbox"/> | | Shortness of breath | | <input checked="" type="checkbox"/> | | Bone, joint or other deformity | | | | |
| | <input checked="" type="checkbox"/> | | Pain or pressure in chest | | <input checked="" type="checkbox"/> | | Lameness | | | | |
| | <input checked="" type="checkbox"/> | | Chronic cough | | <input checked="" type="checkbox"/> | | Loss of finger or toe | | | | |
| | <input checked="" type="checkbox"/> | | Palpitation or pounding heart | | <input checked="" type="checkbox"/> | | Painful or "trick" shoulder or elbow | | | | |
| | <input checked="" type="checkbox"/> | | Heart trouble | | <input checked="" type="checkbox"/> | | Recurrent back pain | | | | |
| | <input checked="" type="checkbox"/> | | High or low blood pressure | | <input checked="" type="checkbox"/> | | | | | | |

| | |
|--|--|
| 13. WHAT IS YOUR USUAL OCCUPATION?
SPECIAL AGENT | 14. ARE YOU (Check one)
<input type="checkbox"/> Right handed <input checked="" type="checkbox"/> Left handed |
|--|--|

Do Not Transmit Enclosed Material
 With Official Personnel Folder.

YES NO CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT

b6
b7c

- ✓ 15. Have you been refused employment or been unable to hold a job or stay in school because of:
 - ✓ A. Sensitivity to chemicals, dust, sunlight, etc.
 - ✓ B. Inability to perform certain motions.
 - ✓ C. Inability to assume certain positions.
 - ✓ D. Other medical reasons (If yes, give reasons.)
- ✓ 16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.)
- ✓ 17. Have you ever been denied life insurance? (If yes, state reason and give details.)
- ✓ 18. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)
- ✓ 19. Have you ever been a patient in any type of hospitals? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)
- ✓ 20. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)
- ✓ 21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)
- ✓ 22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)
- ✓ 23. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)
- ✓ 24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)

18. Mole Removed by Surgery From Rt. Shoulder
Blade area of the back Age 6 - 1958
Tonsillectomy Age 8 - 1960
Appendix Removal Age 11 - 1963

19. Hospitalized for Above Surgery only
1958 - Rahlderbrant Hospital
Ventnor, N.J. [Redacted]

1960 - Same as above.

1963 - Atlantic City Hospital
Atlantic City, N.J. [Redacted]

21. High Blood Pressure
1978 [Redacted]
Owings Mills, Md.

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.
I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE: **JOHN P. O'NEILL** SIGNATURE: *John P. O'Neill*

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."
25. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

18-19-21 - No sequelae

| | | | | | |
|-----------------------------------|---------|----------|----------|------------|---------------------------|
| TYPED OR PRINTED NAME OF EXAMINER | WOL USA | OR P. A. | DATE | SIGN | NUMBER OF ATTACHED SHEETS |
| | | | 6 AUG 71 | [Redacted] | |

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

| | | | |
|--|------------------------------------|--|--|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME
O'Neill John P. | | 2. SOCIAL SECURITY OR IDENTIFICATION NO.
147-42-1004 | |
| 3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE)
<i>7142 AMBASSADOR RD, BALTO, MD</i> | | 4. POSITION (title, grade, component)
Special Agent | |
| 5. PURPOSE OF EXAMINATION
Fitness for duty | 6. DATE OF EXAMINATION
10/18/82 | 7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code)
Central Medical Center, Hunt Valley Md. | |

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint exists)

Excellent, No medications used

| 9. HAVE YOU EVER (Please check each item) | | | | 10. DO YOU (Please check each item) | | | |
|---|-------------------------------------|---|--|-------------------------------------|-------------------------------------|--------------------------------|--|
| YES | NO | (Check each item) | | YES | NO | (Check each item) | |
| | <input checked="" type="checkbox"/> | Lived with anyone who had tuberculosis | | <input checked="" type="checkbox"/> | | Wear glasses or contact lenses | |
| | <input checked="" type="checkbox"/> | Coughed up blood | | <input checked="" type="checkbox"/> | | Have vision in both eyes | |
| | <input checked="" type="checkbox"/> | Bled excessively after injury or tooth extraction | | | <input checked="" type="checkbox"/> | Wear a hearing aid | |
| | <input checked="" type="checkbox"/> | Attempted suicide | | | <input checked="" type="checkbox"/> | Stutter or stammer habitually | |
| | <input checked="" type="checkbox"/> | Been a sleepwalker | | | <input checked="" type="checkbox"/> | Wear a brace or back support | |

| 11. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item) | | | | | | | | | | | |
|---|-------------------------------------|------------|-------------------------------|--|--|-----|-------------------------------------|------------|--|--|--|
| YES | NO | DON'T KNOW | (Check each item) | | | YES | NO | DON'T KNOW | (Check each item) | | |
| | <input checked="" type="checkbox"/> | | Scarlet fever, erysipelas | | | | <input checked="" type="checkbox"/> | | Cramps in your legs | | |
| | <input checked="" type="checkbox"/> | | Rheumatic fever | | | | <input checked="" type="checkbox"/> | | Frequent indigestion | | |
| | <input checked="" type="checkbox"/> | | Swollen or painful joints | | | | <input checked="" type="checkbox"/> | | Stomach, liver, or intestinal trouble | | |
| | <input checked="" type="checkbox"/> | | Frequent or severe headache | | | | <input checked="" type="checkbox"/> | | Gall bladder trouble or gallstones | | |
| | <input checked="" type="checkbox"/> | | Dizziness or fainting spells | | | | <input checked="" type="checkbox"/> | | Jaundice or hepatitis | | |
| | <input checked="" type="checkbox"/> | | Eye trouble | | | | <input checked="" type="checkbox"/> | | Adverse reaction to serum, drug, or medicine | | |
| | <input checked="" type="checkbox"/> | | Ear, nose, or throat trouble | | | | <input checked="" type="checkbox"/> | | Broken bones | | |
| | <input checked="" type="checkbox"/> | | Hearing loss | | | | <input checked="" type="checkbox"/> | | Tumor, growth, cyst, cancer | | |
| | <input checked="" type="checkbox"/> | | Chronic or frequent colds | | | | <input checked="" type="checkbox"/> | | Rupture/hernia | | |
| | <input checked="" type="checkbox"/> | | Severe tooth or gum trouble | | | | <input checked="" type="checkbox"/> | | Piles or rectal disease | | |
| | <input checked="" type="checkbox"/> | | Sinusitis | | | | <input checked="" type="checkbox"/> | | Frequent or painful urination | | |
| | <input checked="" type="checkbox"/> | | Hay Fever | | | | <input checked="" type="checkbox"/> | | Bed wetting since age 12 | | |
| | <input checked="" type="checkbox"/> | | Head Injury | | | | <input checked="" type="checkbox"/> | | Kidney stone or blood in urine | | |
| | <input checked="" type="checkbox"/> | | Skin diseases | | | | <input checked="" type="checkbox"/> | | Sugar or albumin in urine | | |
| | <input checked="" type="checkbox"/> | | Thyroid trouble | | | | <input checked="" type="checkbox"/> | | VD—Syphilis, gonorrhea, etc. | | |
| | <input checked="" type="checkbox"/> | | Tuberculosis | | | | <input checked="" type="checkbox"/> | | Recent gain or loss of weight | | |
| | <input checked="" type="checkbox"/> | | Asthma | | | | <input checked="" type="checkbox"/> | | Arthritis, Rheumatism, or Bursitis | | |
| | <input checked="" type="checkbox"/> | | Shortness of breath | | | | <input checked="" type="checkbox"/> | | Bone, joint or other deformity | | |
| | <input checked="" type="checkbox"/> | | Pain or pressure in chest | | | | <input checked="" type="checkbox"/> | | Lameness | | |
| | <input checked="" type="checkbox"/> | | Chronic cough | | | | <input checked="" type="checkbox"/> | | Loss of finger or toe | | |
| | <input checked="" type="checkbox"/> | | Palpitation or pounding heart | | | | <input checked="" type="checkbox"/> | | Painful or "trick" shoulder or elbow | | |
| | <input checked="" type="checkbox"/> | | Heart trouble | | | | <input checked="" type="checkbox"/> | | Recurrent back pain | | |
| | <input checked="" type="checkbox"/> | | High or low blood pressure | | | | <input checked="" type="checkbox"/> | | | | |

| 12. FEMALES ONLY: HAVE YOU EVER | | | |
|---------------------------------|--|--|------------------------------------|
| | | | Been treated for a female disorder |
| | | | Had a change in menstrual pattern |

| | |
|--|--|
| 13. WHAT IS YOUR USUAL OCCUPATION?
<i>SPECIAL AGENT</i> | 14. ARE YOU (Check one)
<input type="checkbox"/> Right handed <input checked="" type="checkbox"/> Left handed |
|--|--|

Not Transmit Enclosed Material
With Official Personnel Folder

| YES | NO | CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT |
|-----|----|---|
| ✓ | | 15. Have you been refused employment or been unable to hold a job or stay in school because of:
A. Sensitivity to chemicals, dust, sunlight, etc. |
| ✓ | | B. Inability to perform certain motions. |
| ✓ | | C. Inability to assume certain positions. |
| ✓ | | D. Other medical reasons (If yes, give reasons.) |
| ✓ | | 16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.) |
| ✓ | | 17. Have you ever been denied life insurance? (If yes, state reason and give details.) |
| ✓ | | 18. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.) |
| ✓ | | 19. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) |
| ✓ | | 20. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) |
| ✓ | | 21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) |
| ✓ | | 22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.) |
| ✓ | | 23. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.) |
| ✓ | | 24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.) |

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b7c

⑱ Mole Removed by Surgery from Right Shoulder Blade about 1958 - age 6
Tonsillotomy - age 8 - 1960
Appendix Removed - age 11 - 1963

⑲ Hospitalized for above Surgery only
1958 - De Kinderbrant's Hospital
Ventnor, N.J. [Redacted]
1960 - ~~Atlantic~~ Same as above.
1963 - Atlantic City Medical Center
Atlantic City, N.J. [Redacted]

⑳ High Blood Pressure
1978 [Redacted]

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE

JOHN P. O'NEILL

SIGNATURE

J.P. O'Neill

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

25. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

- 1) High Blood pressure readings 1978 - No sustained HBP
No meds for 4 yrs.
- 2) Removal of Venus - Back - 1958
- 3) T & A 1960
- 4) Appendectomy 1963

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER

M. P.

DATE

10/18/72

SI

NUMBER OF ATTACHED SHEETS

3

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

| | | | |
|--|---|--|--|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME
O'NEILL, JOHN P. | | 2. SOCIAL SECURITY OR IDENTIFICATION NO.
147-42-1004 | |
| 3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE)
n/a | | 4. POSITION (title, grade, component)
SUPERVISORY SPECIAL AGENT | |
| 5. PURPOSE OF EXAMINATION
FITNESS FOR DUTY | 6. DATE OF EXAMINATION
11/22/85 | 7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code)
Life Resources, 200 Hospital Dr.
Glen Burnie, MD 21061 | |

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint exists)

Excellent! No Medications Used

| 9. HAVE YOU EVER (Please check each item) | | 10. DO YOU (Please check each item) | |
|---|---|-------------------------------------|-------------------------------------|
| YES | NO | YES | NO |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| (Check each item) | | (Check each item) | |
| <input checked="" type="checkbox"/> | Lived with anyone who had tuberculosis | <input checked="" type="checkbox"/> | Wear glasses or contact lenses |
| <input checked="" type="checkbox"/> | Coughed up blood | <input checked="" type="checkbox"/> | Have vision in both eyes |
| <input checked="" type="checkbox"/> | Bled excessively after injury or tooth extraction | <input checked="" type="checkbox"/> | Wear a hearing aid |
| <input checked="" type="checkbox"/> | Attempted suicide | <input checked="" type="checkbox"/> | Stutter or stammer habitually |
| <input checked="" type="checkbox"/> | Been a sleepwalker | <input checked="" type="checkbox"/> | Wear a brace or back support |

| 11. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item) | | | | | | | | | | | |
|---|-------------------------------------|-------------------------------------|-------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|--|-------------------------------------|-------------------------------------|-------------------------------------|---------------------------------|
| YES | NO | DON'T KNOW | (Check each item) | YES | NO | DON'T KNOW | (Check each item) | YES | NO | DON'T KNOW | (Check each item) |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Scarlet fever, erysipelas | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Cramps in your legs | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | "Trick" or locked knee |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Rheumatic fever | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Frequent indigestion | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Foot trouble |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Swollen or painful joints | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Stomach, liver, or intestinal trouble | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Neuritis |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Frequent or severe headache | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Gall bladder trouble or gallstones | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Paralysis (include infantile) |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Dizziness or fainting spells | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Jaundice or hepatitis | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Epilepsy or fits |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Eye trouble | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Adverse reaction to serum, drug, or medicine | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Car, train, sea or air sickness |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Ear, nose, or throat trouble | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Broken bones | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Frequent trouble sleeping |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hearing loss | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Tumor, growth, cyst, cancer | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Depression or excessive worry |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Chronic or frequent colds | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Rupture/hernia | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Loss of memory or amnesia |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Severe tooth or gum trouble | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Piles or rectal disease | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Nervous trouble of any sort |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Sinusitis | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Frequent or painful urination | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Periods of unconsciousness |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hay Fever | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Bed wetting since age 12 | | | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Head injury | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Kidney stone or blood in urine | | | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Skin diseases | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Sugar or albumin in urine | | | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Thyroid trouble | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | VD—Syphilis, gonorrhea, etc. | | | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Tuberculosis | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Recent gain or loss of weight | | | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Asthma | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Arthritis, Rheumatism, or Bursitis | | | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Shortness of breath | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Bone, joint or other deformity | | | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Pain or pressure in chest | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Lameness | | | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Chronic cough | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Loss of finger or toe | | | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Palpitation or pounding heart | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Painful or "trick" shoulder or elbow | | | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Heart trouble | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Recurrent back pain | | | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | High or low blood pressure | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | | | | | |

| 12. FEMALES ONLY: HAVE YOU EVER | |
|---------------------------------|------------------------------------|
| <input type="checkbox"/> | Been treated for a female disorder |
| <input type="checkbox"/> | Had a change in menstrual pattern |

| | |
|---|--|
| 13. WHAT IS YOUR USUAL OCCUPATION?
SUPERVISORY SPECIAL AGENT - FBI. | 14. ARE YOU (Check one)
<input type="checkbox"/> Right handed <input checked="" type="checkbox"/> Left handed |
|---|--|

Do Not Transmit Enclosed Material
With Official Personnel Folder.

| YES | NO | CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT |
|-------------------------------------|--------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 15. Have you been refused employment or been unable to hold a job or stay in school because of:
A. Sensitivity to chemicals, dust, sunlight, etc. |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | B. Inability to perform certain motions. |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | C. Inability to assume certain positions. |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | D. Other medical reasons (If yes, give reasons.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 17. Have you ever been denied life insurance? (If yes, state reason and give details.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 18. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 19. Have you ever been a patient in any type of hospitals? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 20. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 23. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.) |

b6
b7c

⑮ Mole removed by surgery from Right shoulder Blade of leg of Back - age 6 - 1958
Tonsillectomy - age 8 - 1960
Appendectomy - age 11 - 1963
⑯ Hospitalized for above Surgery only
1958 - DeWaldesbrant's Hospital
Ventnor, N.J.
1960 - Same as 1958.
1963 - Atlantic City Medical Center
Atlantic City, N.J.

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE, **John P. O'Neill** SIGNATURE *John P. O'Neill*

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."
25. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

| | | | |
|------------|-----------|-----------|---------------------------|
| TYPED EXAM | DATE | SIGNATURE | NUMBER OF ATTACHED SHEETS |
| | MD 6/2/58 | | |

REVERSE



1007 ELECTRIC AVENUE
VIENNA, VIRGINIA 22180
PHONE (703) 281-5100

FEDERAL BUREAU OF INVESTIGATION HDQTS.
10TH AND PENN. AVENUE NW
WASHINGTON DC 20535

(202) 324-4976 RTE S 05

PATIENT NAME ONEILL JOHN P SEX M AGE 37 ACCESSION 590477 DATE OF ACCESSION 03/22/89 DATE OF REPORT 03/23/89 ACCOUNT NO. 2710012 0431

| TEST | RESULTS | ABNORMAL FLAG | NORMAL VALUES |
|---|----------------------|---------------|--|
| FINAL REPORT | | | |
| PROFILE 5477 | | | |
| HEALTH SURVEY PROFILE I | | | |
| GLUCOSE | 69 MG/DL | | 65 - 115 |
| BLOOD UREA NITROGEN | 17 MG/DL | | 7 - 25 |
| CREATININE | 1.0 MG/DL | | 0.6 - 1.5 |
| SODIUM | 142 MEQ/L | | 135 - 147 |
| POTASSIUM | 4.0 MEQ/L | | 3.5 - 5.3 |
| CHLORIDE | 105 MEQ/L | | 96 - 109 |
| CARBON DIOXIDE | 20 MEQ/L | LOW | 22 - 32 |
| URIC ACID | 12.5 MG/DL | HI | M: 3.0 - 9.0
F: 2.2 - 7.7 |
| TOTAL PROTEIN | 7.8 G/DL | | 6.0 - 8.5 |
| ALBUMIN | 5.2 G/DL | | 3.5 - 5.5 |
| GLOBULIN | 2.6 G/DL | | 2.0 - 3.5 |
| A/G RATIO | 2.0 | | 1.0 - 2.4 |
| CALCIUM | 10.2 MG/DL | | 8.5 - 10.8 |
| PHOSPHORUS | 3.8 MG/DL | | 2.5 - 4.5 |
| CHOLESTEROL | 194 MG/DL | | DESIRABLE: < 200
BORDERLINE: 200-239
ELEVATED: > 239 |
| HDL CHOLESTEROL | 41 MG/DL | | M: 30 - 75
F: 40 - 90 |
| LDL CHOLESTEROL (CALC.) | 139 MG/DL | *** | DESIRABLE: < 130
BORDERLINE: 130-159
ELEVATED: > 159 |
| LDL-CHOL. REFERENCE RANGES ARE BASED ON N.I.H. GUIDELINES | | | |
| CHOLESTEROL/HDL CHOL. RATIO | 4.7 | | CHD RISK TOTAL/HDL CHOL RATIO
M F
0.5 X AVG 3.4 3.3
1.0 X AVG 5.0 4.4
2.0 X AVG 9.6 7.1
3.0 X AVG 13.4 11.0 |
| LDL/HDL CHOLESTEROL RATIO | 3.40 | | LESS THAN 3.1 |
| TRIGLYCERIDES | 68 MG/DL | | 30 - 150 |
| ALKALINE PHOSPHATASE | 90 U/L | | <17 YRS: 80 - 490
>17 YRS: 25 - 140 |
| S G O T | 26 U/L | | 0 - 40 |
| S G P T | 28 U/L | | 0 - 45 |
| IF SGPT >45 DO GGT | NOT INDICATED | | |
| LACTIC DEHYDROGENASE | 139 U/L | | 100 - 240 |
| TOTAL BILIRUBIN | 1.4 MG/DL | HI | 0.2 - 1.2 |
| IRON | 106 MCG/DL | | 35 - 180 |
| C B C WITH PLATELET | | | |
| HEMATOCRIT | 48.1 % | | M: 39-54 F: 35-48 |
| HEMOGLOBIN | 16.8 G/DL | | M: 13.0 - 18.0
F: 11.5 - 16.0 |
| RED BLOOD COUNT | 5.03 MILLION /CU.MM. | | MALE: 4.4 - 6.2 |

b6
b7c

HP
5/18/89

Director of Laboratories



**National
Health
Laboratories**

INCORPORATED

1007 ELECTRIC AVENUE

VIENNA, VIRGINIA 22180

PHONE (703) 281-5100

FEDERAL BUREAU OF
INVESTIGATION HDQTS.
400 NORTH AND PENN. AVENUE NW
WASHINGTON DC 20535

(202) 324-4976 RTE 5 05

PATIENT NAME
ONEILL JOHN P

SEX AGE

ACCESSION
612085

DATE OF ACCESSION
03/27/89

DATE OF REPORT
03/29/89

ACCOUNT NO.
2710012

0901

TEST

RESULTS

**ABNORMAL
FLAG**

NORMAL VALUES

LAB SPEC PREV SENT
OCULT BLOOD - FECES
NEGATIVE FOR OCULT BLOOD.

FINAL REPORT
SOURCE: STOOL
NEGATIVE FOR OCULT BLOOD.

PAGE 1 OF 1

MC

FINAL REPORT

b6
b7C



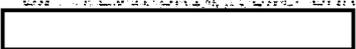
Director of Laboratories

SPIROTECH, INCORPORATED

ATLANTA, GEORGIA
SPIROTECH MODEL 900

SUMMARY TABLE PRINTOUT

PATIENT NAME: DNI...
ID: NONE
DATE: 5/22/89
TEMP: 21.60
PST CORR: 1.098
SEX: MALE
RACE: WHITE
HEIGHT: 72.0
WEIGHT: 37.0
AGE: 37
FEV1: 5.09
FEV3: 5.77
REF 25%: 8.45
REF 50%: 6.95
REF 75%: 2.67
FEV1/VC: 0.84
FEV3/VC: 0.96



MOST REPRESENTATIVE TEST RESULTS

| PARAMETER | ACT | PRED | %PRED |
|-----------|------|------|-------|
| FEV1 | 5.09 | 5.73 | 89% |
| FEV3 | 5.77 | 6.43 | 90% |
| REF 25% | 8.45 | 9.12 | 93% |
| REF 50% | 6.95 | 7.62 | 91% |
| REF 75% | 2.67 | 2.97 | 90% |
| FEV1/VC | 0.84 | 0.83 | 102% |
| FEV3/VC | 0.96 | 0.94 | 102% |

Non Smoker
EXCELLENT



5/18/89

INDIVIDUALS PROGRAM RESULTS

| PARAMETER | ACT | PRED | %PRED |
|-----------|-------|-------|-------|
| FEV1 | 5.78 | 6.03 | 96% |
| FEV3 | 6.74 | 7.30 | 92% |
| REF 25% | 10.90 | 11.69 | 93% |
| REF 50% | 8.58 | 9.29 | 92% |
| REF 75% | 2.31 | 2.56 | 90% |
| FEV1/VC | 0.83 | 0.84 | 102% |
| FEV3/VC | 0.96 | 0.96 | 100% |

¹
O'Neill
3-22-89

7
6
5
4
3
2
1

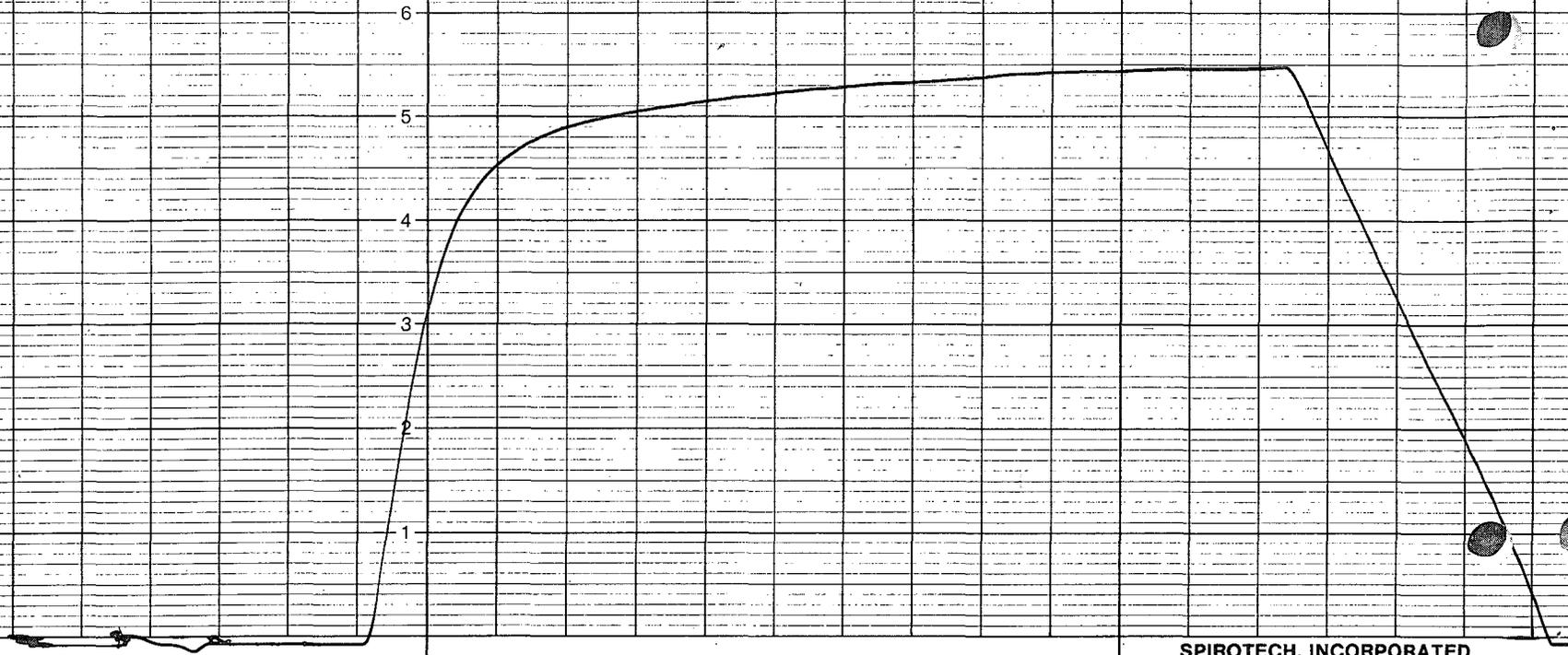
SPIROTECH, INCORPORATED

ATLANTA, GA.

REORDER P/N S010-02

PRINTED IN U.S.A.

7
6
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1



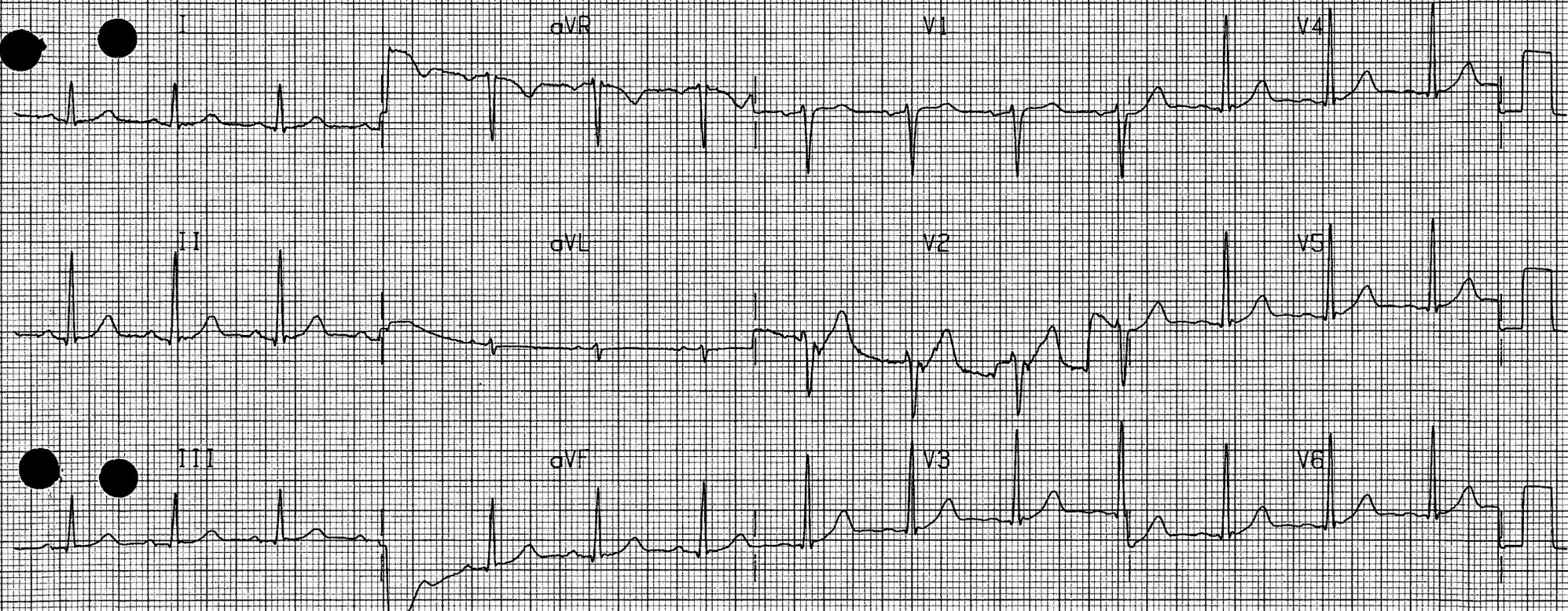
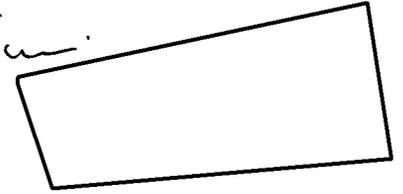
SPIROTECH, INCORPORATED

ATT

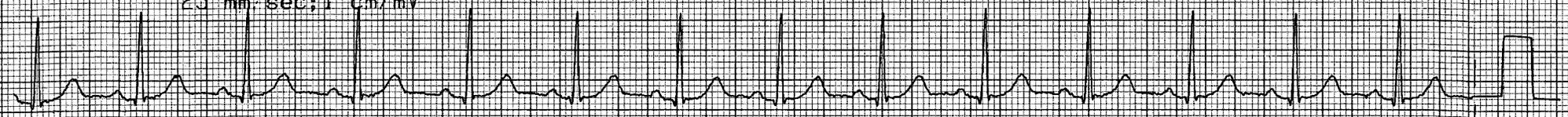
O'Neill John
3-22-89

WNC
Rate 88/minute

b6
b7c



RHYTHM STRIP: II
25 mm/sec; 1 cm/mV



REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

| | |
|--|---|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME
<i>O'Neill, John P.</i> | 2. SOCIAL SECURITY OR IDENTIFICATION NO.
<i>147-42-1004</i> |
| 3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE)
<i>Baltimore, Md</i> | 4. POSITION (title, grade, component)
<i>Supervisory Special Agent</i> |
| 5. PURPOSE OF EXAMINATION | 7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code) |
| 6. DATE OF EXAMINATION | |

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint exists)
Excellent.

| 9. HAVE YOU EVER (Please check each item) | | 10. DO YOU (Please check each item) | |
|---|--------------------------|-------------------------------------|--------------------------|
| YES | NO | YES | NO |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <i>(Check each item)</i> | | <i>(Check each item)</i> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

11. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)

| YES | NO | DON'T KNOW | (Check each item) | YES | NO | DON'T KNOW | (Check each item) | YES | NO | DON'T KNOW | (Check each item) |
|-------------------------------------|--------------------------|--------------------------|-------------------------------|-------------------------------------|--------------------------|--------------------------|--|-------------------------------------|--------------------------|--------------------------|---------------------------------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet fever, erysipelas | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cramps in your legs | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | "Trick" or locked knee |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent indigestion | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Foot trouble |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swollen or painful joints | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stomach, liver, or intestinal trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neuritis |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent or severe headache | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder trouble or gallstones | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis (include infantile) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness or fainting spells | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice or hepatitis | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or fits |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adverse reaction to serum, drug, or medicine | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Car, train, sea or air sickness |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear, nose, or throat trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Broken bones | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent trouble sleeping |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tumor, growth, cyst, cancer | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression or excessive worry |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic or frequent colds | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rupture/hernia | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of memory or amnesia |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Severe tooth or gum trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Piles or rectal disease | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous trouble of any sort |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinusitis | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent or painful urination | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Periods of unconsciousness |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bed wetting since age 12 | | | | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Head injury | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney stone or blood in urine | | | | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin diseases | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sugar or albumin in urine | | | | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | VD—Syphilis, gonorrhea, etc. | | | | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Recent gain or loss of weight | | | | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, Rheumatism, or Bursitis <i>(see over)</i> | | | | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bone, joint or other deformity | | | | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain or pressure in chest | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lameness | | | | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of finger or toe | | | | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Palpitation or pounding heart | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful or "trick" shoulder or elbow | | | | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Recurrent back pain | | | | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High or low blood pressure | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |

13. WHAT IS YOUR USUAL OCCUPATION?
SSA

14. ARE YOU (Check one)
 Right handed Left handed

| YES | NO | CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT |
|-----|----|---|
| ✓ | | 15. Have you been refused employment or been unable to hold a job or stay in school because of:
A. Sensitivity to chemicals, dust, sunlight, etc. |
| ✓ | | B. Inability to perform certain motions. |
| ✓ | | C. Inability to assume certain positions. |
| ✓ | | D. Other medical reasons (If yes, give reasons.) |
| ✓ | | 16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.) |
| ✓ | | 17. Have you ever been denied life insurance? (If yes, state reason and give details.) |
| ✓ | | 18. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.) |
| ✓ | | 19. Have you ever been a patient in any type of hospitals? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) |
| ✓ | | 20. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) |
| ✓ | | 21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) |
| ✓ | | 22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.) |
| ✓ | | 23. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.) |
| ✓ | | 24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.) |

*(18) @ 6 yrs of age, mole removed @ 8 yrs of age
@ age 10 tonsils.
(19) All for above reasons. @ 1958, DeHeldersbarts Hospital, Ventnor, N.J. @ 1960, ~~same~~ at the City Medical Center, A.C. N.J. @ 1962, DeHeldersbarts Hospital, Ventnor, N.J.
(20) Treated for arthritis, 1987, [redacted]
222 Cold Spring Lane, Baltz, Md.*

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

| | |
|---|-----------------------------------|
| TYPED OR PRINTED NAME OF EXAMINEE
<i>John R. O'Neill</i> | SIGNATURE
<i>J. R. O'Neill</i> |
|---|-----------------------------------|

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."
25. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

Healthy for -

| | | | |
|--|------------------------|-----------|---------------------------|
| TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER | DATE
<i>5/18/89</i> | SIGNATURE | NUMBER OF ATTACHED SHEETS |
|--|------------------------|-----------|---------------------------|

**Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner**

Name of Examinee O'Neill John P.
(Type or print) Last First Middle

The following portions of the attached examination report form need not be completed:

| | | | | |
|---|----|----|----|----|
| 3 | 9 | 17 | 67 | 76 |
| 4 | 11 | 62 | 68 | |
| 8 | 14 | 65 | 72 | |

45, 46, 47 and 49; required for all Special Agent and FBI National Academy applicants but not for any other applicant unless the examining physician deems one, two, three or all four of the examinations necessary. 45, 46 and 47 are required in examination of any current employee.

48. Required for (1) all Special Agent applicants; (2) all FBI National Academy applicants; (3) all examinees over 35 years of age; (4) any other where examination indicates such as desirable.

69. Required for all examinees over 40 years of age.

71. Audiometer examinations must be afforded for all Special Agent applicants and Special Agents and decibel readings must be recorded at 500, 1000, 2000, 3000 and 4000 Hertz. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 25 decibel average (ANSI) in either ear in the frequency range 1000, 2000, and 3000 Hertz. No single reading in that range may exceed 35 decibels and no applicant will be accepted if found to have a hearing loss exceeding 35 decibels at 500 or 45 decibels at 4000 Hertz.

For All Examinees, Whether Clerical or Special Agent Applicants, National Academy Applicants, or Employees:

The medical examiner should answer the following question:

Examinee is is not qualified for strenuous physical exertion.

To be Answered in the Case of All Special Agents, Special Agent Applicants, and National Academy Applicants:

1. Does examinee have any defects restricting or prohibiting his/her participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

No Yes If "yes" please specify defects. _____

To be Answered in the Case of All Special Agents, Special Agent Applicants, and other Employees who drive Bureau vehicles:

1. Does examinee have any defects prohibiting safe operation of motor vehicles?

No Yes If "yes" please specify defects. _____

2. For safe driving of motor vehicles, Office of Personnel Management requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? Yes No

If recommendation is based on a factor other than above standard, indicate basis _____

DESIRABLE WEIGHT RANGES

| MALES | | | | FEMALES | | | |
|--------|-------------|--------------|-------------|---------|-------------|--------------|-------------|
| Height | Small Frame | Medium Frame | Large Frame | Height | Small Frame | Medium Frame | Large Frame |
| 5'4" | 117 - 138 | 123 - 149 | 131 - 163 | 5'0" | 96 - 114 | 101 - 124 | 109 - 138 |
| 5'5" | 120 - 142 | 126 - 153 | 134 - 167 | 5'1" | 99 - 118 | 104 - 128 | 112 - 141 |
| 5'6" | 124 - 146 | 130 - 157 | 138 - 173 | 5'2" | 102 - 121 | 107 - 131 | 115 - 144 |
| 5'7" | 128 - 151 | 134 - 163 | 143 - 178 | 5'3" | 105 - 124 | 110 - 135 | 118 - 149 |
| 5'8" | 132 - 155 | 138 - 167 | 147 - 183 | 5'4" | 108 - 128 | 113 - 139 | 121 - 152 |
| 5'9" | 136 - 161 | 142 - 172 | 151 - 187 | 5'5" | 111 - 132 | 117 - 144 | 125 - 156 |
| 5'10" | 140 - 165 | 146 - 177 | 155 - 193 | 5'6" | 114 - 135 | 120 - 149 | 129 - 161 |
| 5'11" | 144 - 169 | 150 - 183 | 160 - 198 | 5'7" | 118 - 140 | 124 - 153 | 133 - 165 |
| 6' | 148 - 174 | 154 - 188 | 164 - 204 | 5'8" | 122 - 144 | 128 - 157 | 137 - 169 |
| 6'1" | 152 - 179 | 158 - 194 | 169 - 209 | 5'9" | 126 - 149 | 132 - 162 | 141 - 174 |
| 6'2" | 156 - 184 | 163 - 199 | 174 - 215 | 5'10" | 130 - 154 | 136 - 166 | 145 - 179 |
| 6'3" | 160 - 188 | 168 - 205 | 178 - 220 | 5'11" | 134 - 158 | 140 - 171 | 149 - 185 |
| 6'4" | 169 - 198 | 178 - 216 | 188 - 231 | 6'0" | 138 - 163 | 144 - 175 | 153 - 190 |
| 6'5" | 174 - 204 | 182 - 222 | 192 - 238 | | | | |

Administrative

4. Examinee's frame is small medium large
5. Considering the above weight table, the examinee's frame, and other individual physical characteristics, I consider his/her present weight Satisfactory Excessive Deficient
6. Under proper medical supervision, employee should lose _____ pounds
 gain _____ pounds

Remarks: _____

Signature



Date

5/18/89

b6
b7c



REPORT OF MEDICAL EXAMINATION

21746

| | | | | | | |
|---|---------------------|--|--|--|---|-----------------|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME
O'Neill, John P. | | | 2. GRADE AND COMPONENT OR POSITION
GA-14 | | 3. IDENTIFICATION NO.
47-42-1004 | |
| 4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code) | | | 5. PURPOSE OF EXAMINATION
PHYSICAL | | 6. DATE OF EXAMINATION
2/9/88 Lab
2/23/88 phy | |
| 7. SEX
M | 8. RACE
W | 9. TOTAL YEARS GOVERNMENT SERVICE
MILITARY CIVILIAN 17 1/2 | | 10. AGENCY
FBI | 11. ORGANIZATION UNIT
CID | |
| 12. DATE OF BIRTH
2/6/52 | | 13. PLACE OF BIRTH
VENTNOR, N.J. | | 14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>
b6
b7C | | |
| 15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS
FBI HQ HS | | | | 16. OTHER INFORMATION | | |
| 17. RATING OR SPECIALTY | | | | TIME IN THIS CAPACITY (Total) | | LAST SIX MONTHS |

| CLINICAL EVALUATION | | |
|---------------------|---|-----------|
| NOR-MAL | (Check each item in appropriate column, enter "NE" if not evaluated) | ABNOR-MAL |
| | 18. HEAD, FACE, NECK AND SCALP | |
| | 19. NOSE | |
| | 20. SINUSES | |
| | 21. MOUTH AND THROAT | |
| | 22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71) | |
| | 23. DRUMS (Perforation) | |
| | 24. EYES—GENERAL (Visual acuity and refraction under items 49, 60 and 67) | |
| | 25. OPHTHALMOSCOPIC | |
| | 26. PUPILS (Equality and reaction) | |
| | 27. OCULAR MOTILITY (Associated parallel movements, nystagmus) | |
| | 28. LUNGS AND CHEST (Include breasts) | |
| | 29. HEART (Thrust, size, rhythm, sounds) | |
| | 30. VASCULAR SYSTEM (Varicosities, etc.) | |
| | 31. ABDOMEN AND VISCERA (Include hernia) | |
| | 32. ANUS AND RECTUM (Hemorrhoids, fistulas) (Prostate, if indicated) | |
| | 33. ENDOCRINE SYSTEM | |
| | 34. G-U SYSTEM | |
| | 35. UPPER EXTREMITIES (Strength, range of motion) | |
| | 36. FEET | |
| | 37. LOWER EXTREMITIES (Except feet) (Strength, range of motion) | X |
| | 38. SPINE, OTHER MUSCULOSKELETAL | X |
| | 39. IDENTIFYING BODY MARKS, SCARS, TATTOOS | X |
| | 40. SKIN, LYMPHATICS | |
| | 41. NEUROLOGIC (Equilibrium tests under item 72) | |
| | 42. PSYCHIATRIC (Specify any personality deviation) | |
| | 43. PELVIC (Females only) (Check how done) | |
| | <input type="checkbox"/> VAGINAL <input type="checkbox"/> RECTAL | |

NOTES (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

2/9/88 P/F machine broken. Advised that D. V. does not meet Bureau requirements

2/25/88 Reviewed.

relaxed in fundal artery related with intension on coughing

Pedic letter to left corrected by 3/8^h left heel h/p

Appendectomy scar OK for status letter

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

| Restorable teeth | | Non-restorable teeth | | Missing teeth | | Replaced by dentures | | Fixed Partial dentures | | | | | | | | | |
|------------------|----|----------------------|----|---------------|----|----------------------|----|------------------------|----|----|----|----|----|----|----|----|---|
| 1 | 2 | 3 | 1 | 2 | 3 | 1 | 2 | 3 | 1 | 2 | 3 | | | | | | |
| 32 | 31 | 30 | 32 | 31 | 30 | 32 | 31 | 30 | 32 | 31 | 30 | | | | | | |
| R | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | L |
| H | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | F |
| T | | | | | | | | | | | | | | | | | T |

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

3/8^h TEW

LABORATORY FINDINGS

| | | | |
|---|------------------------|---|-----------------|
| 45. URINALYSIS: A. SPECIFIC GRAVITY | | 46. CHEST X-RAY (Place, date, film number and result) | |
| B. ALBUMIN | D. MICROSCOPIC | | |
| C. SUGAR | | | |
| 47. SEROLOGY (Specify test used and result) | 48. EKG
WASH | 49. BLOOD TYPE AND RH FACTOR | 50. OTHER TESTS |

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT 6' 52. WEIGHT 197 53. COLOR HAIR 54. COLOR EYES 55. BUILD: SLENDER MEDIUM HEAVY OBESE 56. TEMPERATURE 97

57. BLOOD PRESSURE (Arm at heart level) 58. PULSE (Arm at heart level)

| | | | | | | | | | | |
|------------|-----------------|--------------|------|----------------------|------|------------|-------------------|-----------------|--------------|--------------------------|
| A. SITTING | SYS. <u>120</u> | B. RECUMBENT | SYS. | C. STANDING (3 min.) | SYS. | A. SITTING | B. AFTER EXERCISE | C. 2 MIN. AFTER | D. RECUMBENT | E. AFTER STANDING 3 MIN. |
| | DIAS. <u>84</u> | | | | | <u>72</u> | | | | |

59. 20/25 DISTANT VISION 60. REFRACTION 61. 20/18 NEAR VISION

| | | | | | | |
|---------------------|--------------|----|----|----|----------|----|
| RIGHT 20/ <u>33</u> | CORR. TO 20/ | BY | S. | CX | CORR. TO | BY |
| LEFT 20/ <u>25</u> | CORR. TO 20/ | BY | S. | CX | CORR. TO | BY |

62. HETEROZOPHORIA (Specify distance)

| | | | | | | | |
|-----|-----|-------|-------|------------|----------------|----|----|
| ES° | EX° | R. H. | L. H. | PRISM DIV. | PRISM CONV. CT | PC | PD |
|-----|-----|-------|-------|------------|----------------|----|----|

63. ACCOMMODATION 64. COLOR VISION (Test used and result) 6/6 passed 65. DEPTH PERCEPTION (Test used and score) 66. FIELD OF VISION 67. NIGHT VISION (Test used and score) 68. RED LENS TEST 69. INTRAOCULAR TENSION OD17, OS13

70. HEARING 71. AUDIOMETER 72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)

| | | | | | | | | | | |
|----------|--------|-----|---------|---------|-----------|-----------|-----------|-----------|-----------|----|
| RIGHT WV | /15 SV | /15 | 250 256 | 500 512 | 1000 1024 | 2000 2048 | 4000 4096 | 8000 8144 | 6000 6100 | |
| LEFT WV | /15 SV | /15 | | 10 | 10 | 5 | 0 | 0 | 20 | 10 |
| | | | | 10 | 5 | 0 | 5 | 20 | 5 | 15 |

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

counselled on diet and exercise

PFS June 2/23/88 - Normal

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

Pelvic tilt to left corrected by 3/8" heel lift

Relaxed in gait, no signs without review

Normal defect not corrected by lens - needs glasses

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

Eye check

Pulmonary function study

Spine

76. A. PHYSICAL PROFILE

| | | | | | |
|---|---|---|---|---|---|
| P | U | L | H | E | S |
| | | | | | |

77. EXAMINEE (Check)

A. IS QUALIFIED FOR

B. IS NOT QUALIFIED FOR

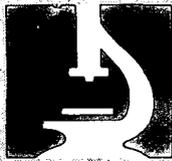
78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

79. TYPED OR PRINTED NAME OF PHYSICIAN [] SIGNATURE []

80. TYPED OR PRINTED NAME OF PHYSICIAN [] SIGNATURE []

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which) SIGNATURE []

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY SIGNATURE [] NUMBER OF ATTACHED SHEETS []



National Health Laboratories
INCORPORATED

1007 ELECTRIC AVENUE
VIENNA, VIRGINIA 22180
PHONE (703) 281-5100

FEDERAL BUREAU OF INVESTIGATION HDQTS.
10TH AND PENN. AVENUE NW
WASHINGTON DC 20535
(202) 324-4976 RTE CV60

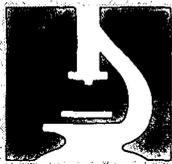
PATIENT NAME: C'NEIL JOHN P SEX: M AGE: 36 ACCESSION: 350138 DATE OF ACCESSION: 02/10/88 DATE OF REPORT: 02/11/88 ACCOUNT NO.: 2710012 5300

| TEST | RESULTS | ABNORMAL FLAG | NORMAL VALUES |
|-------------------------------|---------------|---------------|--|
| FINAL REPORT | | | |
| PROFILE 5477 | | * | |
| HEALTH SURVEY I - (S M A C) | | * | |
| GLUCOSE | 95 MG/DL | * | 65 - 115 |
| BLOOD UREA NITROGEN | 11 MG/DL | * | 7 - 25 |
| CREATININE | 1.2 MG/DL | * | 0.6 - 1.5 |
| SDIUM | 143 MEQ/L | * | 135 - 147 |
| POTASSIUM | 4.8 MEQ/L | * | 3.5 - 5.3 |
| CHLORIDE | 101 MEQ/L | * | 96 - 109 |
| CARBON DIOXIDE | 30 MEQ/L | * | 22 - 32 |
| URIC ACID | 8.2 MG/DL | * | M: 3.0 - 9.0
F: 2.2 - 7.7 |
| TOTAL PROTEIN | 7.6 G/DL | * | 6.0 - 8.5 |
| ALBUMIN | 4.7 G/DL | * | 3.5 - 5.5 |
| GLOBULIN | 2.9 G/DL | * | 2.0 - 3.5 |
| A/G RATIO | 1.6 | * | 1.0 - 2.4 |
| CALCIUM | 10.1 MG/DL | * | 8.5 - 10.8 |
| P-ESPECROLS | 3.3 MG/DL | * | 2.5 - 4.5 |
| CHOLESTEROL | 193 MG/DL | * | AGE ***RISK***
MOD. HIGH
2-19 >170 >185
20-29 >200 >220
30-39 >220 >240
>39 >240 >260
M: 30 - 75
F: 40 - 90
LESS THAN 150
CHD RISK TOTAL/HDL
CHCL RATIO
(M) F
0.5 X AVG 3.4 13.3
1.0 X AVG 5.0 4.4
2.0 X AVG 9.6 7.1
3.0 X AVG 13.4 11.0
LESS THAN 3.1 |
| HDL CHOLESTEROL | 34 MG/DL | * | |
| LDL CHOLESTEROL-CALCULATED | 134 MG/DL | * | |
| CHOLESTEROL/HDL CHCL. RATIO | 5.7 | * | |
| LDL/HDL CHOLESTEROL RATIO | 3.94 | * | |
| TRIGLYCERIDES | 126 MG/DL | * | 30 - 150 |
| ALKALINE PHOSPHATASE | 93 U/L | * | <17 YRS: 80 - 490
>17 YRS: 25 - 140 |
| S.G.C.T | 18 U/L | * | 0 - 40 |
| S.G.P.T | 30 U/L | * | 0 - 45 |
| IF SGPT >45 DO GGT | NOT INDICATED | * | |
| LACTIC DEHYDROGENASE | 116 U/L | * | 100 - 240 |
| TOTAL BILIRUBIN | 1.3 MG/DL | * | 0.2 - 1.2 |
| IRON | 114 MCG/DL | * | 35 - 180 |
| C B C WITH PLATELET | | | |
| HEMATOCRIT | 50.5 % | * | M: 39-54 F: 35-48 |
| HEMOGLOBIN | 16.9 G/DL | * | M: 13.0 - 18.0
F: 11.5 - 16.0 |

Handwritten signature and date: 2/23/88

b6
b7c

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(202) 324-4976 RTE 6V60

PATIENT NAME

C'NEIL JOHN P

SEX

M

AGE

36

ACCESSION

350138

DATE OF ACCESSION

02/10/88

DATE OF REPORT

02/11/88

ACCOUNT NO.

2710012

5301

TEST

RESULTS

ABNORMAL FLAG

NORMAL VALUES

REC BLOOD COUNT

FINAL REPORT
5.25 MILLION /CU.MM.

*

MALE: 4.4 - 6.2
FEMALE: 3.8 - 5.4

MCV

96 CU. MICRONS

*

80 - 100

MCH

32.3 MICRO-MICRO GMS

*

27.0 - 34.0

MCHC

33.6 %

*

31.0 - 36.0

WHITE BLOOD COUNT

5.4 THOUS/CU.MM.

*

4.0 - 11.0

LYMPHOCYTE

31 %

*

18 - 46

NEUTROPHIL

61 %

*

45 - 75

MONOCYTE

4 %

*

0 - 11

EOSINOPHIL

3 %

*

0 - 6

BASOPHIL

1 %

*

0 - 2

CBC RUN TWICE

PLATELET COUNT

305 THOUS/CU.MM.

*

140 - 450

THYROXINE (T4) - RIA

8.7 MCG/DL

*

4.5 - 12.5

BILIRUBIN - INDIRECT

1.2 MG/DL

*

HI 0.2 - 1.0

BILIRUBIN - DIRECT

0.1 MG/DL

*

0.0 - 0.4

URINALYSIS - ROUTINE

COLOR

YELLOW

*

URINE PH

5.0

*

5.0 - 9.0

SPECIFIC GRAVITY

1.024

*

1.003 - 1.030

GLUCOSE

NEGATIVE

*

NEGATIVE

PROTEIN

NEGATIVE

*

NEGATIVE

KETONES

NEGATIVE

*

NEGATIVE

BLOOD

NEGATIVE

*

NEGATIVE

BILIRUBIN

NEGATIVE

*

NEGATIVE

UROBILINOGEN

NEGATIVE

*

0 - 1+

LEUKOCYTE ESTERASE

NEGATIVE

*

NEGATIVE

NITRITE

NEGATIVE

*

NEGATIVE

SEROLGY (RPR) - QUAL.

NON REACTIVE

*

NCN-REACTIVE

SEROLGY (RPR) - QUANT.

NOT INDICATED

*

NCN-REACTIVE

FTA (IF RPR REACTIVE)

NOT INDICATED

*

PAGE 2 OF 2

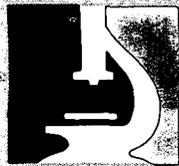
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WASHINGTON DC 20535

(202) 324-4976 RTE GV60

PATIENT NAME

SEX

AGE

ACCESSION

DATE OF ACCESSION

DATE OF REPORT

ACCOUNT NO.

O'NEIL JOHN P

M

680142

02/11/88

02/13/88

2710012

4705

TEST

RESULTS

ABNORMAL FLAG

NORMAL VALUES

PART OF PROFILE-NO CHARGE

OCCULT BLOOD - FECES

NEGATIVE FOR OCCULT BLOOD.

FINAL REPORT

SOURCE: STOOL

*

PAGE 1 OF 1

MC

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2/25/88

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DIRECTOR OF LABORATORIES

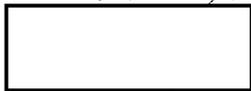
SPIROTECH, INCORPORATED
 ATLANTA, GEORGIA
 SPIROTECH MODEL 900
 SUMMARY TABLE PRINTOUT

PATIENT NAME: O'NEILL JOHN
 ID: NONE
 DATE: 2/23/88 TEMP=36.4C BTPS CORR=1.004 B
 MALE WHITE HEIGHT: 72.0IN AGE: 36YRS DK
 FVC CRIT= 5% FEV1 CRIT= 5% BAR PR=760.0 F0
 NORMALS:

b6
 b7c

..... MOST REPRESENTATIVE TEST RESULTS

| PARAM | ACT | PRED | XPRED |
|----------|------|------|-------|
| FVC | 5.54 | 5.38 | 103% |
| FEV.5 | 2.75 | 3.41 | 110% |
| FEV1 | 4.71 | 4.83 | 103% |
| FEV3 | 5.30 | 5.18 | 103% |
| PEFR | 9.63 | 9.94 | 97% |
| MMEF | 5.70 | 5.25 | 103% |
| PEF25% | 8.90 | 9.22 | 97% |
| PEF50% | 7.49 | 6.68 | 112% |
| PEF75% | 2.48 | 3.47 | 71% |
| FEV.5/VC | .88 | | |
| FEV1/VC | .85 | .83 | 103% |
| FEV3/VC | .86 | | |



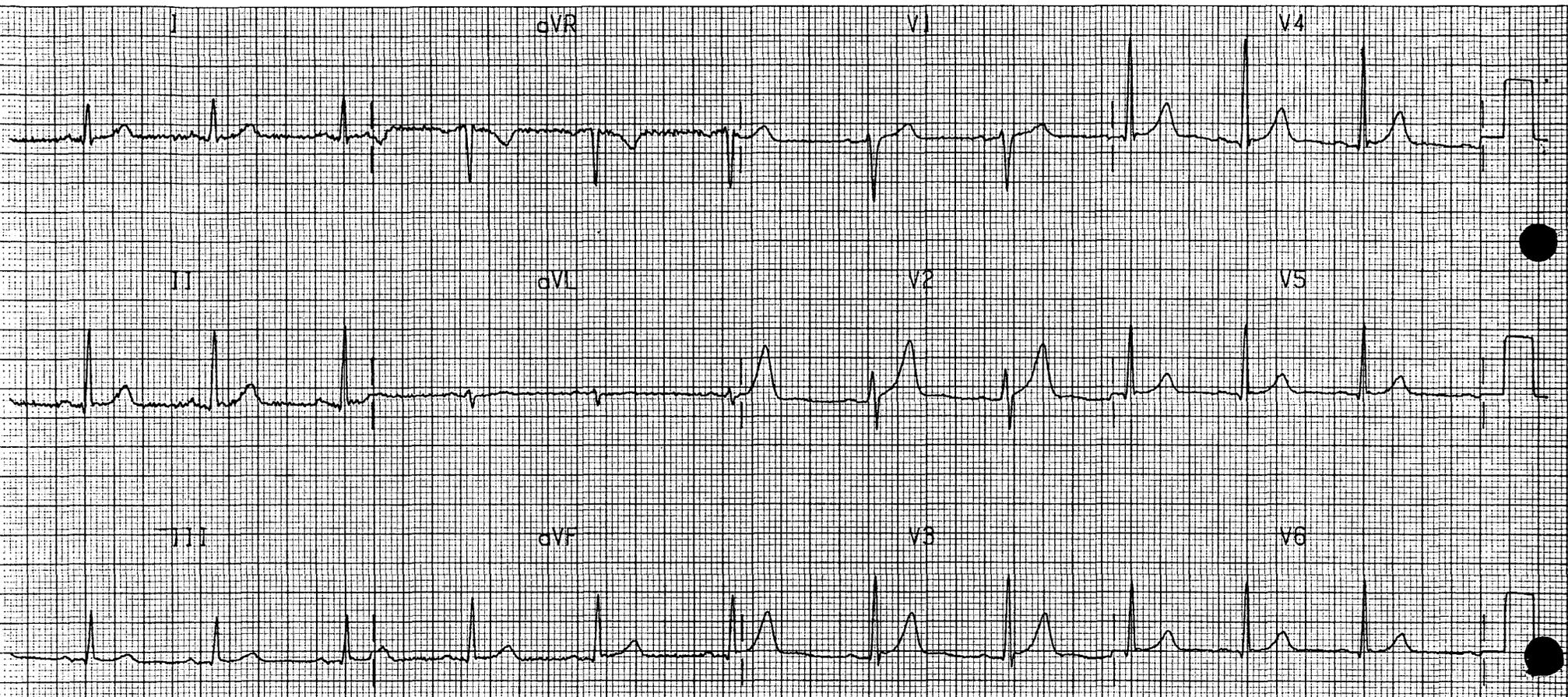
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 JW
 2/23/88

..... INDIVIDUAL SPIROGRAM RESULTS

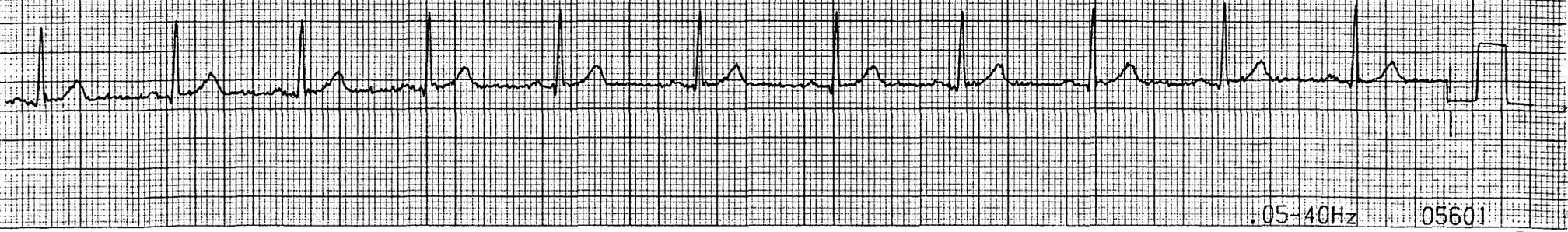
| | 1# 9:07 | 2# 9:07 | 3 9:07 |
|----------|------------|------------|-----------|
| | ACT XPRED | ACT XPRED | ACT XPRED |
| FVC | 5.35 89% | 5.53 103% | 5.54 103% |
| FEV.5 | 3.63 105% | 3.72 103% | 3.75 110% |
| FEV1 | 4.57 105% | 4.70 103% | 4.71 103% |
| FEV3 | 5.20 101% | 5.30 103% | 5.28 102% |
| PEFR | 10.22 103% | 10.72 103% | 9.63 97% |
| MMEF | 5.71 103% | 5.67 103% | 5.70 103% |
| PEF25% | 7.82 85% | 7.84 85% | 8.90 97% |
| PEF50% | 6.74 101% | 7.18 103% | 7.49 112% |
| PEF75% | 2.76 75% | 2.71 78% | 2.48 71% |
| FEV.5/VC | .88 | .67 | .88 |
| FEV1/VC | .85 103% | .85 103% | .85 103% |
| FEV3/VC | .87 | .86 | .85 |

O'neil John P
2/9/88

WNL / ASD
2/23/88



RHYTHM STRIP: II
25 mm/sec: 1 cm/mV



REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

| | |
|---|--|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME
O'Neill, John P. | 2. SOCIAL SECURITY OR IDENTIFICATION NO.
147-42-1004 |
| 3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE) | 4. POSITION (title, grade, component)
SSA, GM-14 |
| 5. PURPOSE OF EXAMINATION
Physical | 6. DATE OF EXAMINATION
2/23/88
2/19/88 Lab
FBI HQ MD |
| 7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code) | |
| 8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint exists)
Excellent Health / No medications currently in use. | |

| 9. HAVE YOU EVER (Please check each item) | | 10. DO YOU (Please check each item) | |
|---|-------------------------------------|-------------------------------------|--------------------------|
| YES | NO | YES | NO |
| (Check each item) | | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Lived with anyone who had tuberculosis | | Wear glasses or contact lenses | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Coughed up blood | | Have vision in both eyes | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Bled excessively after injury or tooth extraction | | Wear a hearing aid | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Attempted suicide | | Stutter or stammer habitually | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Been a sleepwalker | | Wear a brace or back support | |

| 11. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item) | | | | | | | | | | | |
|---|--------------------------|--------------------------|-------------------------------|-------------------------------------|--------------------------|--------------------------|--|-------------------------------------|--------------------------|--------------------------|---------------------------------|
| YES | NO | DON'T KNOW | (Check each item) | YES | NO | DON'T KNOW | (Check each item) | YES | NO | DON'T KNOW | (Check each item) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet fever, erysipelas | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cramps in your legs | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | "Trick" or locked knee |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent indigestion | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Foot trouble |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swollen or painful joints | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stomach, liver, or intestinal trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neuritis |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent or severe headache | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder trouble or gallstones | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis (include infantile) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness or fainting spells | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice or hepatitis | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or fits |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adverse reaction to serum, drug, or medicine | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Car, train, sea or air sickness |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear, nose, or throat trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Broken bones | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent trouble sleeping |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tumor, growth, cyst, cancer | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression or excessive worry |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic or frequent colds | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rupture/hernia | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of memory or amnesia |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Severe tooth or gum trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Piles or rectal disease | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous trouble of any sort |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinusitis | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent or painful urination | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Periods of unconsciousness |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bed wetting since age 12 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Head Injury | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney stone or blood in urine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin diseases | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sugar or albumin in urine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | VD—Syphilis, gonorrhea, etc. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Recent gain or loss of weight | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, Rheumatism, or Bunitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bone, joint or other deformity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain or pressure in chest | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lameness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of finger or toe | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Palpitation or pounding heart | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful or "trick" shoulder or elbow | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Recurrent back pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High or low blood pressure | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

| | |
|--|---|
| 13. WHAT IS YOUR USUAL OCCUPATION?
Supervisory Special Agent | 14. ARE YOU (Check one)
<input type="checkbox"/> Right handed <input checked="" type="checkbox"/> Left handed |
|--|---|

Do Not Transcribe
With Official Personnel File

| YES | NO | CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT |
|-----|----|---|
| ✓ | | 15. Have you been refused employment or been unable to hold a job or stay in school because of:
A. Sensitivity to chemicals, dust, sunlight, etc. |
| ✓ | | B. Inability to perform certain motions. |
| ✓ | | C. Inability to assume certain positions. |
| ✓ | | D. Other medical reasons (If yes, give reasons.) |
| ✓ | | 16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.) |
| ✓ | | 17. Have you ever been denied life insurance? (If yes, state reason and give details.) |
| ✓ | | 18. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.) |
| ✓ | | 19. Have you ever been a patient in any type of hospitals? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) |
| ✓ | | 20. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) |
| ✓ | | 21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) |
| ✓ | | 22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.) |
| ✓ | | 23. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.) |
| ✓ | | 24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.) |

-18/11 - age 6, Tonsillectomy
 age 8, mole surgically removed
 age 10, appendectomy

19. ① 1958, Dehillebrant Hospital, Ventnor NJ
 [redacted]
 ② 1960, Dehillebrant Hospital, Ventnor NJ.
 [redacted]
 ③ 1963, Atlantic City Hospital, Atlantic City NJ
 [redacted]

④ 1980 High blood pressure - treated for @ 2 months - [redacted] Maryland, Balto, Md - No further problems

4/1987 arthritis, treated by [redacted] Balto, Md. for 2 months - No further problems.

b6
b7c

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

| | |
|---|-------------------------------------|
| TYPED OR PRINTED NAME OF EXAMINEE
<i>John P. O'Neill</i> | SIGNATURE
<i>John P. O'Neill</i> |
|---|-------------------------------------|

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."
 25. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

Arthritis affecting knees and ankles
 for 6 weeks in March 1987 -
 Rx c Indocin
 Re. LYME ARTHRITIS.

| | | | |
|--|------------------------|-------------------------|--------------------------------|
| TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER | DATE
<i>2/23/88</i> | SIGNATURE
[redacted] | NUMBER OF ATTACHED SHEETS
1 |
|--|------------------------|-------------------------|--------------------------------|

DESIRABLE WEIGHT RANGES

| MALES | | | | FEMALES | | | |
|--------|-------------|--------------|-------------|---------|-------------|--------------|-------------|
| Height | Small Frame | Medium Frame | Large Frame | Height | Small Frame | Medium Frame | Large Frame |
| 5'4" | 117 - 138 | 123 - 149 | 131 - 163 | 5'0" | 96 - 114 | 101 - 124 | 109 - 138 |
| 5'5" | 120 - 142 | 126 - 153 | 134 - 167 | 5'1" | 99 - 118 | 104 - 128 | 112 - 141 |
| 5'6" | 124 - 146 | 130 - 157 | 138 - 173 | 5'2" | 102 - 121 | 107 - 131 | 115 - 144 |
| 5'7" | 128 - 151 | 134 - 163 | 143 - 178 | 5'3" | 105 - 124 | 110 - 135 | 118 - 149 |
| 5'8" | 132 - 155 | 138 - 167 | 147 - 183 | 5'4" | 108 - 128 | 113 - 139 | 121 - 152 |
| 5'9" | 136 - 161 | 142 - 172 | 151 - 187 | 5'5" | 111 - 132 | 117 - 144 | 125 - 156 |
| 5'10" | 140 - 165 | 146 - 177 | 155 - 193 | 5'6" | 114 - 135 | 120 - 149 | 129 - 161 |
| 5'11" | 144 - 169 | 150 - 183 | 160 - 198 | 5'7" | 118 - 140 | 124 - 153 | 133 - 165 |
| 6' | 148 - 174 | 154 - 188 | 164 - 204 | 5'8" | 122 - 144 | 128 - 157 | 137 - 169 |
| 6'1" | 152 - 179 | 158 - 194 | 169 - 209 | 5'9" | 126 - 149 | 132 - 162 | 141 - 174 |
| 6'2" | 156 - 184 | 163 - 199 | 174 - 215 | 5'10" | 130 - 154 | 136 - 166 | 145 - 179 |
| 6'3" | 160 - 188 | 168 - 205 | 178 - 220 | 5'11" | 134 - 158 | 140 - 171 | 149 - 185 |
| 6'4" | 169 - 198 | 178 - 216 | 188 - 231 | 6'0" | 138 - 163 | 144 - 175 | 153 - 190 |
| 6'5" | 174 - 204 | 182 - 222 | 192 - 238 | | | | |

4. Examinee's frame is small medium large

5. Considering the above weight table, the examinee's frame, and other individual physical characteristics, I consider his/her present weight Satisfactory Excessive Deficient

6. Under proper medical supervision, employee should lose _____ pounds
 gain _____ pounds

Remarks: _____

S

Date 2/23/88

b6
b7c

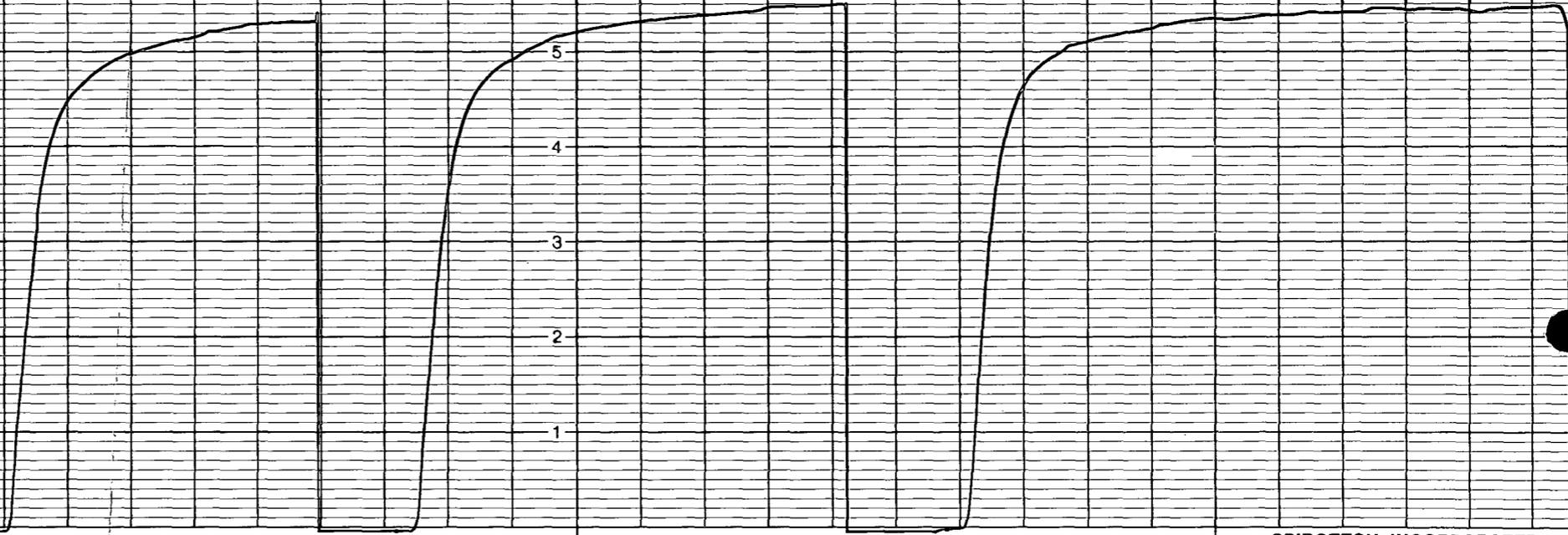
1 sec. at 20mm/sec.

1 sec. at 10mm/sec.

1 sec. at 20mm/sec.

1 sec. at 10mm/sec.

O'Neill, John P
2/23/88



REPORT OF MEDICAL EXAMINATION

| | | | | | |
|---|---------------------|---|--|---|--|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME
O'NEILL JOHN P. | | 2. GRADE AND COMPONENT POSITION
GS-14 SSA | | 3. IDENTIFICATION NO. | |
| 4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)
BALTIMORE, MD | | 5. PURPOSE OF EXAMINATION
FITNESS FOR DUTY | | 6. DATE OF EXAMINATION
3-22-89 Phase I
5/18/89 phase II | |
| 7. SEX
W | 8. RACE
M | 9. TOTAL YEARS GOVERNMENT SERVICE
MILITARY CIVILIAN 19 | | 10. AGENCY
FBI | |
| 11. ORGANIZATION UNIT | | 12. DATE OF BIRTH
2-6-52 | | 13. PLACE OF BIRTH
VENTNOR, NJ. | |
| 14. NAME RELATIONSHIP AND ADDRESS OF NEXT OF KIN | | 15. EXAMINING FACILITY OR EXAMINER AND ADDRESS
Health Services Room 6344 JEH Building | | 16. OTHER INFORMATION | |
| 17. RATING OR SPECIALTY | | TIME IN THIS CAPACITY (Total) | | LAST SIX MONTHS | |

| CLINICAL EVALUATION | | |
|---------------------|---|-----------|
| NOR-MAL | (Check each item in appropriate column, enter "NE" if not evaluated) | ABNOR-MAL |
| | 18. HEAD, FACE, NECK AND SCALP | |
| | 19. NOSE | |
| | 20. SINUSES | |
| | 21. MOUTH AND THROAT | |
| | 22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71) | |
| | 23. DRUMS (Perforation) | |
| | 24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67) | |
| | 25. OPHTHALMOSCOPIC | |
| | 26. PUPILS (Equality and reaction) | |
| | 27. OCULAR MOTILITY (Associated parallel movements, nystagmus) | |
| | 28. LUNGS AND CHEST (Include breasts) | |
| | 29. HEART (Thrust, size, rhythm, sounds) | |
| | 30. VASCULAR SYSTEM (Varicosities, etc.) | |
| | 31. ABDOMEN AND VISCERA (Include hernia) | |
| | 32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate, if indicated) | |
| | 33. ENDOCRINE SYSTEM | |
| | 34. G-U SYSTEM | |
| | 35. UPPER EXTREMITIES (Strength, range of motion) | |
| | 36. FEET | |
| | 37. LOWER EXTREMITIES (Exempt feet) (Strength, range of motion) | |
| | 38. SPINE, OTHER MUSCULOSKELETAL | |
| | 39. IDENTIFYING BODY MARKS, SCARS, TATTOOS | |
| | 40. SKIN, LYMPHATICS | |
| | 41. NEUROLOGIC (Equilibrium tests under item 72) | |
| | 42. PSYCHIATRIC (Specify any personality deviation) | |
| | 43. PELVIC (Females only) (Check how done) | |
| | <input type="checkbox"/> VAGINAL <input type="checkbox"/> RECTAL | |

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

Rectal - Normal
 Prostate - Normal.
 Physical reviewed in FBIHQ HCPU
 by [redacted]
 on MAY 19 1989

← mainly here.
 Relaxed in femur mgs

Appendix - midline vertical
 Back - midline removal scar

OK for fitness test
 [redacted]

| | | | | | | | | | | | | | | | | | |
|--|----|----|---|----|----|---|----|----|--|----|----|--|----|----|----|----|---|
| 44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.) | | | | | | | | | | | | | | | | | |
| 0
1 2 3 Restorable teeth
32 31 30 | | | Non-restorable teeth
1 2 3
32 31 30 | | | Missing teeth
x x x
1 2 3
32 31 30 | | | Replaced by dentures
x x x
1 2 3
32 31 30 | | | Fixed Partial dentures
x x x
1 2 3
32 31 30 | | | | | |
| R | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | L |
| I | | | | | | | | | | | | | | | | | E |
| G | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | F |
| H | | | | | | | | | | | | | | | | | |
| T | | | | | | | | | | | | | | | | | T |

REMARKS AND ADDITIONAL DEFECTS AND DISEASES
 3
 KRS

| | | | | | | | |
|---|--|-----------------------|--|---|--|-----------------|--|
| 45. URINALYSIS: A. SPECIFIC GRAVITY | | | | 46. CHEST X-RAY (Place, date, film number and result) | | | |
| B. ALBUMIN | | D. MICROSCOPIC | | | | | |
| C. SUGAR | | | | | | | |
| 47. SEROLOGY (Specify test used and result) | | 48. EKG
WNL | | 49. BLOOD TYPE AND RH FACTOR | | 50. OTHER TESTS | |

Tachycardia

MEASUREMENTS AND OTHER FINDINGS

| | | | | | |
|--|--------------------------|--|--------------------------------|--|--------------------------------|
| 51. HEIGHT
<i>6'</i> | 52. WEIGHT
<i>195</i> | 53. COLOR HAIR | 54. COLOR EYES | 55. BUILD:
<input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE | 56. TEMPERATURE
<i>95.5</i> |
| 57. BLOOD PRESSURE (Arm at heart level) | | | 58. PULSE (Arm at heart level) | | |
| A. SITTING
SYS. <i>128</i>
DIAS. <i>82</i> | | B. RECUMBENT
SYS.
DIAS.
<i>64</i> | | C. 2 MIN. AFTER | |
| 59. DISTANT VISION | | 60. REFRACTION | | 61. NEAR VISION | |
| RIGHT 20/ <i>29</i> | CORR. TO 20/ <i>20</i> | BY <i>S.</i> | CX <i>CX</i> | <i>20/20</i> | CORR. TO <i>BY</i> |
| LEFT 20/ <i>25</i> | CORR. TO 20/ <i>20</i> | BY <i>S.</i> | CX <i>CX</i> | <i>20/20</i> | CORR. TO <i>BY</i> |

62. HETEROPHORIA (Specify distance)

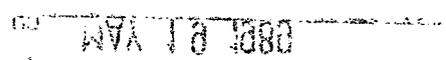
| | | | | | | | |
|-----|-----|-------|-------|------------|----------------|----|----|
| ES° | EX° | R. H. | L. H. | PRISM DIV. | PRISM CONV. CT | PC | PD |
|-----|-----|-------|-------|------------|----------------|----|----|

| | | | |
|--|--|--|---|
| 63. ACCOMMODATION
RIGHT _____
LEFT _____ | 64. COLOR VISION (Test used and result)
<i>passed prev.</i> | 65. DEPTH PERCEPTION (Test used and score) | UNCORRECTED _____
CORRECTED _____ |
| 66. FIELD OF VISION | 67. NIGHT VISION (Test used and score) | 68. RED LENS TEST | 69. INTRAOCULAR TENSION
<i>OD-14 OS-14</i> |

| 70. HEARING | 71. AUDIOMETER | 72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------|---|--|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|-------|--|----------|-----------|-----------|----------|-----------|-----------|--|--------------------|--|----------|----------|----------|-----------|-----------|-----------|--|--|
| RIGHT WV /15 SV /15 | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th></th> <th>250
256</th> <th>500
512</th> <th>1000
1024</th> <th>2000
2048</th> <th>3000
2896</th> <th>4000
4096</th> <th>6000
6144</th> <th>8000
8192</th> </tr> <tr> <td>RIGHT</td> <td></td> <td><i>5</i></td> <td><i>10</i></td> <td><i>10</i></td> <td><i>5</i></td> <td><i>10</i></td> <td><i>15</i></td> <td></td> </tr> <tr> <td>LEFT WV /15 SV /15</td> <td></td> <td><i>5</i></td> <td><i>5</i></td> <td><i>0</i></td> <td><i>10</i></td> <td><i>20</i></td> <td><i>10</i></td> <td></td> </tr> </table> | | 250
256 | 500
512 | 1000
1024 | 2000
2048 | 3000
2896 | 4000
4096 | 6000
6144 | 8000
8192 | RIGHT | | <i>5</i> | <i>10</i> | <i>10</i> | <i>5</i> | <i>10</i> | <i>15</i> | | LEFT WV /15 SV /15 | | <i>5</i> | <i>5</i> | <i>0</i> | <i>10</i> | <i>20</i> | <i>10</i> | | |
| | 250
256 | 500
512 | 1000
1024 | 2000
2048 | 3000
2896 | 4000
4096 | 6000
6144 | 8000
8192 | | | | | | | | | | | | | | | | | | | | | |
| RIGHT | | <i>5</i> | <i>10</i> | <i>10</i> | <i>5</i> | <i>10</i> | <i>15</i> | | | | | | | | | | | | | | | | | | | | | | |
| LEFT WV /15 SV /15 | | <i>5</i> | <i>5</i> | <i>0</i> | <i>10</i> | <i>20</i> | <i>10</i> | | | | | | | | | | | | | | | | | | | | | | |

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

*Has modified diet E ↓ chl -
and ↑ IDL -
to modify intake*


 (Use additional sheets if necessary)
 HEALTH CARE CENTER
Health

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

Health

| 75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)
<i>Access to - White line 10 minutes next year</i> | 76. A. PHYSICAL PROFILE | | | | | | | | | | | | |
|---|--|---|---|---|---|---|---|--|--|--|--|--|--|
| | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>P</th> <th>U</th> <th>L</th> <th>H</th> <th>E</th> <th>S</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table> | P | U | L | H | E | S | | | | | | |
| P | U | L | H | E | S | | | | | | | | |
| | | | | | | | | | | | | | |

| 77. EXAMINEE (Check)
A. <input checked="" type="checkbox"/> IS QUALIFIED FOR
B. <input type="checkbox"/> IS NOT QUALIFIED FOR
<i>Full duty</i> | 76. B. PHYSICAL CATEGORY | | | | | | | | |
|---|--|---|---|---|---|--|--|--|--|
| | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>A</th> <th>B</th> <th>C</th> <th>E</th> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table> | A | B | C | E | | | | |
| A | B | C | E | | | | | | |
| | | | | | | | | | |

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

| | |
|--|--|
| 79. TYPED OR PRINTED NAME OF PHYSICIAN
<div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block;"></div> M.D. | SIGNATURE
<div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block;"></div> |
| 80. TYPED OR PRINTED NAME OF PHYSICIAN | SIGNATURE |
| 81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which) | SIGNATURE |
| 82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR AUTHORITY | SIGNATURE |

NUMBER OF ATTACHED SHEETS

MEDICAL REPORTS

Personnel File No. SA JOHN P. O'NEILL

Personnel File No. _____

Memorandum



WOB/AD
TO : Director, FBI

Date 5/21/93

From : SAC, CHICAGO

Attention: Administrative Services Division
 (1) Staffing & Pay Administration Unit
 (2) Health Care Programs Unit

Subject: JOHN P. O'NEILL
 SPECIAL AGENT (ASAC)
 PHYSICAL EXAMINATION MATTER

Remylet _____
 ReBulet _____

- Re physical examination 2/5/93
 Dental work was completed on _____
 Vision has been corrected to 20/20 both eyes . Employee specifically instructed 3/25/93 by _____ R.N. that he/she can operate a Bureau car only when wearing the necessary glasses.
 Results of chest X ray patch test urinalysis serology were negative.
 Enclosed physician's statement indicates employee is: Qualified for strenuous physical exertion and use of firearms; Qualified for firearms, exclusive of defensive tactics. SAC concurs, Yes No. If answered no, explain under remarks.
 Future participation in firearms is remote and weapon will be returned to the Bureau.
 Enclosed are paid unpaid medical bills.
 Attached are Bureau of Employees' Compensation forms _____
 Time and attendance (T&A) records checked and showed employee was on _____ hours (check one: Continuation of Pay Annual Leave Sick Leave Leave Without Pay) at time employee sustained injury. (THIS MUST AGREE WITH CA-1). Enclosed is copy of T&A record.
 Physical examination reports are enclosed.
 Employee is scheduled for physical examination on _____
 Physical examination report has been reviewed and initialed.
 Employee returned to active duty _____
 Employee's physical condition is _____
 UACB he/she is being removed from limited duty.
 UACB he/she is being placed on limited duty.

If employee is a Resident Agent, is there a sufficient amount of nonarduous work available to keep him/her fully occupied and are sufficient agents available to handle emergency assignments. Yes No If answer is no, separately and immediately submit your recommendation for the return of this agent to headquarters city.

Remarks: ASAC O'NEILL is aware of the results of his physical. Per the examining doctor's recommendations, he was given information on following a low calorie, low cholesterol diet while engaging in a gradual aerobic exercise program. He was also encouraged to recheck his cholesterol level periodically.

① Bureau
 1- Chicago
 SC/sjp
 (2)

Enclosure

3/egm

b6
 b7c

SA/ET ANNUAL FITNESS-FOR-DUTY EXAM CHECKLIST

NAME John A. O'Neill FIELD OFFICE Chicago
 D.O.B. 2-6-52
 D.O.P. 2-5-93
 S.S.N. 147-42-1004

Please place a check mark before each of the following items to indicate that they have been completed. If any items are incomplete or have been omitted, the results should be obtained and attached to the physical exam report before it is submitted to FBIHQ. The completed checklist must be attached to the physical exam report.

REPORT OF MEDICAL EXAMINATION (SF-88)

- Questions 1 through 16
- Clinical Evaluation Section 18 through 42, should each be checked by the examining physician.
- Height #51
- Weight #52 (Indicate if overweight)
- Body fat if applicable no recent body fat reading
- Blood pressure #57 (Not all three positions are necessary).
- Pulse #58
- Distant vision #59 (uncorrected must be noted and also the corrected vision if applicable).
- Near vision #61 (uncorrected and corrected).
- Color vision #64 (Specify the type of test used and the results such as normal, WNL, passed, or failed).
- Intra Ocular Tension #69 (Glaucoma test) Age 40 and over.
- Audiometer #71 (Baseline decibel readings must be recorded at 500, 1000, 2000, 3000, and 4000 frequency ranges).
- EKG #48 with interpretation.
- Pulmonary Function Test (PFT) every 2 years.
- Exercise Stress Test every 2 years (Must indicate test results and date).
- N/A Thallium test, date, and results, (if medically indicated).
- Certification for strenuous duty #77 - must be checked.
- Signature and title of examining physician.

LABORATORY FINDINGS (Questions 45 and 47 through 50)

- | | |
|---|--|
| <input checked="" type="checkbox"/> Urinalysis (Microscopic if medically indicated) | <input checked="" type="checkbox"/> Thyroid Test (T-4) |
| <input checked="" type="checkbox"/> CBC (Complete Blood Count) | <input checked="" type="checkbox"/> Hemoccult Slide |
| <input checked="" type="checkbox"/> Blood Chemistry Profile (SMA 24) | <input checked="" type="checkbox"/> Chest X-ray - PA & lateral (Only if medically indicated) |

(Continued)

REPORT OF MEDICAL HISTORY (SF-93)

- Check #'s 1 through 25 (#12 females only)
- Signature of SA
- Signature and title of examining physician and the date.
- Physician to comment on all abnormal findings and items clarify all checked items.

FORM FD-300

1. **Must** indicate if qualified for strenuous physical exertion. (See additional information.)
2. #1 - Must be checked regarding participation in defensive tactics.
3. #1 & #2 - Must be checked regarding operating a motor vehicle.
4. #4 - Frame
5. #5 - Present weight - satisfactory (excessive) deficient
6. Signature of medical examiner and date.

Additional Information

- *Is SA/Electronic Technician on Limited Duty?
Yes No
If "Yes" SF 88 and FD 300 **must** reflect same.
- *Is ET overweight according to Bureau Standards?
Yes No
- *Was SA/ET advised of examiner's recommendations?
Yes No

- All questions **must** be answered.
- Signature and title of examining physician and the date.

REVIEWED BY:

b6
b7C

TITLE:

Occupational Health Nurse

DATE:

5/12/93

REPORT OF MEDICAL EXAMINATION

| | | | | | | |
|--|-------------------------|--|--|--|---|-----------------|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME
O'NEILL, JOHN P. | | | 2. GRADE AND COMPONENT OR POSITION
SPECIAL AGENT | | 3. IDENTIFICATION NO.
147-42-1004 | |
| 4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code) <i>Chgo. Il. 60604</i>
209 S. Dearborn Rm 905 | | | 5. PURPOSE OF EXAMINATION
ANNUAL | | 6. DATE OF EXAMINATION
2/5/93 | |
| 7. SEX
MALE | 8. RACE
White | 9. TOTAL YEARS GOVERNMENT SERVICE
MILITARY _____ CIVILIAN 22 | | 10. AGENCY
FBI | 11. ORGANIZATION UNIT
CHICAGO | |
| 12. DATE OF BIRTH
2/6/52 | | 13. PLACE OF BIRTH
VENTNOR, N.J. | | 14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN | | |
| 15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS
The Center For Cardiovascular Health
3933 N. Cicero Ave.
Chicago, IL 60641 | | | | 16. OTHER INFORMATION | | |
| 17. RATING OR SPECIALTY | | | | TIME IN THIS CAPACITY (Total) | | LAST SIX MONTHS |

| CLINICAL EVALUATION | | ABNOR-
MAL |
|-------------------------------------|--|---------------|
| NOR-
MAL | (Check each item in appropriate column, enter "NE" if not evaluated.) | |
| <input checked="" type="checkbox"/> | 18. HEAD, FACE, NECK AND SCALP | |
| <input checked="" type="checkbox"/> | 19. NOSE | |
| <input checked="" type="checkbox"/> | 20. SINUSES | |
| <input checked="" type="checkbox"/> | 21. MOUTH AND THROAT | |
| <input checked="" type="checkbox"/> | 22. EARS—GENERAL (INTERNAL CANALS) (Auditory acuity under items 70 and 71) | |
| <input checked="" type="checkbox"/> | 23. DRUMS (Perforation) | |
| <input checked="" type="checkbox"/> | 24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67) | |
| <input checked="" type="checkbox"/> | 25. OPHTHALMOSCOPIC | |
| <input checked="" type="checkbox"/> | 26. PUPILS (Equality and reaction) | |
| <input checked="" type="checkbox"/> | 27. OCULAR MOTILITY (Associated parallel movements nystagmus) | |
| <input checked="" type="checkbox"/> | 28. LUNGS AND CHEST (Include breasts) | |
| <input checked="" type="checkbox"/> | 29. HEART (Thrust, size, rhythm, sounds) | |
| <input checked="" type="checkbox"/> | 30. VASCULAR SYSTEM (Varicosities, etc.) | |
| <input checked="" type="checkbox"/> | 31. ABDOMEN AND VISCERA (Include hernia) | |
| <input checked="" type="checkbox"/> | 32. ANUS AND RECTUM (Hemorrhoids, Fistular Prostate, if indicated) | |
| <input checked="" type="checkbox"/> | 33. ENDOCRINE SYSTEM | |
| <input checked="" type="checkbox"/> | 34. G-U SYSTEM | |
| <input checked="" type="checkbox"/> | 35. UPPER EXTREMITIES (Strength, range of motion) | |
| <input checked="" type="checkbox"/> | 36. FEET | |
| <input checked="" type="checkbox"/> | 37. LOWER EXTREMITIES (Except feet) (Strength, range of motion) | |
| <input checked="" type="checkbox"/> | 38. SPINE, OTHER MUSCULOSKELETAL | |
| <input checked="" type="checkbox"/> | 39. IDENTIFYING BODY MARKS, SCARS, TATTOOS | |
| <input checked="" type="checkbox"/> | 40. SKIN, LYMPHATICS | |
| <input checked="" type="checkbox"/> | 41. NEUROLOGIC (Equilibrium tests under item 72) | |
| <input checked="" type="checkbox"/> | 42. PSYCHIATRIC (Specify any personality deviation) | |
| <input checked="" type="checkbox"/> | 43. PELVIC (Females only) (Check how done) | |
| | <input type="checkbox"/> VAGINAL <input type="checkbox"/> RECTAL | |

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

Reviewed by *RJ.*
Chicago Office 5/12/93

Physical reviewed in FBIHQ HCPU
by
on June 29, 1993

TPO
3/25/93

b6
b7c

(Continue in item 73)

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|--|--|--|--|---|---|---|----|----|----|---|--|--|---|--|--|--|---|---|---|----|----|----|---|--|--|--|--|--|--|---|---|---|----|----|----|---|---|---|--|--|--|--|---|---|---|----|----|----|---|--|--|
| 44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table style="margin: auto;"> <tr><td>0</td><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td><td></td></tr> <tr><td>0</td><td></td><td></td><td></td></tr> </table> Restorable Teeth | | | | 0 | 1 | 2 | 3 | 32 | 31 | 30 | | 0 | | | | <table style="margin: auto;"> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td>/</td><td></td><td></td></tr> </table> Non-restorable teeth | | | | 1 | 2 | 3 | 32 | 31 | 30 | / | | | <table style="margin: auto;"> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td>x</td><td></td><td></td></tr> </table> Missing Teeth | | | | 1 | 2 | 3 | 32 | 31 | 30 | x | | | <table style="margin: auto;"> <tr><td>x</td><td>x</td><td>x</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td>x</td><td>x</td><td>x</td></tr> </table> Replaced by Dentures | | | | x | x | x | 32 | 31 | 30 | x | x | x | <table style="margin: auto;"> <tr><td>x</td><td>x</td><td>x</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td>x</td><td></td><td></td></tr> </table> Fixed Partial dentures | | | | x | x | x | 32 | 31 | 30 | x | | |
| 0 | 1 | 2 | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 32 | 31 | 30 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 | 2 | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 32 | 31 | 30 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| / | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 | 2 | 3 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 32 | 31 | 30 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| x | x | x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 32 | 31 | 30 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| x | x | x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| x | x | x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 32 | 31 | 30 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| R | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| T | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

| | | | |
|---|----------------|---|-----------------|
| 45. URINALYSIS: A. SPECIFIC GRAVITY | | 48. CHEST X-RAY (Place, date, film number and result) | |
| B. ALBUMIN | D. MICROSCOPIC | | |
| C. SUGAR | | | |
| 47. SEROLOGY (Specify test used and result) | 48. EKG | 49. BLOOD TYPE AND RH FACTOR | 50. OTHER TESTS |

MEASUREMENTS AND OTHER FINDINGS

| | | | | | |
|---|-------------------------------|---------------------------------------|---|--|-------------------------|
| 51. HEIGHT
71 1/2" | 52. WEIGHT
224 | 53. COLOR HAIR | 54. COLOR EYES | 55. BUILD:
<input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM <input checked="" type="checkbox"/> HEAVY <input type="checkbox"/> OBESSE | 56. TEMPERATURE
98.2 |
| 57. BLOOD PRESSURE (Arm at heart level) | | | 58. PULSE (Arm at heart level) | | |
| A. SITTING
SYS. 132
DIAS. 80 | B. RECUMBENT
SYS.
DIAS. | C. STANDING (5 min.)
SYS.
DIAS. | A. SITTING
12-88 | B. AFTER EXERCISE | C. 2 MIN. AFTER |
| 59. DISTANT VISION
RIGHT 20/ CORR. TO 20/ BY S. CX
LEFT 20/ CORR. TO 20/ BY S. CX | | | 60. NEAR VISION
REFRACTION
BY S. CX | | |

62. HETEROPHORIA (Specify distance)

| | | | | | | | |
|-----|-----|------|------|------------|----------------|----|----|
| ES° | EX° | R.H. | L.H. | PRISM DIV. | PRISM CONV. CT | PC | PD |
|-----|-----|------|------|------------|----------------|----|----|

| | | | |
|---------------------------------|---|--|--------------------------|
| 63. ACCOMMODATION
RIGHT LEFT | 64. COLOR VISION (Test used and result) | 65. DEPTH PERCEPTION (Test used and score) | UNCORRECTED
CORRECTED |
| 66. FIELD OF VISION | 67. NIGHT VISION (Test used and score) | 68. RED LENS TEST | 69. INTRAOCULAR TENSION |

| | | |
|--|---|--|
| 70. HEARING
RIGHT WV /15 SV /15
LEFT WV /15 SV /15 | 71. AUDIOMETER
see attached | 72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score) |
| | 250 256 500 512 1000 1024 2000 2048 3000 2896 4000 4096 6000 6144 8000 8192 | |
| | RIGHT | |
| | LEFT | |

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

OU

DA

30/30/30 15/15/15

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

1) About 20lbs overweight → lose ≈ 20lbs ↓ to DBW

2) Hypercholesterolemia with elevated LDL-C → @ risk for cardiovascular event. → weight loss, exercise + diet. Recheck periodically.

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

see #74 above.

77. EXAMINEE (Check)

A. IS QUALIFIED FOR

B. IS NOT QUALIFIED FOR

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

| | | | |
|---|---|---|---|
| A | B | C | E |
| | | | |

Signature: [Handwritten Signature]

82. TYPED OR PRINTED NAME OR REVIEWING OFFICER OR APPROVING AUTHORITY

Signature: [Handwritten Signature]

NUMBER OF ATTACHED SHEETS

CENTER FOR CARDIOVASCULAR HEALTH
PHYSICAL EXAM FORM

NAME John O'Neill

DATE 2-5-93 AGE 40

T 98.2 P 88 BP 132/80 HT 7'1 1/2" WT 224

GENERAL HEALTH Good

HEAD/NECK _____

EYES _____

EARS/NOSE _____

MOUTH/THROAT _____

THYROID _____

CHEST/LUNGS _____

HEART WNL

BREASTS _____

ABDOMEN _____

EXTREMITIES/BACK _____

LYMPH NODES _____

SKIN _____

GENITALIA / ~~WNL~~ _____

PROCTO _____

RECTAL _____

NEURO _____

DISPOSITION b7C lgs

RECOMMENDATIONS _____

SIGNATURE



b6
b7C

836 W. WELLINGTON
CHICAGO, IL 60657
312/296-7099 OR 312/296-7871
[REDACTED] MD, DIRECTOR

PATIENT NAME: O'NEILL, JOHN
ACCOUNT NUMBER: F000000205308
MED REC NO: 205308
ATTENDING DR: [REDACTED] MD
ORDERING DR: [REDACTED] MD

ILLINOIS MASONIC MEDICAL CENTER
FINAL REPORT

| TEST | RESULT | H/L NORMALS | UNITS | VL | LOW | NORMAL | HIGH | VH |
|------|--------|-------------|-------|----|-----|--------|------|----|
|------|--------|-------------|-------|----|-----|--------|------|----|

Collected: 02/05/93 03:00PM

- - - HEMATOLOGY - - -
- - - CBC - - -

| | | | | | | | | |
|-----------|------|-----------|--------|---|--|---|--|---|
| WBC | 7.4 | 3.5-11.0 | X THOU | < | | | | > |
| RBC | 5.10 | | X MIL | < | | | | > |
| HGB | 16.6 | | GM/DL | < | | | | > |
| HCT | 49.7 | 42-52 | % | < | | | | > |
| MCV | 97.5 | | CUMIC | < | | | | > |
| MCH | 32.5 | | PG | < | | | | > |
| MCHC | 33.4 | | % | < | | | | > |
| PLT | 359 | 150-450 | X THOU | < | | | | > |
| RDW | 12.8 | 11.5-14.5 | % | < | | | | > |
| MPV | 10.3 | 7.4-10.4 | CUMIC | < | | | | > |
| NEUT% | 65.7 | 35-70 | % | < | | | | > |
| LYMPH% | 23.5 | 20-40 | % | < | | | | > |
| MONOX | 6.6 | 1.7-9.3 | % | < | | * | | > |
| EOS% | 3.1 | 0-4 | % | < | | * | | > |
| BASOX | 1.1 | 0-2 | % | < | | * | | > |
| RBC MORPH | NORM | NORMAL | | < | | | | > |

- - - ROUTINE URINALYSIS - - -

| | | | | | | | | |
|--------------|--------|-------------|-------|---|--|---|--|---|
| COLOR | YELLOW | YELLOW | | < | | | | > |
| APPEARANCE | CLOUDY | * CLEAR | | < | | | | > |
| SPEC GRAV | 1.025 | 1.003-1.030 | | < | | * | | > |
| WBC ESTERASE | NEG | NEG | | < | | | | > |
| NITRITE | NEG | NEG | | < | | | | > |
| PH | 5.0 | 5.0-6.5 | | < | | | | > |
| PROTEIN | NEG | NEG | MG/DL | < | | | | > |
| GLUCOSE | NEG | NEG | MG/DL | < | | | | > |
| KETONE | NEG | NEG | MG/DL | < | | | | > |
| UROBILINOGEN | 0.2 | 0-1.0 | MG/DL | < | | | | > |
| BILIRUBIN | NEG | NEG | | < | | | | > |
| BLOOD | NEG | NEG | | < | | | | > |
| RBC | 0-2 | 0-2 | /HPF | < | | | | > |
| WBC | 0-2 | 0-5 | /HPF | < | | | | > |
| BACTERIA | 3+ | * NEG | /HPF | < | | | | > |
| EPITHELIAL | 1+ | * NEG | /LPF | < | | | | > |
| MUCOUS | 1+ | * NEG | /HPF | < | | | | > |

836 W. WELLINGTON
 CHICAGO, IL 60657
 312/296-7099 OR 312/296-7871
 [REDACTED] MD, DIRECTOR

PATIENT NAME: O'NEILL, JOHN
 ACCOUNT NUMBER: F00000205308
 MED REC NO: 205308
 ATTENDING DR: [REDACTED] MD
 ORDERING DR: [REDACTED] MD

b6
 b7c

ILLINOIS MASONIC MEDICAL CENTER
 FINAL REPORT

| TEST | RESULT | H/L | NORMALS | UNITS | VL | LOW | NORMAL | HIGH | VH |
|------|--------|-----|---------|-------|----|-----|--------|------|----|
|------|--------|-----|---------|-------|----|-----|--------|------|----|

Collected: 02/05/93 03:00PM

--- ROUTINE URINALYSIS ---

AMORPHOUS MOD URATES /HPF < >

--- GENERAL CHEMISTRY I ---

| | | | | | | | | | |
|--------------|-------|---|------------|--------|---|---|---|---|----|
| T. PROTEIN | 7.5 | | 6.0-8.0 | GM/DL | < | | | * | > |
| ALBUMIN | 4.9 | | 3.0-5.5 | GM/DL | < | | | * | > |
| CALCIUM | 10.2 | | 8.5-10.5 | MG/DL | < | | | * | > |
| PHOSPHORUS | 3.2 | | 2.5-4.5 | MG/DL | < | | * | | > |
| CHOLESTEROL | 248.0 | ✓ | *H 150-200 | MG/DL | < | | | | >* |
| GLUCOSE | 100.0 | | 65-110 | MG/DL | < | | | * | > |
| BUN | 11.0 | | 10-20 | MG/DL | < | * | | | > |
| URIC ACID | 7.6 | | 2.5-8.0 | MG/DL | < | | | * | > |
| CREATININE | 1.10 | | 0.5-1.4 | MG/DL | < | | | * | > |
| T. BILIRUBIN | 0.90 | | 0.2-1.0 | MG/DL | < | | | * | > |
| ALK PHOS | 84.0 | | 25-110 | MU/L | < | | | * | > |
| LDH | 151.0 | | 90-200 | MU/ML | < | | | * | > |
| AST (GOT) | 45.0 | | *H 10-40 | MU/ML | < | | | * | > |
| CHLORIDE | 102.0 | | 98-106 | MEQ/L | < | | | * | > |
| SODIUM | 141.0 | | 135-142 | MEQ/L | < | | | * | > |
| POTASSIUM | 4.6 | | 3.7-5.2 | MEQ/L | < | | | * | > |
| CO2 | 25.0 | | 24-30 | MEQ/L | < | * | | | > |
| TOTAL CK | 96.0 | | 0-225 | MU/ML | < | | | * | > |
| GAMMA GT | 125.0 | | *H 15-85 | IU/L | < | | | * | > |
| IRON | 133.0 | | 50-160 | MCG/DL | < | | | * | > |
| TRIG | 195.0 | ✓ | *H 10-190 | MG/DL | < | | | * | > |

--- CALCULATED VALUES ---

| | | | | | | | | | |
|--------------|-------|--|------|--------|---|--|--|---|---|
| CALC. AGAP | 14.0 | | 7-17 | MMOL/L | < | | | * | > |
| CALC. OSMO | 271.7 | | | MOS/KG | < | | | | > |
| CALC. GLOB | 2.6 | | | G/DL | < | | | | > |
| CALC. A/G | 1.9 | | | | < | | | | > |
| CALC. BUN/CR | 10.0 | | | | < | | | | > |

--- GENERAL CHEMISTRY ---
 LIPOPROTEIN PROFILE



836 W. WELLINGTON
CHICAGO, IL 60657
312/296-7099 OR 312/296-7871
[REDACTED] MD, DIRECTOR

PATIENT NAME: O'NEILL, JOHN
ACCOUNT NUMBER: F000000205308
MED REC NO: 205308
ATTENDING DR: [REDACTED] MD
ORDERING DR: [REDACTED] MD

ILLINOIS MASONIC MEDICAL CENTER
FINAL REPORT

| TEST | RESULT | H/L NORMALS | UNITS | VL | LOW | NORMAL | HIGH | VH |
|------|--------|-------------|-------|----|-----|--------|------|----|
|------|--------|-------------|-------|----|-----|--------|------|----|

Collected: 02/05/93 03:00PM

--- GENERAL CHEMISTRY ---
LIPOPROTEIN PROFILE

| | | | | | | | | |
|-------|-------|-----------|-------|---|--|---|--|-----|
| HDL-C | 37 | 31-75 | MG/DL | < | | * | | > |
| LDL-C | 172.0 | *H 50-130 | MG/DL | < | | | | * > |
| =1= | | | | | | | | |

COMMENTS :

=1=: CHOLESTEROL LEVEL CLINICAL INTERPRETATION

| | |
|------------------------|---------------------|
| LESS THAN 200 MG/DL | DESIRABLE LEVEL |
| 200-240 MG/DL | MODERATE RISK LEVEL |
| GREATER THAN 240 MG/DL | HIGH RISK LEVEL |

=====

| | |
|------------------------|---------------------|
| LESS THAN 130 MG/DL | DESIRABLE LEVEL |
| 130-160MG/DL | MODERATE RISK LEVEL |
| GREATER THAN 160 MG/DL | HIGH RISK LEVEL |

=====

INFORMATION PROVIDED BY:
NATIONAL CHOLESTEROL EDUCATION PROGRAM

--- THYROID PROFILE ---

| | | | | | | | | |
|----|-----|----------|--------|---|--|---|--|---|
| T4 | 6.3 | 4.5-12.0 | MCG/DL | < | | * | | > |
|----|-----|----------|--------|---|--|---|--|---|

CENTER FOR CARDIOVASCULAR HEALTH
ELECTROCARDIOGRAM DIAGNOSTIC REPORT

NAME John O'neil

DATE 2-5-93

GROUP DIAGNOSIS

- I NORMAL EKG
- ___ NORMAL EKG WITH FINDINGS
- ___ ABNORMAL NON-SPECIFIC
- ___ ABNORMAL EKG
- ___ UNSATISFACTORY EKG
- ___ CLINICAL CORRELATION SUGGESTED

M-40

- II ___ SINUS TACHYCARDIA
- ___ SINUS BRADYCARDIA
- ___ SINUS ARRHYTHMIA
- ___ SUPRA VENTRICULAR TACHYCARDIA
- ___ ATRIAL FIBRILLATION
- ___ ATRIAL FLUTTER
- ___ FREQUENT PREMATURE ATRIAL CONTRACTIONS (PAC)
- ___ OCCASIONAL PREMATURE ATRIAL CONTRACTIONS (PAC)
- ___ NODAL RHYTHM

- III ___ 1 DEGREE BLOCK
- ___ 2 DEGREE BLOCK
- ___ 3 DEGREE BLOCK
- ___ RIGHT BUNDLE BRANCH BLOCK
- ___ LEFT BUNDLE BRANCH BLOCK
- ___ FREQUENT PREMATURE VENTRICULAR CONTRACTIONS (PVC)
- ___ OCCASIONAL PREMATURE VENTRICULAR CONTRACTIONS (PVC)
- ___ INTRAVENTRICULAR CONDUCTION DELAY

- IV ___ ABNORMAL P WAVE
- ___ W-P-W (WOLFF-PARKINSON-WHITE)
- ___ ABNORMAL Q-T (INTERVAL)
- ___ ABNORMAL S-T SEGMENT
- ___ ABNORMAL T WAVE
- ___ ELECTROLYTE IMBALANCE

- V ___ OLD ANTERIOR M.I.
- ___ RECENT ANTERIOR M.I.
- ___ OLD ANTEROLATERAL M.I.
- ___ RECENT ANTEROLATERAL M.I.
- ___ OLD ANTEROSEPTAL M.I.
- ___ RECENT ANTEROSEPTAL M.I.
- ___ OLD POSTERIOR M.I.
- ___ RECENT POSTERIOR M.I.
- ___ OLD POSTEROLATERAL M.I.
- ___ OLD INFERIOR WALL M.I.
- ___ RECENT POSTEROLATERAL M.I.
- ___ DIGITALIS EFFECT
- ___ LEFT VENTRICULAR HYPERTROPHY
- ___ RIGHT VENTRICULAR HYPERTROPHY
- ___ AXIS DEVIATION - RIGHT
- ___ AXIS DEVIATION - LEFT

b6
b7c



M.D.

 CENTER FOR CARDIOVASCULAR HEALTH
 VISION, HEARING, TONOMETRY

NAME: John O'Neill
 DATE: 2-8-93

 VISION

 RIGHT (UNCORRECTED): 20/40 (CORRECTED): 20/20 NEAR: 20/20
 LEFT (UNCORRECTED): 20/25 (CORRECTED): 20/20 NEAR: 20/20
 COLOR: Normal
 TONOMETRY: (RIGHT): 12 (LEFT): 13



 HEARING

| | 250 | 500 | 1000 | 1500 | 2000 | 3000 | 4000 | 6000 | 8000 |
|-------|-----|-----|------|------|------|------|------|------|------|
| LEFT | 25 | 15 | 10 | 10 | 10 | 20 | 35 | 20 | 30 |
| RIGHT | 10 | 10 | 10 | 15 | 10 | 15 | 15 | 20 | 25 |

b6
 b7c

COMMENTS:

LEFT EAR: hearing is within Normal Limits, except for mild loss 4000 Hz. and 8000 Hz
 RIGHT EAR: hearing is WNL



RECOMMEND: WEAR HEARING PROTECTION WHEN POSSIBLE

** ALL AUDIOMETRIC THRESHOLDS ARE IN dBHL ACCORDING TO ANSI-1969 STANDARDS. **

Rufinus MD, CC-A
 Audiology Manager

CENTER-CARDIO.HEALTH
CHICAGO IL 736-8654

b6
b7c

Patient: JOHN O NEILL Physician: Date: 2-5-93
 Address: Phone:
 Patient ID: AGENT Height: Weight: Age: 40 Sex: M

Brief History:

Medications: NO MEDICATIONS Target HR: 156

Protocol: V5 ST Level at J + 80ms V5 ST Slope from J + 10ms to J + 60ms

| Event | Time | Speed (MPH) | Grade (%) | HR (BPM) | ST Level (mm) | ST Slope (mm/sec) | BP | Comments |
|-----------------|------|-------------|-----------|----------|---------------|-------------------|--------|----------|
| rest | 1 | | | | +0.0 | +4 | 120/70 | |
| stage 1 | 3:00 | 1.7 | 10.0 | | -0.1 | +4 | 130/80 | |
| stage 2 | 3:00 | 2.5 | 12.0 | | -0.1 | +4 | 150/80 | |
| stage 3 | 3:00 | 3.4 | 14.0 | | -0.1 | +4 | 160/80 | |
| stage 4 | 3:00 | 4.2 | 16.0 | | -0.1 | +4 | 180/80 | |
| stage 5 | 3:00 | 5.0 | 18.0 | | -0.1 | +4 | 190/80 | |
| stage 6 | 0:06 | 5.5 | 20.0 | | -0.1 | +4 | | |
| stop exercise @ | | | | | | | | |
| recovery | 0:01 | | | | -0.1 | +4 | 190/80 | |
| recovery | 1:00 | | | | +0.0 | +4 | 170/80 | |
| recovery | 2:00 | | | | -0.1 | +4 | 150/70 | |
| recovery | 3:00 | | | | +0.0 | +4 | 160/80 | |
| recovery | 6:00 | | | | +0.0 | +6 | 140/90 | |
| recovery | 8:00 | | | | -0.1 | +4 | 125/80 | |

Interpretation: METS achieved:

BOTH THE RESTING AND EXERCISE (MAXIMAL) ECG'S WERE NORMAL
 THERE WERE PREMATURE VENTRICULAR COMPLEXES SEEN RARELY
 BOTH THE RESTING AND EXERCISE BLOOD PRESSURES WERE NORMAL
 TEST TERMINATION WAS DUE TO GENERAL FATIGUE
 PATIENT HAS CLEARANCE FOR EXERCISE PRESCRIPTON WITH NO FURTHER EVALUATION

M.D.
CARDIOLOGIST

Quinton Instrument Co. Seattle, WA 98121 USA Recorder 15022-001

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

| | | | | | | | |
|---|-------------------------------------|---|--|-------------------------------------|-------------------------------------|---|--|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME
O'NEILL, JOHN P. | | | 2. SOCIAL SECURITY OR IDENTIFICATION NO.
147-42-1004 | | | | |
| 3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE)
109 So. Dearborn Rm 905 Chgo. Ill. 60604 | | | 4. POSITION (title, grade, component)
SPECIAL AGENT | | | | |
| 5. PURPOSE OF EXAMINATION
ANNUAL | | 6. DATE OF EXAMINATION
2/5/93 | 7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code)
The Center For Cardiovascular Health
5877 N Cicero Ave
Chicago, IL 60641 | | | | |
| 8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint exists)
Excellent.
No Medications | | | | | | | |
| 9. HAVE YOU EVER (Please check each item) | | | 10. DO YOU (Please check each item) | | | | |
| YES | NO | (Check each item) | YES | NO | (Check each item) | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Lived with anyone who had tuberculosis | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Wear glasses or contact lenses | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Spoughed up blood | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Have vision in both eyes | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Bled excessively after injury or tooth extraction | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Wear a hearing aid | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Attempted suicide | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Stutter or stammer habitually | | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Been a sleepwalker | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Wear a brace or back support | | |
| 11. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item) | | | | | | | |
| YES | NO | DON'T KNOW | (Check each item) | YES | NO | DON'T KNOW | (Check each item) |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Scarlet fever, erysipelas | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Cramps in your legs |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Rheumatic fever | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Frequent indigestion |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Swollen or painful joints | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Stomach, liver, or intestinal trouble |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Frequent or severe headache | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Gall bladder trouble or gallstones |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Dizziness or fainting spells | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Jaundice or hepatitis |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Eye trouble | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Adverse reaction to serum, drug, or medicine |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Ear, nose, or throat trouble | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Broken bones |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hearing loss | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Tumor, growth, cyst, cancer |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Chronic or frequent colds | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Rupture/hernia |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Severe tooth or gum trouble | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Piles or rectal disease |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Sinusitis | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Frequent or painful urination |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hay Fever | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Bed wetting since age 12 |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Head injury | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Kidney stone or blood in urine |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Skin diseases | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Sugar or albumin in urine |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Thyroid trouble | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | VD—Syphilis, gonorrhea, etc. |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Tuberculosis | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Recent gain or loss of weight |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Asthma | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Arthritis, Rheumatism, or Bursitis |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Shortness of breath | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Bone, joint or other deformity |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Pain or pressure in chest | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Lameness |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Chronic cough | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Loss of finger or toe |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Palpitation or pounding heart | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Painful or "trick" shoulder or elbow |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Heart trouble | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Recurrent back pain |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | High or low blood pressure | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | |
| 13. WHAT IS YOUR USUAL OCCUPATION? | | | | | | 14. ARE YOU (Check one) | |
| | | | | | | <input type="checkbox"/> Right handed <input checked="" type="checkbox"/> Left handed | |

| YES | NO | CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT |
|-----|----|---|
| ✓ | | 15. Have you been refused employment or been unable to hold a job or stay in school because of:
A. Sensitivity to chemicals, dust, sunlight, etc. |
| ✓ | | B. Inability to perform certain motions. |
| ✓ | | C. Inability to assume certain positions. |
| ✓ | | D. Other medical reasons (If yes, give reasons.) |
| ✓ | | 16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.) |
| ✓ | | 17. Have you ever been denied life insurance? (If yes, state reason and give details.) |
| ✓ | | 18. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.) |
| ✓ | | 19. Have you ever been a patient in any type of hospitals? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) |
| ✓ | | 20. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) |
| ✓ | | 21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) |
| ✓ | | 22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.) |
| ✓ | | 23. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.) |
| ✓ | | 24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.) |

*Basic 1958
Appendix 1962*

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE
JOHN A. O'NEILL

SIGNATURE
JOHN A. O'NEILL

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."
25. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in Items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

[Empty box]

DATE
2/5/63

[Empty box]

NUMBER OF ATTACHED SHEETS

b6
b7C

**Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner**

Name of Examinee O'NEILL JOHN P.
(Type or print) Last First Middle

The following portions of the attached examination report form need not be completed:

| | | | | |
|---|----|----|----|----|
| 3 | 9 | 17 | 67 | 76 |
| 4 | 11 | 62 | 68 | |
| 8 | 14 | 65 | 72 | |

45, 46, 47 and 49; required for all Special Agent and FBI National Academy applicants but not for any other applicant unless the examining physician deems one, two, three or all four of the examinations necessary. 45, 46 and 47 are required in examination of any current employee.

48. Required for (1) all Special Agent applicants; (2) all FBI National Academy applicants; (3) all examinees over 35 years of age; (4) any other where examination indicates such as desirable.

69. Required for all examinees over 40 years of age.

71. Audiometer examinations must be afforded for all Special Agent applicants and Special Agents and decibel readings must be recorded at 500, 1000, 2000, 3000 and 4000 Hertz. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 25 decibel average (ANSI) in either ear in the frequency range 1000, 2000, and 3000 Hertz. No single reading in that range may exceed 35 decibels and no applicant will be accepted if found to have a hearing loss exceeding 35 decibels at 500 or 45 decibels at 4000 Hertz.

For All Examinees, Whether Clerical or Special Agent Applicants, National Academy Applicants, or Employees:

The medical examiner should answer the following question:

Examinee is is not qualified for strenuous physical exertion.

To be Answered in the Case of All Special Agents, Special Agent Applicants, and National Academy Applicants:

1. Does examinee have any defects restricting or prohibiting his/her participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

No Yes If "yes" please specify defects. _____ *[Signature]*

To be Answered in the Case of All Special Agents, Special Agent Applicants, and other Employees who drive Bureau vehicles:

1. Does examinee have any defects prohibiting safe operation of motor vehicles?

No Yes If "yes" please specify defects. _____

2. For safe driving of motor vehicles, Office of Personnel Management requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? Yes No

If recommendation is based on a factor other than above standard, indicate basis _____

DESIRABLE WEIGHT RANGES

| MALES | | | | FEMALES | | | |
|--------|-------------|--------------|-------------|---------|-------------|--------------|-------------|
| Height | Small Frame | Medium Frame | Large Frame | Height | Small Frame | Medium Frame | Large Frame |
| 5'4" | 117 - 138 | 123 - 149 | 131 - 163 | 5'0" | 96 - 114 | 101 - 124 | 109 - 138 |
| 5'5" | 120 - 142 | 126 - 153 | 134 - 167 | 5'1" | 99 - 118 | 104 - 128 | 112 - 141 |
| 5'6" | 124 - 146 | 130 - 157 | 138 - 173 | 5'2" | 102 - 121 | 107 - 131 | 115 - 144 |
| 5'7" | 128 - 151 | 134 - 163 | 143 - 178 | 5'3" | 105 - 124 | 110 - 135 | 118 - 149 |
| 5'8" | 132 - 155 | 138 - 167 | 147 - 183 | 5'4" | 108 - 128 | 113 - 139 | 121 - 152 |
| 5'9" | 136 - 161 | 142 - 172 | 151 - 187 | 5'5" | 111 - 132 | 117 - 144 | 125 - 156 |
| 5'10" | 140 - 165 | 146 - 177 | 155 - 193 | 5'6" | 114 - 135 | 120 - 149 | 129 - 161 |
| 5'11" | 144 - 169 | 150 - 183 | 160 - 198 | 5'7" | 118 - 140 | 124 - 153 | 133 - 165 |
| 6' | 148 - 174 | 154 - 188 | 164 - 204 | 5'8" | 122 - 144 | 128 - 157 | 137 - 169 |
| 6'1" | 152 - 179 | 158 - 194 | 169 - 209 | 5'9" | 126 - 149 | 132 - 162 | 141 - 174 |
| 6'2" | 156 - 184 | 163 - 199 | 174 - 215 | 5'10" | 130 - 154 | 136 - 166 | 145 - 179 |
| 6'3" | 160 - 188 | 168 - 205 | 178 - 220 | 5'11" | 134 - 158 | 140 - 171 | 149 - 185 |
| 6'4" | 169 - 198 | 178 - 216 | 188 - 231 | 6'0" | 138 - 163 | 144 - 175 | 153 - 190 |
| 6'5" | 174 - 204 | 182 - 222 | 192 - 238 | | | | |

4. Examinee's frame is small medium large

5. Considering the above weight table, the examinee's frame, and other individual physical characteristics, I consider his/her present weight Satisfactory Excessive Deficient

6. Under proper medical supervision, employee should lose 20 pounds
 gain _____ pounds

Remarks: _____

[Signature]

b6
b7C

2/5/93
Date

REPORT OF MEDICAL EXAMINATION

Div #10

| | | | | | |
|---|---------------------|--|--|--|---|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME
<i>O'Neill, John P.</i> | | 2. GRADE AND COMPONENT POSITION
<i>GM-14</i> | | 3. IDENTIFICATION NO. | |
| 4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code) | | | 5. PURPOSE OF EXAMINATION
<i>FITNESS FOR DUTY</i> | | 6. DATE OF EXAMINATION
<i>10/04/90 (2)
8/29/90 PHE</i> |
| 7. SEX
<i>M</i> | 8. RACE
<i>W</i> | 9. TOTAL YEARS GOVERNMENT SERVICE
MILITARY CIVILIAN <i>20</i> | | 10. AGENCY
<i>FBI</i> | 11. ORGANIZATION UNIT
<i>Div 10</i> |
| 12. DATE OF BIRTH
<i>2/6/52 (38)</i> | | 13. PLACE OF BIRTH
<i>VENTNOR, NJ</i> | | 14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN | |
| 15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS
<i>FBIHQHS</i> | | | | 16. OTHER INFORMATION | |
| 17. RATING OR SPECIALTY | | TIME IN THIS CAPACITY (Total) | | LAST SIX MONTHS | |

| CLINICAL EVALUATION | | ABNOR-MAL |
|---------------------|---|-----------|
| NOR-MAL | (Check each item in appropriate column; enter "NE" if not evaluated.) | |
| 18. | HEAD, FACE, NECK AND SCALP | |
| 19. | NOSE | |
| 20. | SINUSES | |
| 21. | MOUTH AND THROAT | |
| 22. | EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71) | |
| 23. | DRUMS (Perforation) | |
| 24. | EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 62) | |
| 25. | OPHTHALMOSCOPIC | |
| 26. | PUPILS (Equality and reaction) | |
| 27. | OCULAR MOTILITY (Associated parallel movements, nystagmus) | |
| 28. | LUNGS AND CHEST (Include breasts) | |
| 29. | HEART (Thrust, size, rhythm, sounds) | |
| 30. | VASCULAR SYSTEM (Varicosities, etc.) | |
| 31. | ABDOMEN AND VISCERA (Include hernia) | |
| 32. | ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate, if indicated) | |
| 33. | ENDOCRINE SYSTEM | |
| 34. | G-U SYSTEM | |
| 35. | UPPER EXTREMITIES (Strength, range of motion) | |
| 36. | FEET | |
| 37. | LOWER EXTREMITIES (Except feet) (Strength, range of motion) | |
| 38. | SPINE, OTHER MUSCULOSKELETAL | |
| 39. | IDENTIFYING BODY MARKS, SCARS, TATTOOS | |
| 40. | SKIN, LYMPHATICS | |
| 41. | NEUROLOGIC (Equilibrium tests under item 72) | |
| 42. | PSYCHIATRIC (Specify any personality deviation) | |
| 43. | PELVIC (Females only) (Check how done) | |
| | <input type="checkbox"/> VAGINAL <input type="checkbox"/> RECTAL | |

NOTES (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

10/4/90 wt. 204# [Redacted] *RU*
Reduct normal
Panties normal

Physical reviewed in FBIHQ HQCPH
 by [Redacted]
 on **OCT 09 1990**

Obese

Res Planus & pronated feet RT & LT
Relive LTR to left asymptomatic

OK for stress test
 [Redacted] *10/4/90*

b6
b7C

| 44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.) | | | | | | | | | | | | | | | | | | REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES | | | | | | | | | | | | | | | |
|--|---|---|----|----|----|----------------------|---|---|---------------|----|----|----------------------|----|----|------------------------|----|----|--|----|----|----|----|----|----|----|----|----|----|----|----|----|----|------------|
| Restorable teeth | | | | | | Non-restorable teeth | | | Missing teeth | | | Replaced by dentures | | | Fixed Partial dentures | | | L
E
F
T | | | | | | | | | | | | | | | |
| 1 | 2 | 3 | 32 | 31 | 30 | 1 | 2 | 3 | 32 | 31 | 30 | 1 | 2 | 3 | 32 | 31 | 30 | | | | | | | | | | | | | | | | |
| R | 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 | 32 | [Redacted] |
| L | 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 | 32 | |

| LABORATORY FINDINGS | | | |
|---|----------------|---|-----------------|
| 45. URINALYSIS: A. SPECIFIC GRAVITY | | 46. CHEST X-RAY (Place, date, film number and result) | |
| B. ALBUMIN | D. MICROSCOPIC | 49. BLOOD TYPE AND RH FACTOR | |
| C. SUGAR | | | |
| 47. SEROLOGY (Specify test used and result) | | 48. EKG
<i>WNL</i> | 50. OTHER TESTS |

10/4/96 Rewatched 204



MEASUREMENTS AND OTHER FINDINGS

| | | | | | | | | | | | |
|---|--|--------------------------------|--|---|--|--------------------------------|--|--|--|--|--|
| 51. HEIGHT
6'0" | | 52. WEIGHT
209 | | 53. COLOR HAIR | | 54. COLOR EYES | | 55. BUILD:
<input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE | | 56. TEMPERATURE | |
| 57. BLOOD PRESSURE (Arm at heart level) | | | | | | 58. PULSE (Arm at heart level) | | | | | |
| A. SITTING
SYS. 110
DIAS. 76 | | B. RECUM-BENT
SYS.
DIAS. | | C. STANDING (3 min.)
SYS.
DIAS. | | A. SITTING
60 | | B. AFTER EXERCISE | | C. 2 MIN. AFTER | |
| 59. DISTANT VISION | | CORR. TO 20/ | | 60. REFRACTION | | BY | | S. | | CX | |
| RIGHT 20/ 25 | | | | | | | | | | 20/25 CORR. TO BY | |
| LEFT 20/ 25 | | | | | | | | | | 20/27 CORR. TO BY | |
| 62. HETEROPHORIA (Specify distance) | | | | | | | | | | | |
| ES° | | EX° | | R. H. | | L. H. | | PRISM DIV. | | PRISM CONV. CT | |
| 63. ACCOMMODATION | | | | 64. COLOR VISION (Test used and result) | | | | 65. DEPTH PERCEPTION (Test used and score) | | UNCORRECTED | |
| RIGHT LEFT | | | | PASSED 6/6 | | | | | | CORRECTED | |
| 66. FIELD OF VISION | | | | 67. NIGHT VISION (Test used and score) | | | | 68. RED LENS TEST | | 69. INTRAOCULAR TENSION | |
| 70. HEARING | | | | 71. AUDIOMETER | | | | | | 72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score) | |
| RIGHT WV | | /15 SV | | /15 | | 250 256 | | 500 512 | | 1000 1024 | |
| LEFT WV | | /15 SV | | /15 | | RIGHT | | 10 | | 10 | |
| | | | | | | LEFT | | 10 | | 10 | |

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

WRIST - 7 1/4 LARGE

59. AGENT NORMALLY WEARS GLASSES - PPT
61. AGENT ADVISED NEAR VISION DOES NOT MEET BUREAU STANDS - PPT

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

Asperger's Anomaly
Per Planus - flattened feet. RT & LF
Polio to left

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)
Written by 20 former recommended

| A. PHYSICAL PROFILE | | | | | |
|---------------------|---|---|---|---|---|
| P | U | L | H | E | S |
| | | | | | |

77. EXAMINEE (Check)
A. IS QUALIFIED FOR
B. IS NOT QUALIFIED FOR
Full duty

| B. PHYSICAL CATEGORY | | | |
|----------------------|---|---|---|
| A | B | C | E |
| | | | |

78. IF NOT QUALIFIED. LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

| | | | |
|---|--|-----------|---------------------------|
| 79. TYPED OR PRINTED NAME OF EXAMINEE | | SIGNATURE | |
| 80. TYPED OR PRINTED NAME OF PHYSICIAN | | SIGNATURE | |
| 81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which) | | SIGNATURE | |
| 82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY | | SIGNATURE | |
| | | | NUMBER OF ATTACHED SHEETS |



13900 PARK CENTER ROAD
HERNDON, VIRGINIA 22071
PHONE (703) 742-3100

FEDERAL BUREAU OF INVESTIGATION HDQTS.
1400 M AND PENN. AVENUE NW
WASHINGTON DC 20535
(202) 324-4976 RTE 5 05

| | | | | | | | |
|--------------------------------------|-----------------|------------------|----------------------------|--------------------------------------|-----------------------------------|-------------------------------|-------------|
| PATIENT NAME
ONEILL JOHN P | SEX
M | AGE
38 | ACCESSION
142078 | DATE OF ACCESSION
09/05/90 | DATE OF REPORT
09/08/90 | ACCOUNT NO.
2710012 | 0390 |
|--------------------------------------|-----------------|------------------|----------------------------|--------------------------------------|-----------------------------------|-------------------------------|-------------|

| TEST | RESULTS | FLAG | REFERENCE RANGES |
|---------------------------|----------------------|------|--|
| FINAL REPORT | | | |
| PROFILE 3471 | | | |
| HEALTH SURVEY PROFILE I | | | |
| GLUCOSE | 96 MG/DL | | 65 - 115 |
| BLOOD UREA NITROGEN | 16 MG/DL | | 7 - 25 |
| CREATININE | 1.0 MG/DL | | 0.6 - 1.5 |
| SODIUM | 139 MEQ/L | | 135 - 147 |
| POTASSIUM | 4.2 MEQ/L | | 3.5 - 5.3 |
| CHLORIDE | 99 MEQ/L | | 96 - 109 |
| CARBON DIOXIDE | 25 MEQ/L | | 22 - 32 |
| URIC ACID | 8.2 MG/DL | | M: 3.0-9.0 F: 2.2-7.7 |
| TOTAL PROTEIN | 7.6 G/DL | | 6.0 - 8.5 |
| ALBUMIN | 4.8 G/DL | | 3.5 - 5.5 |
| GLOBULIN | 2.8 G/DL | | 2.0 - 3.5 |
| A/G RATIO | 1.7 | | 1.0 - 2.4 |
| CALCIUM | 10.2 MG/DL | | 8.5 - 10.8 |
| PHOSPHORUS | 3.1 MG/DL | | <17 YRS: 4.5 - 6.5
>17 YRS: 2.5 - 4.5 |
| CHOLESTEROL | 190 MG/DL | | DESIRABLE: < 200
BORDERLINE: 200-239
ELEVATED: > 239 |
| HDL CHOLESTEROL | 31 MG/DL | | M: 30-75, F: 40-90 |
| LDL CHOLESTEROL (CALC.) | 142 MG/DL | *** | DESIRABLE: < 130
BORDERLINE: 130-159
ELEVATED: > 159 |
| CHOLESTEROL/HDL RATIO | 6.1 | | RATIO
RISK M F
0.5X STD 3.4 3.3
1.0X STD 5.0 4.4
2.0X STD 9.6 7.1
3.0X STD 14.0 11.0
LESS THAN 3.1
30 - 150 |
| LDL/HDL CHOLESTEROL RATIO | 4.57 | | <17 YRS: 80-490
>17 YRS: 25-140 |
| TRIGLYCERIDES | 86 MG/DL | | 0 - 40 |
| ALKALINE PHOSPHATASE | 117 U/L | | 0 - 45 |
| S G O T | 32 U/L | | 100 - 240 |
| S G P T | 38 U/L | | 0.2 - 1.2 |
| LACTIC DEHYDROGENASE | 148 U/L | | MALE 20-450
FEMALE <45YR. 7-200
FEMALE >45YR. 10-350 |
| TOTAL BILIRUBIN | 1.2 MG/DL | | M: 0-65, F: 0-45 |
| FERRITIN | 375 NG/ML | | M: 39-54 F: 35-48
M: 13.0 - 18.0
F: 11.5 - 16.0 |
| G G T | 46 U/L | | MALE: 4.4 - 6.2 |
| C B C WITH PLATELET | | | |
| HEMATOCRIT | 45.5 % | | |
| HENOGLOBIN | 15.7 G/DL | | |
| RED BLOOD COUNT | 4.86 MILLION /CU.MM. | | |

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b7c

OK
10/10/90
CH/10/90



Director of Laboratories

*CHOLESTEROL LEVELS

| | |
|---------------|-----------------|
| 130-200 | DESIRABLE |
| 200-239 | LOWER LINE HIGH |
| 240 AND ABOVE | HIGH |

CHD RISK

| CHD RISK | CHOL/HDL RATIO | |
|---------------------|----------------|------|
| | M | F |
| Half of Average | 3.4 | 3.5 |
| Average | 5.0 | 4.4 |
| Two Times Average | 9.6 | 7.1 |
| Three Times Average | 13.5 | 11.0 |

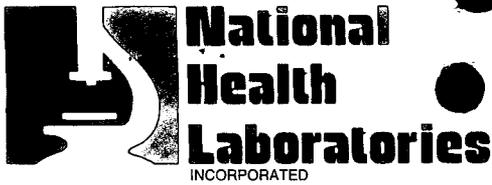
Ref. NIH Consensus Development Conference, 1984 - JAMA 253:2080 - 2086, 1985.

SUGGESTED PEDIATRIC REFERENCE RANGES

| TEST | AGE | 95% | 99% | TEST | AGE | 95% | 99% |
|-----------------------------|-------------|----------|-------------------|--------------------------------|-------------------|---------|---------|
| GLUCOSE
MG/DL | 0-1 MO | 41-95 | 25-111 | TOTAL
PROTEIN
GM/DL | 0-1 MO | 4.0-6.8 | 3.3-7.5 |
| | 1MO-3 YR | 62-115 | 49-128 | | 2 MO-17 MO | 5.0-7.1 | 4.5-7.6 |
| | 4-6 YR | 70-118 | 58-130 | | 18 MO-2 YR | 5.5-7.1 | 5.1-7.5 |
| | 7 YR | 86-119 | 78-127 | | 3-16 YR | 5.8-7.7 | 5.3-8.2 |
| | 8-16 YR | 77-117 | 67-127 | | | | |
| CREATININE
MG/DL | 6 WK-2 YR | 0.3-0.7 | 0.2-0.8 | ALBUMIN
GM/DL | 0-1 MO | 2.4-4.8 | 1.8-5.4 |
| | 3-7 YR | 0.4-0.8 | 0.3-0.9 | | 2 MO-2 YR | 3.5-4.7 | 3.2-5.0 |
| | 8-13 YR | 0.5-0.9 | 0.4-1.0 | | 3-4 YR | 3.8-5.0 | 3.5-5.3 |
| | 14 YR | 0.6-1.0 | 0.5-1.1 | | 5-7 YR | 3.7-4.8 | 3.4-5.1 |
| | 15-16 YR | 0.6-1.4 | 0.4-1.6 | | 8-12 YR | 3.8-4.9 | 3.5-5.2 |
| | | | 13-16 YR | | 3.5-4.9 | 3.2-5.2 | |
| TRIGLY-
CERIDES
MG/DL | 0-1 MO | 0-171 | 0-215 | ALKALINE
PHOSPHATASE
U/L | 0-1 MO | 62-350 | 0-422 |
| | 2 MO-16 YR | 6-134 | 0-166 | | 1 MO-17 MO | 118-354 | 59-413 |
| CALCIUM
MG/DL | 0-1 MO | 6.3-11.9 | 4.9-13.3 | | 18 MO-2 YR | 81-339 | 16-404 |
| | 2-17 MO | 8.9-11.3 | 8.3-11.9 | | 3-9 YR | 108-295 | 61-342 |
| | 18 MO-15 YR | 9.0-10.8 | 8.5-11.3 | | 10-11 YR, F | 96-414 | 17-493 |
| | 16 YR | 8.4-10.8 | 7.8-11.4 | | 10-11 YR, M | 75-347 | 7-415 |
| PHOSPHORUS
MG/DL | 0-1 MO | 4.3-8.2 | 3.2-9.2 | | 12 YR | 159-387 | 102-444 |
| | 1 MO-17 MO | 3.8-6.7 | 3.1-7.4 | | 13-14 YR, F | 12-284 | 0-352 |
| | 13 MO-2 YR | 2.9-5.9 | 2.1-6.7 | | 13-14 YR, M | 100-420 | 20-500 |
| | 3-14 YR | 3.6-5.6 | 3.1-6.1 | | 15 YR, F | 35-117 | 14-138 |
| | 15-16 YR | 2.4-5.4 | 1.6-6.2 | 15 YR, M | 43-267 | 0-323 | |
| SODIUM
MEQ/L | 6 WK-14 YR | 135-145 | 132-148 | LD/(LDH)
U/L | 0-1 MO | >500 | |
| | 15 YR | 137-146 | 135-148 | | 1 MO-17 MO | 208-473 | 142-540 |
| | 16 YR | 136-145 | 133-147 | | 18 MO-2 YR | 249-403 | 210-442 |
| POTASSIUM
MEQ/L | 6 WK-17 MO | 3.4-6.6 | 2.6-7.4 | | 3-7 YR | 191-381 | 144-429 |
| | 19 MO-15 YR | 3.4-5.4 | 2.9-5.9 | | 8-11 YR | 173-326 | 135-364 |
| CHLORIDE
MEQ/L | 6 WK-7 YR | 99-111 | 96-111 | | 12-13 YR, F | 129-276 | 92-313 |
| | | | | | 12-13 YR, M | 174-314 | 139-349 |
| CARBON
DIOXIDE
MEQ/L | 6 WK-7 YR | 17-29 | 14-32 | | 14 YR | 150-278 | 118-310 |
| | 8-15 YR | 22-31 | 19-35 | | 15 YR | 117-279 | 77-320 |
| URIC ACID
MG/DL | 0-1 MO | 1.2-8.8 | 0.1-10.7 | | AST (SGOT)
U/L | 0-1 MO | 14-70 |
| | 1 MO-2 YR | 2.0-7.6 | 0.6-9.0 | 1 MO-17 MO | | 13-64 | 0-77 |
| | 3-11 YR | 2.3-6.1 | 1.4-7.0 | 18 MO-4 YR | | 16-46 | 9-54 |
| | 12-16 YR | 3.1-7.6 | 2.0-8.7 | 5-10 YR | | 10-41 | 2-49 |
| | | | 11-12 YR | 9-33 | | 3-39 | |
| | | | F, 13-14 YR | 5-30 | | 0-37 | |
| | | | M, 13-14 YR | 9-36 | 2-43 | | |
| | | | 15 YR | 3-33 | 0-41 | | |
| | | | ALT (SGPT)
U/L | 0-1 MO | 0-34 | 0-43 | |
| | | | | 1 MO-17 MO | 0-53 | 0-66 | |
| | | | | 18 MO-15 YR | 0-35 | 0-44 | |
| | | | IRON
MCG/DL | 0-1 MO | 20-157 | 20-198 | |
| | | | | 2 MO-2 YR | 20-115 | 20-145 | |
| | | | | 3-8 YR | 20-141 | 20-177 | |
| | | | | 9-13 YR | 20-151 | 20-184 | |
| | | | | 14-16 | 20-181 | 20-228 | |

CBC REFERENCE RANGES FOR CHILDREN

| AGE | WBC | RBC (± 5) | HGB (± 1.0) |
|----------|--------------|-----------------------|---------------|
| 1 YEAR | 6,000-17,500 | 4.5 × 10 ⁶ | 11.3 g/dl |
| 2 YEARS | 6,000-17,000 | 4.7 × 10 ⁶ | 11.9 g/dl |
| 4 YEARS | 5,500-15,500 | 4.7 × 10 ⁶ | 12.6 g/dl |
| 6 YEARS | 5,000-14,500 | 4.7 × 10 ⁶ | 13.0 g/dl |
| 8 YEARS | 4,500-13,500 | 4.7 × 10 ⁶ | 13.2 g/dl |
| 10 YEARS | 4,500-13,500 | 4.8 × 10 ⁶ | 13.4 g/dl |
| 12 YEARS | 4,500-13,500 | 4.8 × 10 ⁶ | 13.6 g/dl |
| 14 YEARS | 4,500-13,000 | 5.1 × 10 ⁶ | 13.8 g/dl |
| 16 YEARS | 4,500-13,000 | ADULT NORMALS | ADULT NORMALS |
| 18 YEARS | 4,500-12,500 | ADULT NORMALS | ADULT NORMALS |
| 20 YEARS | 4,500-11,500 | ADULT NORMALS | ADULT NORMALS |
| 21 YEARS | 4,500-11,000 | ADULT NORMALS | ADULT NORMALS |



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PHONE (703) 742-3100

FEDERAL BUREAU OF INVESTIGATION HDQTS.
1000 PENN. AVENUE NW
WASHINGTON DC 20535
(202) 324-4976 RTE 5 05

| | | | | | | | |
|--------------------------------------|-----------------|------------------|----------------------------|--------------------------------------|-----------------------------------|-------------------------------|-------------|
| PATIENT NAME
ONEILL JOHN P | SEX
M | AGE
38 | ACCESSION
142078 | DATE OF ACCESSION
09/05/90 | DATE OF REPORT
09/08/90 | ACCOUNT NO.
2710012 | 0391 |
|--------------------------------------|-----------------|------------------|----------------------------|--------------------------------------|-----------------------------------|-------------------------------|-------------|

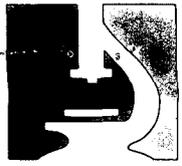
| TEST | RESULTS | FLAG | REFERENCE RANGES |
|-----------------------------------|--|------|--------------------|
| | FINAL REPORT | | |
| MCV | 94 CU. MICRONS | | FEMALES: 3.8 - 5.4 |
| MCH | 32.2 MICRO-MICRO GMS | | 80 - 100 |
| MCHC | 34.4 % | | 27.0 - 34.0 |
| WHITE BLOOD COUNT | 5.4 THOUS/CU.MM. | | 31.0 - 36.0 |
| LYMPHOCYTE | 41 % | | 4.0 - 11.0 |
| NEUTROPHIL | 50 % | | 18 - 46 |
| MONOCYTE | 6 % | | 45 - 75 |
| EOSINOPHIL | 2 % | | 0 - 11 |
| BASOPHIL | 1 % | | 0 - 6 |
| PLATELET COUNT | 337 THOUS/CU.MM. | | 0 - 2 |
| THYROXINE (T4) - RIA | 7.6 MCG/DL | | 140 - 450 |
| BILIRUBIN - INDIRECT | 1.1 MG/DL | HI | 4.5 - 12.5 |
| BILIRUBIN - DIRECT | 0.1 MG/DL | | 0.2 - 1.0 |
| URINALYSIS WITH MICROSCOPIC COLOR | BROWN | | 0.0 - 0.4 |
| MICROSCOPIC EXAM. REQUIRED | | | |
| APPEARANCE | CLEAR | | |
| URINE PH | 6.0 | | 5.0 - 9.0 |
| SPECIFIC GRAVITY | 1.027 | | 1.003 - 1.030 |
| GLUCOSE | NEGATIVE | | NEGATIVE |
| PROTEIN | NEGATIVE | | NEGATIVE |
| KETONES | TRACE | | NEGATIVE |
| BLOOD | NEGATIVE | | NEGATIVE |
| BILIRUBIN | NEGATIVE | | NEGATIVE |
| UROBILINOGEN | NEGATIVE | | 0 - 1+ |
| LEUKOCYTE ESTERASE | NEGATIVE | | NEGATIVE |
| NITRITE | NEGATIVE | | NEGATIVE |
| OCCULT BLOOD - FECES | SOURCE: = = | | |
| SERDLOGY (RPR) - QUAL. | NO SPECIMEN RECEIVED-PLEASE RESUBMIT AT NO CHARGE. | | |
| SERDLOGY (RPR) - QUANT. | NON REACTIVE | | |
| FTA (IF RPR REACTIVE) | NOT INDICATED | | |
| | NOT INDICATED | | |

Handwritten: 10/4/90

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4TH AND PENN. AVENUE NW
WASHINGTON DC 20535

(202) 324-4976 RTE S 05

| | | | | | | | |
|---------------------------------|-----------------|-----|----------------------------|--------------------------------------|-----------------------------------|-------------------------------|-------------|
| PATIENT NAME
ONIELL P | SEX
M | AGE | ACCESSION
176716 | DATE OF ACCESSION
09/11/90 | DATE OF REPORT
09/13/90 | ACCOUNT NO.
2710012 | 0562 |
|---------------------------------|-----------------|-----|----------------------------|--------------------------------------|-----------------------------------|-------------------------------|-------------|

| TEST | RESULTS | FLAG | REFERENCE RANGES |
|------|---------|------|------------------|
|------|---------|------|------------------|

8-28
OCCULT BLOOD - FECES

FINAL REPORT
SOURCE: STOOL ⚡ ⚡
NEGATIVE FOR OCCULT BLOOD.

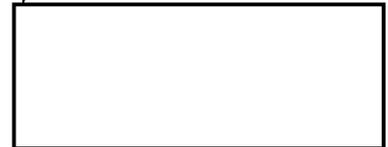
FLAG

REFERENCE RANGES

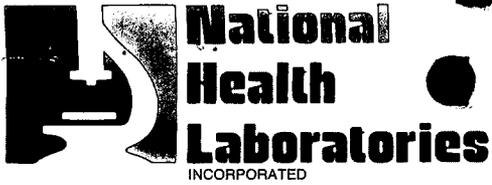
PAGE 1 OF 1

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400 AND PENN. AVENUE NW
WASHINGTON DC 20535
(202) 324-4976 RTE 5 05

| | | | | | | | |
|-----------------------------------|-----------------|-----|----------------------------|--------------------------------------|-----------------------------------|-------------------------------|-------------|
| PATIENT NAME
ONIELL J P | SEX
M | AGE | ACCESSION
176717 | DATE OF ACCESSION
09/11/90 | DATE OF REPORT
09/13/90 | ACCOUNT NO.
2710012 | 0563 |
|-----------------------------------|-----------------|-----|----------------------------|--------------------------------------|-----------------------------------|-------------------------------|-------------|

| TEST | RESULTS | FLAG | REFERENCE RANGES |
|------|---------|------|------------------|
|------|---------|------|------------------|

8-29
OCCULT BLOOD - FECES

FINAL REPORT
SOURCE: STOOL ⇄ ⇄
NEGATIVE FOR OCCULT BLOOD.

PAGE 1 OF 1

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SPIROTECH, INCORPORATED

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ATLANTA, GEORGIA

SPIROTECH MODEL 300

SUMMARY TABLE PRINTOUT

PATIENT NAME: ONIELL

ID: NONE

DATE: 8/ 6/80 TEMP=37.5C BTPS CORR= .997

SEX: MALE RACE: WHITE HEIGHT: 72.0IN AGE: 38YRS

FEV1 CRIT= 5% FEV3 CRIT= 5% BAR PR= 760.0

ABNORMALS: [REDACTED]

MOST REPRESENTATIVE TEST RESULTS

| PARAM | ACT | %PRED | %EXP |
|---------|-------|-------|------|
| FEV1 | 5.11 | 5.33 | 96% |
| FEV1.5 | 3.50 | 3.37 | 104% |
| FEV1 | 4.36 | 4.28 | 102% |
| FEV3 | 4.97 | 5.10 | 98% |
| FEFR | 10.34 | 9.87 | 105% |
| MMEF | 5.21 | 5.19 | 101% |
| REF25% | 8.18 | 8.15 | 99% |
| REF50% | 6.29 | 6.65 | 95% |
| REF75% | 2.05 | 3.45 | 59% |
| FEV1/VC | .68 | .71 | 96% |
| FEV1/VC | .85 | .82 | 104% |
| FEV3/VC | .97 | .98 | 99% |

High Normal

[REDACTED]

10/4/80

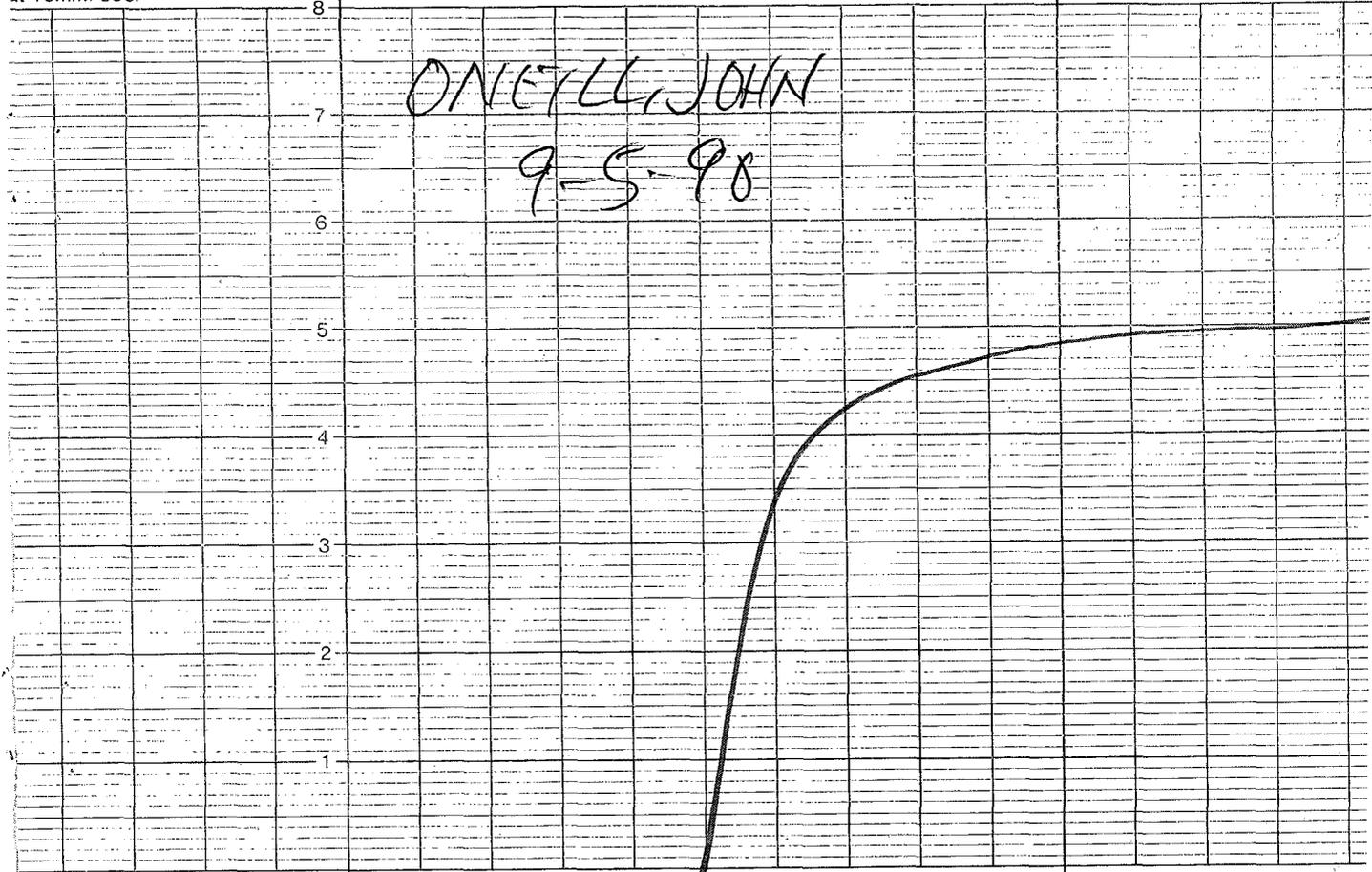
INDIVIDUAL SPIROGRAM RESULTS

| PARAM | ACT | %PRED | ACT | %PRED | ACT | %PRED |
|---------|-------|-------|-------|-------|------|-------|
| FEV1 | 5.11 | 96% | 4.97 | 93% | 5.05 | 95% |
| FEV1.5 | 3.47 | 103% | 3.37 | 100% | 3.50 | 104% |
| FEV1 | 4.32 | 101% | 4.28 | 99% | 4.36 | 102% |
| FEV3 | 4.97 | 98% | 4.80 | 94% | 4.89 | 96% |
| FEFR | 10.34 | 105% | 10.43 | 106% | 9.71 | 98% |
| MMEF | 5.21 | 101% | 5.06 | 97% | 5.56 | 107% |
| REF25% | 8.18 | 89% | 7.66 | 94% | 7.79 | 85% |
| REF50% | 6.29 | 85% | 6.30 | 95% | 6.70 | 101% |
| REF75% | 2.05 | 59% | 1.98 | 57% | 2.32 | 67% |
| FEV1/VC | .68 | 96% | .69 | 93% | .69 | 96% |
| FEV1/VC | .85 | 103% | .85 | 103% | .86 | 105% |
| FEV3/VC | .97 | 96% | .97 | 94% | .97 | 96% |

at 10mm/sec.

← 1 sec. at 20mm/sec. →

ONEYLL, JOHN
9-5-98



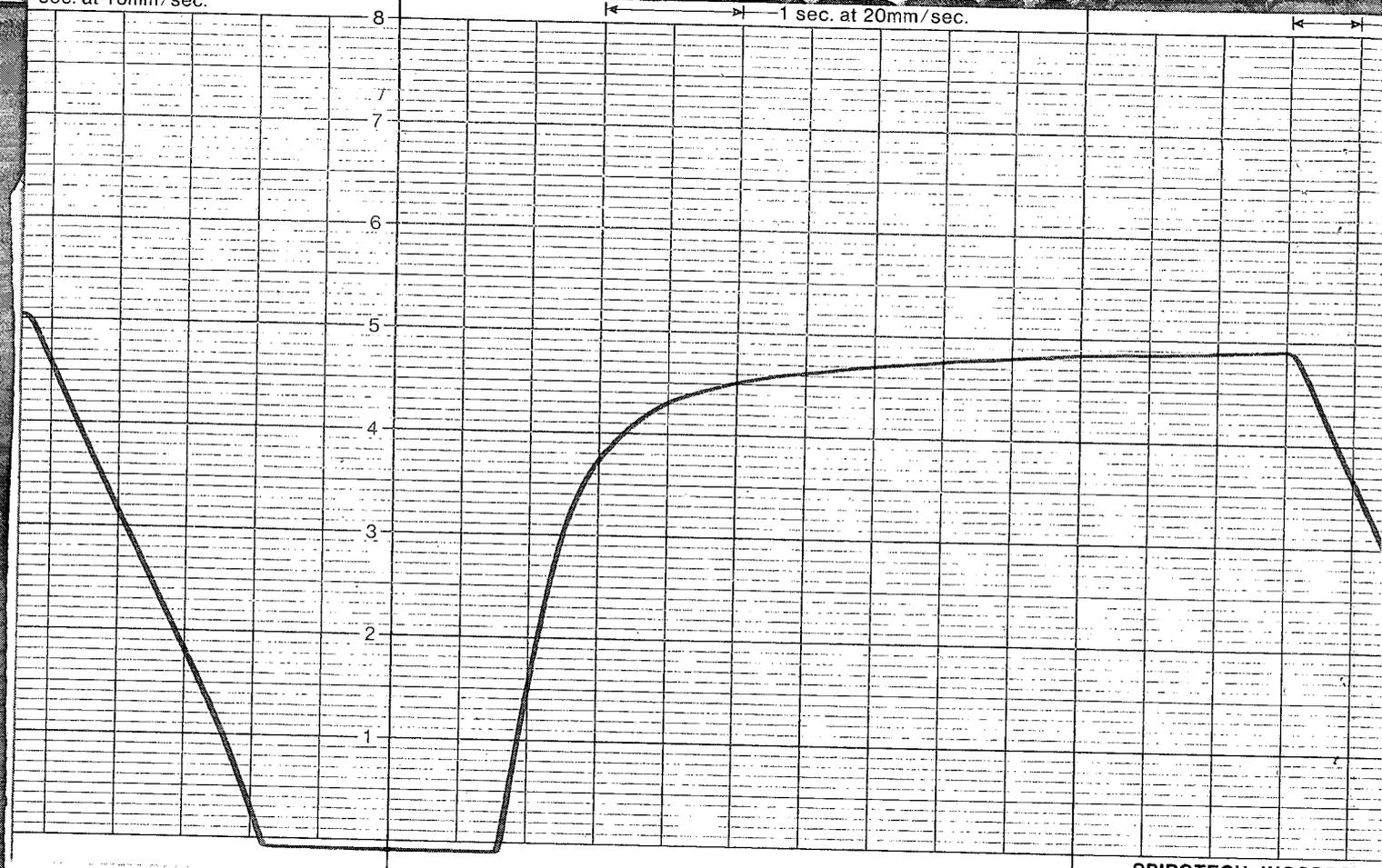
ATLANTA, GA.

REORDER P/N S010-02

PRINTED IN U.S.A.

sec. at 10mm/sec.

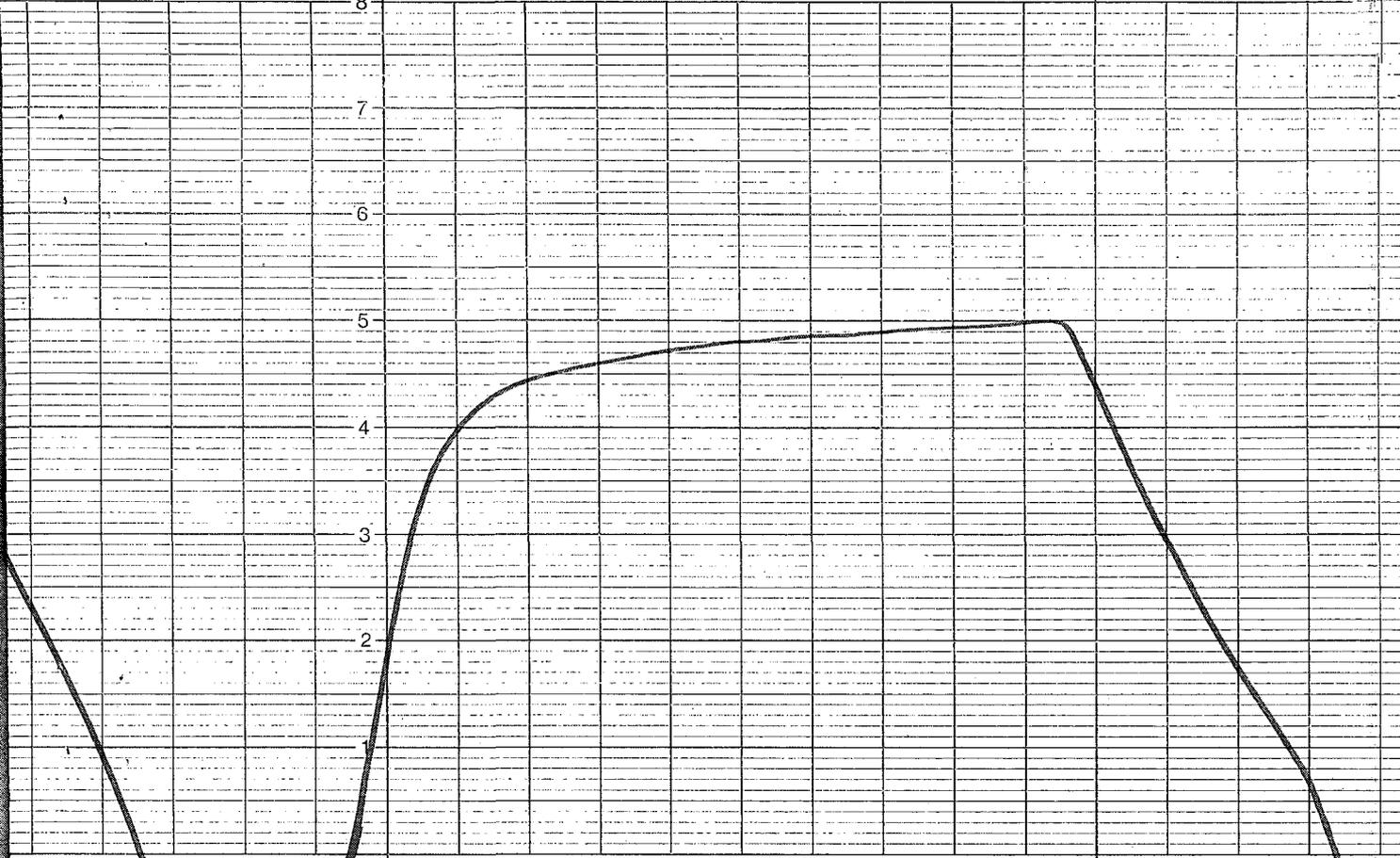
1 sec. at 20mm/sec.



SPIROTECH, INCORPORA

sec. at 10mm/sec.

1 sec. at 20mm/sec.

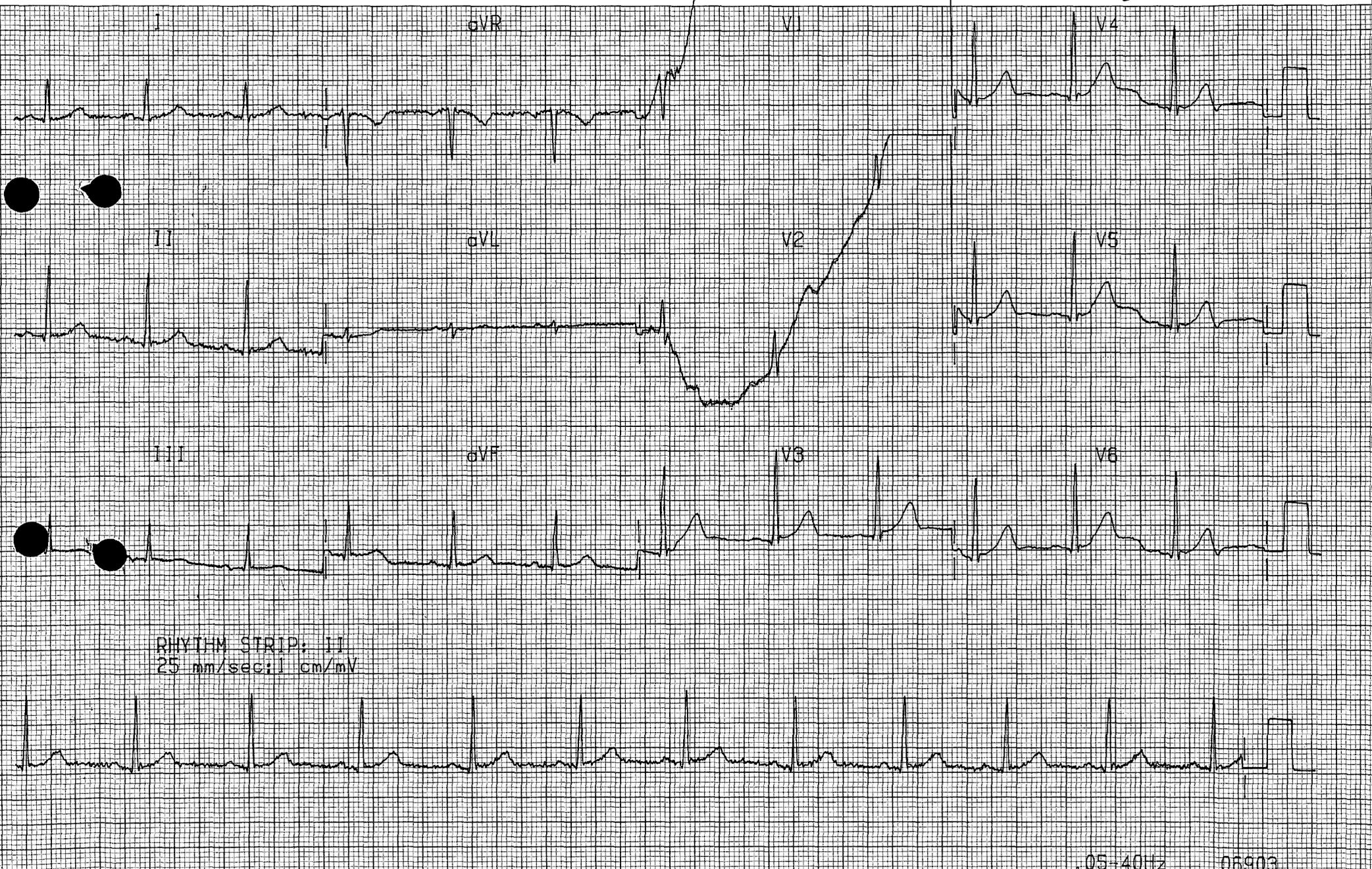


O'NEILL, JOHN
9-5-90

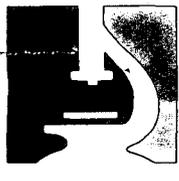
Rate 70/min
WNC

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b7c

7/8/90



RHYTHM STRIP: II
25 mm/sec; 1 cm/mV



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400 AND PENN. AVENUE NW
WASHINGTON DC 20535

(202) 324-4976 RTE 5 05

| | | | | | | | |
|-----------------------------------|-----------------|-----|----------------------------|--------------------------------------|-----------------------------------|-------------------------------|-------------|
| PATIENT NAME
ONIELL J P | SEX
M | AGE | ACCESSION
176718 | DATE OF ACCESSION
09/11/90 | DATE OF REPORT
09/13/90 | ACCOUNT NO.
2710012 | 0564 |
|-----------------------------------|-----------------|-----|----------------------------|--------------------------------------|-----------------------------------|-------------------------------|-------------|

| TEST | RESULTS | FLAG | REFERENCE RANGES |
|------|---------|------|------------------|
|------|---------|------|------------------|

| | | | |
|------------------------------------|--|--|--|
| <p>9-4
OCULT BLOOD - FECES</p> | <p>FINAL REPORT
SOURCE: STOOL ⚡ ⚡
NEGATIVE FOR OCULT BLOOD.</p> | | <p>PAGE 1 OF 1</p> <p>NC</p> |
|------------------------------------|--|--|--|

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Director of Laboratories

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Name of Examinee O'NEILL John P.
(Type or print) Last First Middle

The following portions of the attached examination report form need not be completed:

| | | | | |
|---|----|----|----|----|
| 3 | 9 | 17 | 67 | 76 |
| 4 | 11 | 62 | 68 | |
| 8 | 14 | 65 | 72 | |

45, 46, 47 and 49; required for all Special Agent and FBI National Academy applicants but not for any other applicant unless the examining physician deems one, two, three or all four of the examinations necessary. 45, 46 and 47 are required in examination of any current employee.

48. Required for (1) all Special Agent applicants; (2) all FBI National Academy applicants; (3) all examinees over 35 years of age; (4) any other where examination indicates such as desirable.

69. Required for all examinees over 40 years of age.

71. Audiometer examinations must be afforded for all Special Agent applicants and Special Agents and decibel readings must be recorded at 500, 1000, 2000, 3000 and 4000 Hertz. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 25 decibel average (ANSI) in either ear in the frequency range 1000, 2000, and 3000 Hertz. No single reading in that range may exceed 35 decibels and no applicant will be accepted if found to have a hearing loss exceeding 35 decibels at 500 or 45 decibels at 4000 Hertz.

For All Examinees, Whether Clerical or Special Agent Applicants, National Academy Applicants, or Employees:

The medical examiner should answer the following question:

Examinee is is not qualified for strenuous physical exertion.

To be Answered in the Case of All Special Agents, Special Agent Applicants, and National Academy Applicants:

1. Does examinee have any defects restricting or prohibiting his/her participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

No Yes If "yes" please specify defects. _____

To be Answered in the Case of All Special Agents, Special Agent Applicants, and other Employees who drive Bureau vehicles:

1. Does examinee have any defects prohibiting safe operation of motor vehicles?

No Yes If "yes" please specify defects. _____

2. For safe driving of motor vehicles, Office of Personnel Management requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? Yes No
If recommendation is based on a factor other than above standard, indicate basis _____

DESIRABLE WEIGHT RANGES

| MALES | | | | FEMALES | | | |
|--------|-------------|--------------|-------------|---------|-------------|--------------|-------------|
| Height | Small Frame | Medium Frame | Large Frame | Height | Small Frame | Medium Frame | Large Frame |
| 5'4" | 117 - 138 | 123 - 149 | 131 - 163 | 5'0" | 96 - 114 | 101 - 124 | 109 - 138 |
| 5'5" | 120 - 142 | 126 - 153 | 134 - 167 | 5'1" | 99 - 118 | 104 - 128 | 112 - 141 |
| 5'6" | 124 - 146 | 130 - 157 | 138 - 173 | 5'2" | 102 - 121 | 107 - 131 | 115 - 144 |
| 5'7" | 128 - 151 | 134 - 163 | 143 - 178 | 5'3" | 105 - 124 | 110 - 135 | 118 - 149 |
| 5'8" | 132 - 155 | 138 - 167 | 147 - 183 | 5'4" | 108 - 128 | 113 - 139 | 121 - 152 |
| 5'9" | 136 - 161 | 142 - 172 | 151 - 187 | 5'5" | 111 - 132 | 117 - 144 | 125 - 156 |
| 5'10" | 140 - 165 | 146 - 177 | 155 - 193 | 5'6" | 114 - 135 | 120 - 149 | 129 - 161 |
| 5'11" | 144 - 169 | 150 - 183 | 160 - 198 | 5'7" | 118 - 140 | 124 - 153 | 133 - 165 |
| 6' | 148 - 174 | 154 - 188 | 164 - 204 | 5'8" | 122 - 144 | 128 - 157 | 137 - 169 |
| 6'1" | 152 - 179 | 158 - 194 | 169 - 209 | 5'9" | 126 - 149 | 132 - 162 | 141 - 174 |
| 6'2" | 156 - 184 | 163 - 199 | 174 - 215 | 5'10" | 130 - 154 | 136 - 166 | 145 - 179 |
| 6'3" | 160 - 188 | 168 - 205 | 178 - 220 | 5'11" | 134 - 158 | 140 - 171 | 149 - 185 |
| 6'4" | 169 - 198 | 178 - 216 | 188 - 231 | 6'0" | 138 - 163 | 144 - 175 | 153 - 190 |
| 6'5" | 174 - 204 | 182 - 222 | 192 - 238 | | | | |

waist 7

4. Examinee's frame is small medium large
5. Considering the above weight table, the examinee's frame, and other individual physical characteristics, I consider his/her present weight Satisfactory Excessive Deficient
6. Under proper medical supervision, employee should lose _____ pounds
 gain _____ pounds

Remarks: skin fold measurements 10/4/90 $\frac{24}{45} = .533$ $\frac{18}{44} = .409$

$\frac{.533 + .409}{2} = .471$ $\frac{22}{84} = .262$ $.471 - .262 = .209$ $.209 \times 75 = 15.7$

[Signature Box]

Signature of Medical Examiner

10/4/90

Date

b6
b7C

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

| | | | |
|--|--|---|--|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME
<i>John P. O'Neill, John P.</i> | | 2. SOCIAL SECURITY OR IDENTIFICATION NO.
<i>147-42-1004</i> | |
| 3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE) | | 4. POSITION (title, grade, component)
<i>GM-14</i> | |
| 5. PURPOSE OF EXAMINATION
<i>FITNESS FOR DUTY</i> | 6. DATE OF EXAMINATION
<i>8/29/90</i> | 7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code)
<i>FBI</i> | |

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint exists)

*Excellent
CURRENTLY TAKING Chloromycetin 25MG FOR CONJUNCTIVITIS
in Both Eyes*

| 9. HAVE YOU EVER (Please check each item) | | 10. DO YOU (Please check each item) | |
|---|-------------------------------------|-------------------------------------|-------------------------------------|
| YES | NO | YES | NO |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| (Check each item) | | (Check each item) | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Lived with anyone who had tuberculosis | | Wear glasses or contact lenses | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Coughed up blood | | Have vision in both eyes | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Bled excessively after injury or tooth extraction | | Wear a hearing aid | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Attempted suicide | | Stutter or stammer habitually | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Been a sleepwalker | | Wear a brace or back support | |

| 11. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item) | | | |
|---|-------------------------------------|-------------------------------------|-------------------------------|
| YES | NO | DON'T KNOW | (Check each item) |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Scarlet fever, erysipelas |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Rheumatic fever |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Swollen or painful joints |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Frequent or severe headache |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Dizziness or fainting spells |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Eye trouble |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Ear, nose, or throat trouble |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hearing loss |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Chronic or frequent colds |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Severe tooth or gum trouble |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Sinusitis |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hay Fever |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Head injury |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Skin diseases |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Thyroid trouble |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Tuberculosis |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Asthma |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Shortness of breath |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Pain or pressure in chest |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Chronic cough |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Palpitation or pounding heart |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Heart trouble |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | High or low blood pressure |

| | |
|---|--|
| 13. WHAT IS YOUR USUAL OCCUPATION?
<i>Inspector's Aide</i> | 14. ARE YOU (Check one)
<input type="checkbox"/> Right handed <input checked="" type="checkbox"/> Left handed |
|---|--|

| YES | NO | CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT |
|-------------------------------------|--------------------------|---|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 15. Have you been refused employment or been unable to hold a job or stay in school because of:
A. Sensitivity to chemicals, dust, sunlight, etc. |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | B. Inability to perform certain motions. |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | C. Inability to assume certain positions. |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | D. Other medical reasons (If yes, give reasons.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 17. Have you ever been denied life insurance? (If yes, state reason and give details.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 18. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 19. Have you ever been a patient in any type of hospitals? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 20. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 23. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | 24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.) |

*Note Removal 1957
Tonsils, 1958
Appendectomy 1960*

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE

John P. O'Neill

SIGNATURE

John P. O'Neill

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."

25. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

*Answer need to control diet, exercise and
control of ETOH*

No diabetes -

No illness -

Low HDL - on high fish diet

b6
b7c

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER

DATE

10/4/90

SIGNATURE

NUMBER OF ATTACHED SHEETS

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

| | | | |
|--|--|--|--|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME
O'NEILL, JOHN P. | | 2. SOCIAL SECURITY OR IDENTIFICATION NO.
147-42-1004 | |
| 3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE)
219 So. Dearborn Chgo. Ill. 60604 | | 4. POSITION (title, grade, component)
SPECIAL AGENT | |
| 5. PURPOSE OF EXAMINATION
ANNUAL | 6. DATE OF EXAMINATION
1/12/95 | 7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code)
GALTER LIFE CENTER
5157 NO. FRANCISCO AVENUE
CHICAGO, ILLINOIS 60625 | |
| 8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint exists)
Veter C
In good health.
Fitness program includes running, weights. | | | |

| 9. HAVE YOU EVER (Please check each item) | | 10. DO YOU (Please check each item) | |
|---|--------------------------|--|--------------------------|
| YES | NO | YES | NO |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> Lived with anyone who had tuberculosis | | <input checked="" type="checkbox"/> Wear glasses or contact lenses | |
| <input checked="" type="checkbox"/> Coughed up blood | | <input checked="" type="checkbox"/> Have vision in both eyes | |
| <input checked="" type="checkbox"/> Bled excessively after injury or tooth extraction | | <input checked="" type="checkbox"/> Wear a hearing aid | |
| <input checked="" type="checkbox"/> Attempted suicide | | <input checked="" type="checkbox"/> Stutter or stammer habitually | |
| <input checked="" type="checkbox"/> Been a sleepwalker | | <input checked="" type="checkbox"/> Wear a brace or back support | |

| 11. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item) | | | | | | | | | | | |
|---|--------------------------|--------------------------|-------------------------------|-------------------------------------|--------------------------|--------------------------|--|-------------------------------------|--------------------------|--------------------------|---------------------------------|
| YES | NO | DON'T KNOW | (Check each item) | YES | NO | DON'T KNOW | (Check each item) | YES | NO | DON'T KNOW | (Check each item) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet fever, erysipelas | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cramps in your legs | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | "Trick" or locked knee |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent indigestion | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Foot trouble |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Swollen or painful joints | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stomach, liver, or intestinal trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neuritis |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent or severe headache | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder trouble or gallstones | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Paralysis (include infantile) |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness or fainting spells | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice or hepatitis | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or fits |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adverse reaction to serum, drug, or medicine | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Car, train, sea or air sickness |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear, nose, or throat trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Broken bones | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent trouble sleeping |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tumor, growth, cyst, cancer | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression or excessive worry |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic or frequent colds | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Rupture/hernia | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of memory or amnesia |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Severe tooth or gum trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Piles or rectal disease | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous trouble of any sort |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sinusitis | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Frequent or painful urination | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Periods of unconsciousness |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bed wetting since age 12 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Head Injury | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney stone or blood in urine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin diseases | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sugar or albumin in urine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | VD—Syphilis, gonorrhea, etc. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Recent gain or loss of weight | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis, Rheumatism, or Bursitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bone, joint or other deformity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pain or pressure in chest | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lameness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of finger or toe | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Palpitation or pounding heart | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Painful or "trick" shoulder or elbow | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Recurrent back pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High or low blood pressure | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

| | |
|---|--|
| 13. WHAT IS YOUR USUAL OCCUPATION?
ASAC | 14. ARE YOU (Check one)
<input type="checkbox"/> Right handed <input checked="" type="checkbox"/> Left handed |
|---|--|

YES NO CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE EXPLAINED IN BLANK SPACE ON RIGHT

| | | |
|---|---|--|
| ✓ | 15. Have you been refused employment or been unable to hold a job or stay in school because of:
A. Sensitivity to chemicals, dust, sunlight, etc. | <p>16-17 - Age 6 - mole removal</p> <p>18-19 - Age 10 - Tonsil</p> <p>18-19 - Age 12 - Appendicitis</p> |
| ✓ | B. Inability to perform certain motions. | |
| ✓ | C. Inability to assume certain positions. | |
| ✓ | D. Other medical reasons (If yes, give reasons.) | |
| ✓ | 16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details). | |
| ✓ | 17. Have you ever been denied life insurance? (If yes, state reason and give details.) | |
| ✓ | 18. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.) | |
| ✓ | 19. Have you ever been a patient in any type of hospitals? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) | |
| ✓ | 20. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) | |
| ✓ | 21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) | |
| ✓ | 22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.) | |
| ✓ | 23. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.) | |
| ✓ | 24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.) | |

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

| | |
|---|-------------------------------------|
| TYPED OR PRINTED NAME OF EXAMINEE
<i>JOHN P. O'NEILL</i> | SIGNATURE
<i>John P. O'Neill</i> |
|---|-------------------------------------|

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."
25. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

No significant medical/surgical problem on Review of Systems.

b6
b7C

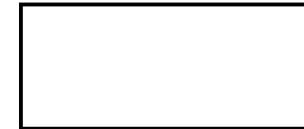
| | | | |
|--|-----------------|-----|---------------------------|
| TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER
[] M.D. | DATE
1-12-95 | [] | NUMBER OF ATTACHED SHEETS |
|--|-----------------|-----|---------------------------|

12 Lead ST Level +0.4 filter on Gain x1
Resting ST Slope -1 HR 73 25 mm/sec

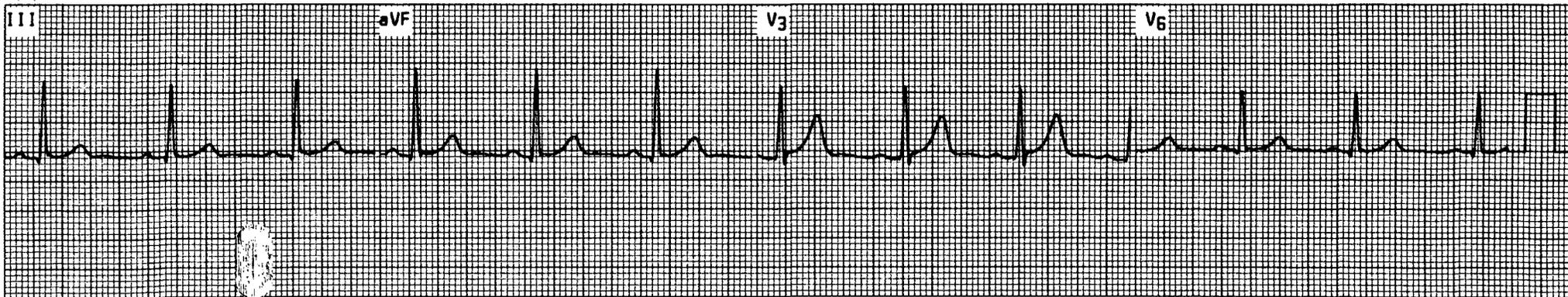
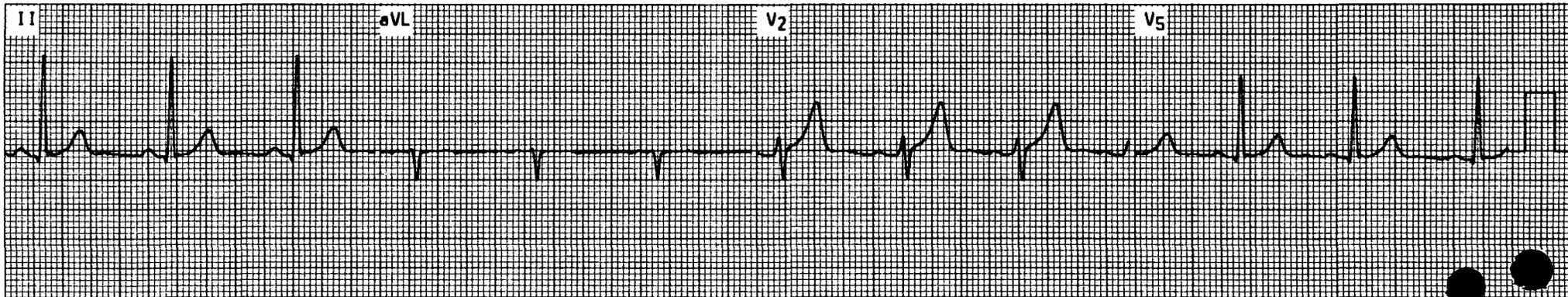
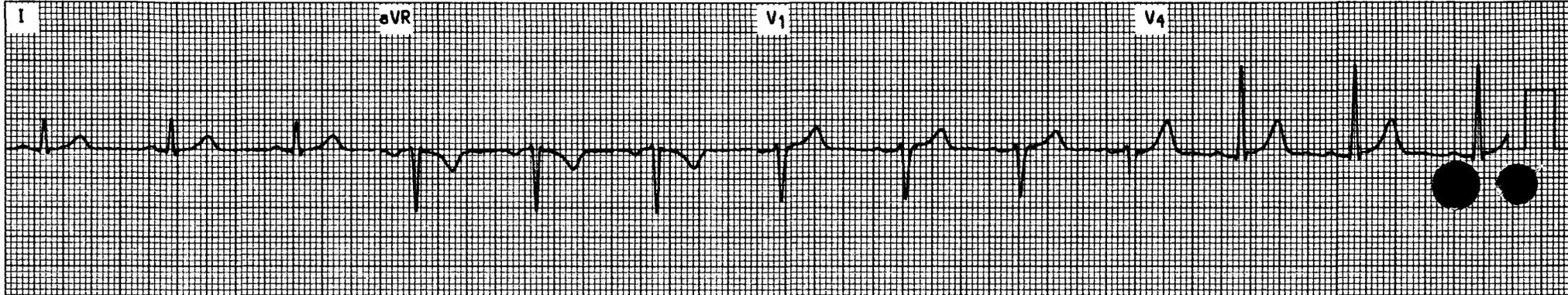
O'NEILL, JOHN
1-12-95
REST-SUPINE

Interpretation: Sinus rhythm.
Normal ECG.

b6
b7c



MD



MEDICAL RECORD

REPORT OF MEDICAL EXAMINATION

DATE OF EXAM

12/6/96

1. LAST NAME-FIRST NAME-MIDDLE NAME: O'NEILL, JOHN P. 2. IDENTIFICATION NUMBER: 147-42-1004 3. GRADE AND COMPONENT OR POSITION: SES-04

4. HOME ADDRESS: [Redacted] 5. EMERGENCY CONTACT: [Redacted]

6. DATE OF BIRTH: 2/06/52 7. AGE: 44 8. SEX: [X] MALE 9. RELATIONSHIP OF CONTACT: [Redacted]

10. PLACE OF BIRTH: VENTNOR, NJ 11. RACE: [X] WHITE 12a. AGENCY: FBI 12b. ORGANIZATION UNIT: [Redacted] 13. TOTAL YEARS GOVERNMENT SERVICE: a. MILITARY: - b. CIVILIAN: 26

14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS: [Redacted] 15. RATING OR SPECIALTY OF EXAMINER: [Redacted]

16. PURPOSE OF EXAMINATION: [Redacted]

17. CLINICAL EVALUATION

Table with columns for Normal/Abnormal and rows for various body systems: A. HEAD, FACE, NECK AND SCALP; B. EARS-GENERAL; C. DRUMS; D. NOSE; E. SINUSES; F. MOUTH AND THROAT; G. EYES-GENERAL; H. OPHTHALMOSCOPIC; I. PUPILS; J. OCULAR MOTILITY; K. LUNGS AND CHEST; L. HEART; M. VASCULAR SYSTEM; N. ABDOMEN AND VISCERA; O. PROSTATE; P. TESTICULAR; Q. ANUS AND RECTUM; R. ENDOCRINE SYSTEM; S. G.U SYSTEM; T. UPPER EXTREMITIES; U. FEET; V. LOWER EXTREMITIES; W. SPINE, OTHER MUSCULOSKELETAL; X. IDENTIFYING BODY MARKS, SCARS, TATTOOS; Y. SKIN, LYMPHATICS; Z. NEUROLOGIC; AA. PSYCHIATRIC; BB. BREASTS; CC. PELVIC.

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)

12/11/96 Blood redrawn. Take stated that there was not enough blood before. [Redacted] 2" scar left interscapular area

Physical reviewed in [Redacted] by [Redacted] on 1-6-97

18. DENTAL table with columns for Restorable Teeth, Non-restorable teeth, Missing Teeth, Replaced by Dentures, Fixed Partial Dentures and rows for Right and Left sides.

19. TEST RESULTS (Copies of results are preferred as attachments)

Table for test results: A. URINALYSIS; B. CHEST X-RAY OR PPD; C. SYPHILIS SEROLOGY; D. EKG; E. BLOOD TYPE AND RH FACTOR; F. OTHER TESTS (12-6-96 PPD pleural fluid screening)

| | | |
|------|-----------------------|------------------------|
| NAME | IDENTIFICATION NUMBER | NO. OF SHEETS ATTACHED |
|------|-----------------------|------------------------|

MEASUREMENTS AND OTHER FINDINGS

| | | | | | |
|-----------------------|-----------------------|----------------|----------------|---|-----------------------------|
| 20. HEIGHT <i>72"</i> | 21. WEIGHT <i>233</i> | 22. COLOR HAIR | 23. COLOR EYES | 24. BUILD
<input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE | 25. TEMPERATURE <i>98.3</i> |
|-----------------------|-----------------------|----------------|----------------|---|-----------------------------|

| | | | | | | | | | | |
|---|-----------------|------------|------|--------------------------------|------|----------------------|--------------|-----------------------|-------------------|------------------|
| 26. BLOOD PRESSURE (Arm at heart level) | | | | 27. PULSE (Arm at heart level) | | | | | | |
| A. SITTING | SYS. <i>128</i> | RECUM-BENT | SYS. | C. STANDING (5 mins.) | SYS. | A. SITTING <i>83</i> | B. RECUMBENT | C. STANDING (3 mins.) | D. AFTER EXERCISE | E. 2 MINS. AFTER |

| | | | | | | | | |
|---------------------|--------------|----|----------------|----|-------|-----------------|----|--|
| 28. DISTANT VISION | | | 29. REFRACTION | | | 30. NEAR VISION | | |
| RIGHT 20/ <i>40</i> | CORR. TO 20/ | BY | S. | CX | 20/20 | CORR. TO | BY | |
| LEFT 20/ <i>20</i> | CORR. TO 20/ | BY | S. | CX | 20/29 | CORR. TO | BY | |

31. HETEROPHORIA (Specify distance)

| | | | | | | | |
|-----|-----|------|------|------------|----------------|----|----|
| ESO | EXO | R.H. | L.H. | PRISM DIV. | PRISM CONV. CT | PC | PD |
|-----|-----|------|------|------------|----------------|----|----|

| | | | | | | | | | | |
|---------------------|--------|--|-------|-----|------|--|------|--|----------------|------|
| 32. ACCOMMODATION | | 33. COLOR VISION (Test used and result) <i>5/6</i> | | | | 34. DEPTH PERCEPTION (Test used and score) | | UNCORRECTED | | |
| RIGHT | LEFT | | | | | | | CORRECTED | | |
| 35. FIELD OF VISION | | 36. NIGHT VISION (Test used and score) | | | | 37. RED LENS TEST | | 38. INTRAOCULAR TENSION | | |
| RIGHT | LEFT | | | | | | | RIGHT <i>20</i> | LEFT <i>19</i> | |
| 39. HEARING | | 40. AUDIOMETER | | | | | | 41. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score) | | |
| RIGHT WV | /15 SV | /15 | 250 | 500 | 1000 | 2000 | 3000 | 4000 | 6000 | 8000 |
| | | | 256 | 512 | 1024 | 2048 | 2896 | 4096 | 6144 | 8192 |
| LEFT WV | /15 SV | /15 | RIGHT | | | | | | | |
| | | | LEFT | | | | | | | |

42. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

1) Hyperlipidemia C ↓HDL + ↑LDL
2) HFHL - AU

| | | | | | | |
|--|-----------------------|---|---|---|---|---|
| 44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)
<i>Low fat diet + Nexscape
Ear plugs + "ears" for hearing, protection</i> | 45A. PHYSICAL PROFILE | | | | | |
| | P | U | L | H | E | S |

46. EXAMINEE (Check)

A. IS QUALIFIED FOR

B. IS NOT QUALIFIED FOR

45B. PHYSICAL CATEGORY b6
b7C

47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

| | | |
|--|---|---|
| | C | E |
|--|---|---|

48. TYPED OR PRINTED NAME OF PHYSICIAN

49. TYPED OR PRINTED NAME OF PHYSICIAN

50. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)

51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY

MD 12/18/96

PROVIDENCE LABORATORY ASSOCIATES ###
11420 ROCKVILLE PIKE - ROCKVILLE, MD 20852 - (301)230-7521

PATIENT NAME: O'NEILL, JOHN
DOCTOR: FBI
D/A DATE: A 09-DEC-96
LOC: PLA SEX: M
SPECIMEN ID: 79827

ACCOUNT #: 147421004
DATE/TIME COLL: 09-DEC-96 09:45 AM
DATE RECEIVED:
DATE/TIME REP: 12-DEC-96 08:58 AM

| TEST NAME
===== | RESULT
===== | ABNORMAL
===== | REFERENCE RANGE
===== |
|--------------------|-----------------|-------------------|--------------------------|
|--------------------|-----------------|-------------------|--------------------------|

URINALYSIS

| | | | |
|-------------|----------|--|-----------|
| STOOL BLOOD | NEGATIVE | | -NEGATIVE |
|-------------|----------|--|-----------|

FBI/HEALTH SERVICES
ATTN:
935 PENNSYLVANIA AVE, NW
WASHINGTON, DC 20535

b6
b7c



*** O'NEILL, JOHN, 12-DEC-96 AT 08:58 *** (CONT)

FINAL PG 3

PROVIDENCE LABORATORY ASSOCIATES ###
 11420 ROCKVILLE PIKE - ROCKVILLE, MD 20852 - (301)230-7521

PATIENT NAME: ONEIL, JOHN
 DOCTOR: FBI
 D/A DATE: A 11-DEC-96
 LOC: PLA SEX: M
 SPECIMEN ID: 83222

ACCOUNT #: 83222
 DATE/TIME COLL: 11-DEC-96 10:10 AM
 DATE RECEIVED: 11-DEC-96
 DATE/TIME REP: 12-DEC-96 08:58 AM

| TEST NAME
===== | RESULT
===== | ABNORMAL
===== | REFERENCE RANGE
===== |
|--------------------|-----------------|-------------------|--------------------------|
|--------------------|-----------------|-------------------|--------------------------|

CHEMISTRY (continued)
 IRON

89

55-175 UG/DL

INTERPRETATION (SEE BELOW)
 CORONARY HEART DISEASE RISK FACTOR ANALYSIS

| | | MEN | WOMEN |
|------------------|---------|----------|-------|
| LDL/HDL RATIO | 4.29 H* | 1.00 | 1.47 |
| | | 3.55 | 3.22 |
| | | 6.25 | 5.03 |
| | | 7.99 | 6.14 |
| TRIGLYCERIDES | 113 | 23-200 | MG/DL |
| CHOLESTEROL | | 145-200 | MG/DL |
| HDL CHOLESTEROL | 35 | 27-67 | MG/DL |
| CHOL/HDL RATIO | | 0.0-4.97 | |
| LDL CHOLESTEROL | 150. | 62-178 | MG/DL |
| VLDL CHOLESTEROL | 23. | 0-40 | MG/DL |
| ALK PHOS | 71 | 37-120 | U/L |

SPECIAL CHEMISTRY

| | | | |
|------------------|-----|----------|-------|
| T4 | 7.1 | 4.5-12.0 | UG/DL |
| PROSTATE SPEC AG | 0.8 | 0.0-2.8 | NG/ML |

FBI/HEALTH SERVICES
 ATTN:
 935 PENNSYLVANIA AVE, NW
 WASHINGTON, DC 20535

b6
 b7C

x. O'Neill, John

DATE: 12 06 96
JOB NO.:
NOISE EXP.:
PROTECTOR:
BIRTH DATE:
SEX: *m*

AUDIOGRAM

L 1K 40+30+20+10+00+
00+
L 5K 10-30+20+10-15+
05-10-15+
L 1K 00-20+10+00+00+
L 2K 10+00-05-10+00-
05-10+
L 3K 20+10-15-20+10-
15-20+
L 4K 30-50+40+30+20-
25-30-35+25-30-
35+
L 6K 45+35+25+15-20-
25-30+20+10-15-
20-25-30+
L 8K 40-60+50+40+30-
35-40-45+35-40-
45+
R 5K 40+30+20+10+00-
05+00-05+
R 1K 15+05+00-05-10+
00-05+00-05+
R 2K 15+05-10+00-05-
10-15+05-10-15+
R 3K 25+15+05-10-15-
20+10-15+05-10-
15+
R 4K 25+15-20+10-15-
20+
R 6K 30+20-25+15-20-
25+
R 8K 35+25-30+20-25-
30+

| FREQ. | L dB | R dB |
|--------|------|------|
| 500HZ | 15 | 05 |
| 1000HZ | 00 | 05 |
| 2000HZ | 10 | 15 |
| 3000HZ | 20 | 15 |
| 4000HZ | 35 | 20 |
| 6000HZ | 30 | 25 |
| 8000HZ | 45 | 30 |

THRESHOLD AVERAGE

| | | |
|-----------|----|----|
| .5-1-2K | 8 | 8 |
| 1-2-3K | 10 | 12 |
| 2-3-4K | 22 | 17 |
| 3-4-6K | 28 | 20 |
| 4-6-8K | 37 | 25 |
| .5-1-2-3K | 11 | 10 |

TEST COMPLETE

MAICO MA728 SN 31993
CALIBRATED 5-96
ANSI S3.6-1969, R1973

EXAMINER:

x. *kn*

b6
b7c

des

44 years
Male

Vent. rate 75 bpm
PR interval 158 ms
QRS duration 82 ms
QT/QTc 374/418 ms
P-R-T axes 46 54 46

Normal sinus rhythm
Normal ECG

WNT

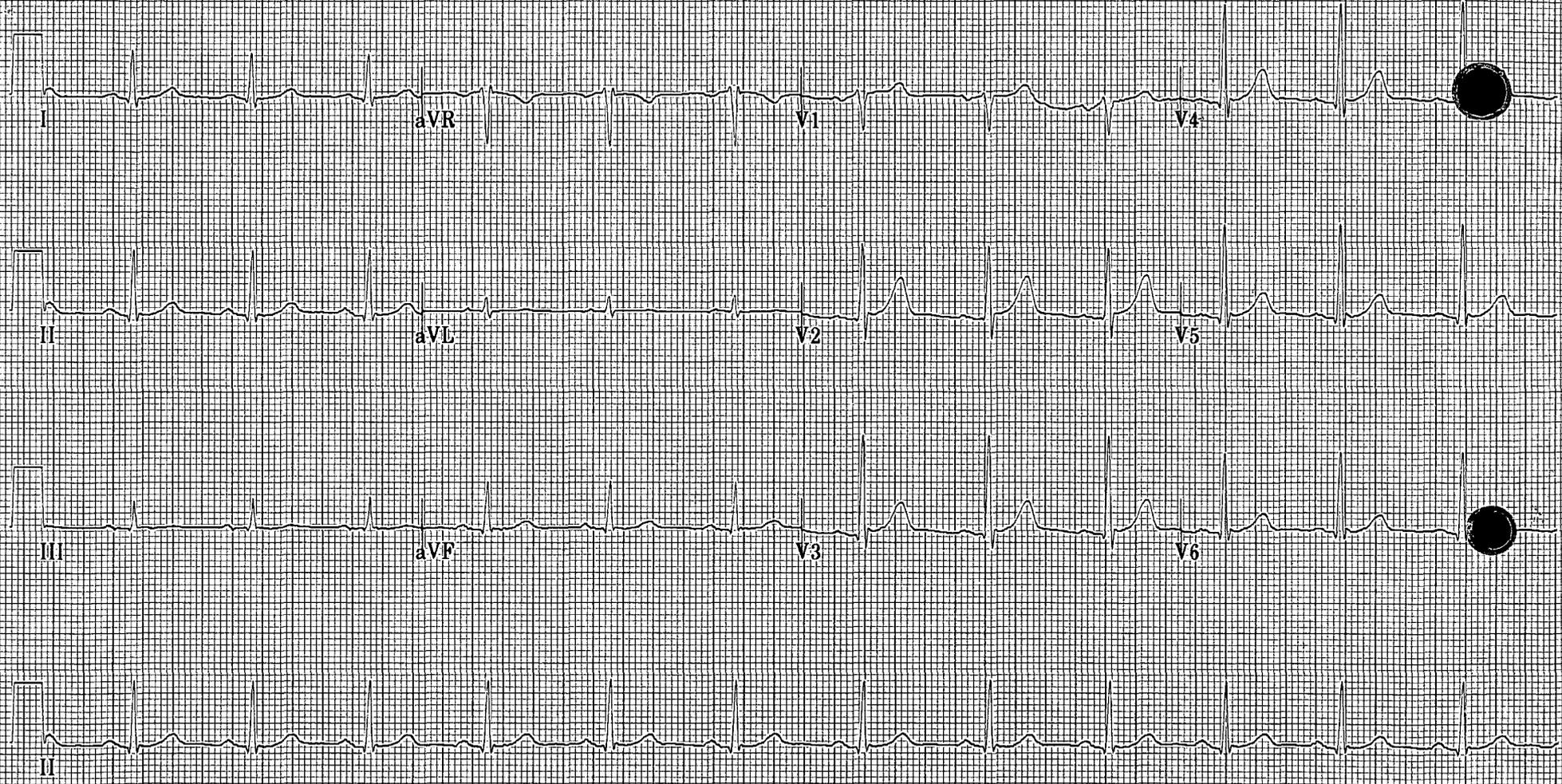


Med

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b7c

12/18/96

Reviewed by:





U.S. Department of Justice

Federal Bureau of Investigation

Washington, D. C. 20535

I, John P. O'Neil, voluntarily take the T.B. Test intradermally as a screening method for tuberculosis. I release Health Service of any liability. I confirm that I have not had a T.B. Test within the last year. I have no known allergy to the T.B. Test.

Have you ever had in the past, a positive reaction to a T.B. intradermal test: Yes () No ()

John P. O'Neil
Employee Signature
147-42-1004
SSAN#

(4) forever
TESTING

Administered by: en Date: 12-6-86 ^{10:40} AM

Read by: _____ Date: _____

Results: _____

b6
b7c

DESIRABLE WEIGHT RANGES

| MALES | | | | FEMALES | | | |
|--------|-------------|--------------|-------------|---------|-------------|--------------|-------------|
| Height | Small Frame | Medium Frame | Large Frame | Height | Small Frame | Medium Frame | Large Frame |
| 5'4" | 117 - 138 | 123 - 149 | 131 - 163 | 5'0" | 96 - 114 | 101 - 124 | 109 - 138 |
| 5'5" | 120 - 142 | 126 - 153 | 134 - 167 | 5'1" | 99 - 118 | 104 - 128 | 112 - 141 |
| 5'6" | 124 - 146 | 130 - 157 | 138 - 173 | 5'2" | 102 - 121 | 107 - 131 | 115 - 144 |
| 5'7" | 128 - 151 | 134 - 163 | 143 - 178 | 5'3" | 105 - 124 | 110 - 135 | 118 - 149 |
| 5'8" | 132 - 155 | 138 - 167 | 147 - 183 | 5'4" | 108 - 128 | 113 - 139 | 121 - 152 |
| 5'9" | 136 - 161 | 142 - 172 | 151 - 187 | 5'5" | 111 - 132 | 117 - 144 | 125 - 156 |
| 5'10" | 140 - 165 | 146 - 177 | 155 - 193 | 5'6" | 114 - 135 | 120 - 149 | 129 - 161 |
| 5'11" | 144 - 169 | 150 - 183 | 160 - 198 | 5'7" | 118 - 140 | 124 - 153 | 133 - 165 |
| 6' | 148 - 174 | 154 - 188 | 164 - 204 | 5'8" | 122 - 144 | 128 - 157 | 137 - 169 |
| 6'1" | 152 - 179 | 158 - 194 | 169 - 209 | 5'9" | 126 - 149 | 132 - 162 | 141 - 174 |
| 6'2" | 156 - 184 | 163 - 199 | 174 - 215 | 5'10" | 130 - 154 | 136 - 166 | 145 - 179 |
| 6'3" | 160 - 188 | 168 - 205 | 178 - 220 | 5'11" | 134 - 158 | 140 - 171 | 149 - 185 |
| 6'4" | 169 - 198 | 178 - 216 | 188 - 231 | 6'0" | 138 - 163 | 144 - 175 | 153 - 190 |
| 6'5" | 174 - 204 | 182 - 222 | 192 - 238 | | | | |

4. Examinee's frame is small medium large
5. Considering the above weight table, the examinee's frame, and other individual physical characteristics, I consider his/her present weight Satisfactory Excessive Deficient
6. Under proper medical supervision, employee should lose 30 pounds
 gain _____ pounds

Remarks: _____


 Examiner

12/18/96
 Date

b6
b7c

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

| | | | |
|---|--|---|--|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME
O'NEILL, JOHN P. | | 2. SOCIAL SECURITY OR IDENTIFICATION NO.
147-42-1004 | |
| 3. HOME ADDRESS (No. street or RFD, city or town, State, and ZIP CODE) | | 4. POSITION (title, grade, component)
SES-04 | |
| 5. PURPOSE OF EXAMINATION
ANNUAL | 6. DATE OF EXAMINATION
12/6/96 | 7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS (Include ZIP Code)
FBIHQ | |
| 8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint exists)
Good. | | | |

| 9. HAVE YOU EVER (Please check each item) | | 10. DO YOU (Please check each item) | |
|---|-------------------------------------|-------------------------------------|-------------------------------------|
| YES | NO | YES | NO |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Lived with anyone who had tuberculosis | | Wear glasses or contact lenses | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Coughed up blood | | Have vision in both eyes | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Bled excessively after injury or tooth extraction | | Wear a hearing aid | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Attempted suicide | | Stutter or stammer habitually | |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> |
| Been a sleepwalker | | Wear a brace or back support | |

| 11. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item) | | | |
|---|-------------------------------------|-------------------------------------|-------------------------------|
| YES | NO | DON'T KNOW | (Check each item) |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Scarlet fever, erysipelas |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Rheumatic fever |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Swollen or painful joints |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Frequent or severe headache |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Dizziness or fainting spells |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Eye trouble |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Ear, nose, or throat trouble |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hearing loss |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Chronic or frequent colds |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Severe tooth or gum trouble |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Sinusitis |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Hay Fever |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Head injury |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Skin diseases |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Thyroid trouble |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Tuberculosis |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Asthma |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Shortness of breath |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Pain or pressure in chest |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Chronic cough |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Palpitation or pounding heart |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Heart trouble |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | High or low blood pressure |

| YES | NO | DON'T KNOW | (Check each item) |
|-------------------------------------|-------------------------------------|-------------------------------------|--|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Cramps in your legs |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Frequent indigestion |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Stomach, liver, or intestinal trouble |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Gall bladder trouble or gallstones |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Jaundice or hepatitis |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Adverse reaction to serum, drug, or medicine |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Broken bones |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Tumor, growth, cyst, cancer |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Rupture/hernia |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Piles or rectal disease |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Frequent or painful urination |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Bed wetting since age 12 |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Kidney stone or blood in urine |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Sugar or albumin in urine |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | VD—Syphilis, gonorrhea, etc. |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Recent gain or loss of weight |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Arthritis, Rheumatism, or Bursitis |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Bone, joint or other deformity |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Lameness |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Loss of finger or toe |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Painful or "trick" shoulder or elbow |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Recurrent back pain |

| | |
|--|--|
| 13. WHAT IS YOUR USUAL OCCUPATION?
Chief of Counterterrorism Section | 14. ARE YOU (Check one)
<input type="checkbox"/> Right handed <input checked="" type="checkbox"/> Left handed |
|--|--|

| YES | NO | CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT |
|-------------------------------------|-------------------------------------|---|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 15. Have you been refused employment or been unable to hold a job or stay in school because of:
A. Sensitivity to chemicals, dust, sunlight, etc.
B. Inability to perform certain motions.
C. Inability to assume certain positions.
D. Other medical reasons (If yes, give reasons.) |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 16. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.) |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 17. Have you ever been denied life insurance? (If yes, state reason and give details.) |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 18. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.) |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 19. Have you ever been a patient in any type of hospitals? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 20. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.) |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 22. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.) |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 23. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge: whether honorable, other than honorable, or unfit or unsuitability.) |
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | 24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.) |

Thought this was medical NOT MENTAL
~~See previous forms~~
See previous forms
 " " "

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

| | |
|---|----------------------------------|
| TYPED OR PRINTED NAME OF EXAMINEE
<i>John P. O'Neill</i> | SIGNATURE
<i>J.P. O'Neill</i> |
|---|----------------------------------|

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE TO BE OPENED BY MEDICAL OFFICER ONLY.
 25. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

No change

b6
b7C

| | | |
|--|-------------------------|---------------------------------------|
| TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER | DATE
<i>12/18/96</i> | NUMBER OF ATTACHED SHEETS
<i>1</i> |
|--|-------------------------|---------------------------------------|

Memorandum



HQ

To : Director, FBI

Date 5/10/95

From : SAC, CHICAGO

Attention: Administrative Services Division
(1) Staffing & Pay Administration Unit
(2) Health Care Programs Unit

Subject: JOHN P. O'NEILL
 SPECIAL AGENT
 PHYSICAL EXAMINATION MATTER

Remylet _____
 ReBulet _____

- Re physical examination 1/12/95
 Dental work was completed on _____
 Vision has been corrected to 20/20 both eyes. Employee specifically instructed 2/1/95 by _____ R.N. that he/she can operate a Bureau car only when wearing the necessary glasses.
 Results of chest X ray patch test urinalysis serology were negative.
 Enclosed physician's statement indicates employee is: Qualified for strenuous physical exertion and use of firearms; Qualified for firearms, exclusive of defensive tactics. SAC concurs, Yes No. If answered no, explain under remarks.
 Future participation in firearms is remote and weapon will be returned to the Bureau.
 Enclosed are paid unpaid medical bills.
 Attached are Bureau of Employees' Compensation forms _____
 Time and attendance (T&A) records checked and showed employee was on _____ hours (check one: Continuation of Pay Annual Leave Sick Leave Leave Without Pay) at time employee sustained injury.
 (THIS MUST AGREE WITH CA-1). Enclosed is copy of T&A record.
 Physical examination reports are enclosed.
 Employee is scheduled for physical examination on _____
 Physical examination report has been reviewed and initialed.
 Employee returned to active duty _____
 Employee's physical condition is _____
 UACB he/she is being removed from limited duty.
 UACB he/she is being placed on limited duty.

If employee is a Resident Agent, is there a sufficient amount of nonarduous work available to keep him/her fully occupied and are sufficient agents available to handle emergency assignments. Yes No If answer is no, separately and immediately submit your recommendation for the return of this agent to headquarters city.

Remarks: ASAC O'NEILL is aware of the results of his physical. Per the examining doctor's recommendations he was advised to follow a low calorie, low fat, low cholesterol, high fiber diet to improve his lipid values and achieve his ideal weight. He was also encouraged to follow up with his personal physician if his cholesterol values do not improve.

1- Bureau
 1- Chicago
 SC/SSP
 (2)

Enclosure

b6
 b7c

REPORT OF MEDICAL EXAMINATION

| | | | | | | |
|--|---------------------|--|---|--|---|-----------------|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME
O'NEILL, JOHN P. | | | 2. GRADE AND COMPONENT POSITION
SPECIAL AGENT | | 3. IDENTIFICATION NO.
147-42-1004 | |
| 4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)
219 So. Dearborn Rm 905 Chgo. Ill. | | | 5. PURPOSE OF EXAMINATION
ANNUAL | | 6. DATE OF EXAMINATION
1/12/95 | |
| 7. SEX
M | 8. RACE
C | 9. TOTAL YEARS GOVERNMENT SERVICE | | 10. AGENCY
FBI | 11. ORGANIZATION UNIT
CHICAGO | |
| 12. DATE OF BIRTH
2/6/52 | | 13. PLACE OF BIRTH
on record | | 14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
on record | | |
| 15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS
GALTER LIFE CENTER, 5157 NO. FRANCISCO AVE. | | | | 16. OTHER INFORMATION | | |
| 17. RATING OR SPECIALTY
CHICAGO, ILLINOIS 60625 | | | | TIME IN THIS CAPACITY (Total) | | LAST SIX MONTHS |

CLINICAL EVALUATION

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

| NOR-MAL | (Check each item in appropriate column, enter "NE" if not evaluated.) | ABNOR-MAL |
|-------------------------------------|---|-----------|
| <input checked="" type="checkbox"/> | 18. HEAD, FACE, NECK AND SCALP | |
| <input checked="" type="checkbox"/> | 19. NOSE | |
| <input checked="" type="checkbox"/> | 20. SINUSES | |
| <input checked="" type="checkbox"/> | 21. MOUTH AND THROAT | |
| <input checked="" type="checkbox"/> | 22. EARS—GENERAL (INTERNAL CANALS) (Auditory acuity under items 70 and 71) | |
| <input checked="" type="checkbox"/> | 23. DRUMS (Perforation) | |
| <input checked="" type="checkbox"/> | 24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67) | |
| <input checked="" type="checkbox"/> | 25. OPHTHALMOSCOPIC | |
| <input checked="" type="checkbox"/> | 26. PUPILS (Equality and reaction) | |
| <input checked="" type="checkbox"/> | 27. OCULAR MOTILITY (Associated bilateral movements nystagmus) | |
| <input checked="" type="checkbox"/> | 28. LUNGS AND CHEST (Include breasts) | |
| <input checked="" type="checkbox"/> | 29. HEART (Thrust, size, rhythm, sounds) | |
| <input checked="" type="checkbox"/> | 30. VASCULAR SYSTEM (Varicosities, etc.) | |
| <input checked="" type="checkbox"/> | 31. ABDOMEN AND VISCERA (Include hernia) | |
| <input checked="" type="checkbox"/> | 32. ANUS AND RECTUM (Hemorrhoids, Fistular Prostate, if indicated) | |
| <input checked="" type="checkbox"/> | 33. ENDOCRINE SYSTEM | |
| <input checked="" type="checkbox"/> | 34. G-U SYSTEM | |
| <input checked="" type="checkbox"/> | 35. UPPER EXTREMITIES (Strength, range of motion) | |
| <input checked="" type="checkbox"/> | 36. FEET | |
| <input checked="" type="checkbox"/> | 37. LOWER EXTREMITIES (Except feet) (Strength, range of motion) | |
| <input checked="" type="checkbox"/> | 38. SPINE, OTHER MUSCULOSKELETAL | |
| <input checked="" type="checkbox"/> | 39. IDENTIFYING BODY MARKS, SCARS, TATTOOS | |
| <input checked="" type="checkbox"/> | 40. SKIN, LYMPHATICS | |
| <input checked="" type="checkbox"/> | 41. NEUROLOGIC (Equilibrium tests under item 72) | |
| <input checked="" type="checkbox"/> | 42. PSYCHIATRIC (Specify any personality deviation) | |
| | 43. PELVIC (Females only) (Check how done) | |
| | <input type="checkbox"/> VAGINAL <input checked="" type="checkbox"/> RECTAL | |

Reviewed by *Chicago office 3/2/95.*

and b6
b7c

AB
2/12/95

(Continue in item 73)

| | | | | | | | | | | | | | | | |
|--|----|--------------------------------------|----|----|---------------------------------|----|----|--|----|----|---|----|----|----|----|
| 44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.) | | | | | | | | | | | | | | | |
| 0
1 2 3 Restorable
32 31 30 Teeth | | 2 3 Non-restorable
32 31 30 teeth | | | 1 2 3 Missing
32 31 30 Teeth | | | x x x Replaced
1 2 3 by
x x x Dentures | | | 1 2 3 Fixed
32 31 30 Partial
x Dentures | | | | |
| U
32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 |
| L | E | F | T | | | | | | | | | | | | |

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

| | | | |
|---|---------|---|-----------------|
| 45. URINALYSIS: A. SPECIFIC GRAVITY | | 46. CHEST X-RAY (Place, date, film number and result) | |
| B. ALBUMIN | | C. MICROSCOPIC | |
| C. SUGAR | | | |
| 47. SEROLOGY (Specify test used and result) | 48. EKG | 49. BLOOD TYPE AND RH FACTOR | 50. OTHER TESTS |

MEASUREMENTS AND OTHER FINDINGS

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--------------------------------|-------------------------|--|--------------------------|--|--------------|--|--------------|--|--------------|--|--|--|
| 51. HEIGHT
6' 1/2" | | 52. WEIGHT
223 | | 53. COLOR
BROWN | | 54. COLOR EYES
HAZEL | | 55. BUILD:
<input type="checkbox"/> SLENDER <input type="checkbox"/> MED <input checked="" type="checkbox"/> HEAVY <input type="checkbox"/> OBESE | | | 56. TEMPERATURE
98.4 | | | | | | | | | | | | |
| 57. BLOOD PRESSURE (Arm at heart level) | | | | | | 58. BLOOD PRESSURE (Arm at heart level) | | | | | | | | | | | | | | | | | |
| A. SITTING
SYS. 138
DIAS. 88 | | B. RECUMBENT
SYS. 128
DIAS. 78 | | STANDING (5 min.)
SYS. 120
DIAS. 80 | | A. SITTING | | B. AFTER EXERCISE | | C. 2 MIN. | | D. RECUMBENT | | E. AFTER STANDING 3 MIN. | | | | | | | | | |
| 59. DISTANT VISION | | | | 60. REFRACTION | | | | 61. NEAR VISION | | | | | | | | | | | | | | | |
| RIGHT 20' | | CORR. TO 20' | | BY | | S. | | CX | | CORR. TO | | BY | | | | | | | | | | | |
| LEFT 20' | | CORR. TO 20' | | BY | | S. | | CX | | CORR. TO | | BY | | | | | | | | | | | |
| 62. HETEROPHORIA (Specify distance) | | | | | | | | | | | | | | | | | | | | | | | |
| ES° | | EX° | | R.H. | | L.H. | | PRISM DIV. | | PRISM CONV. CT | | PC | | PD | | | | | | | | | |
| 63. ACCOMMODATION | | | | 64. COLOR VISION (Test used and result) | | | | 65. DEPTH PERCEPTION (Test used and score) | | | | UNCORRECTED | | | | | | | | | | | |
| RIGHT | | | | LEFT | | | | | | | | CORRECTED | | | | | | | | | | | |
| 66. FIELD OF VISION | | | | 67. NIGHT VISION (Test used and score) | | | | 68. RED LENS TEST | | | | 69. INTRAOCULAR TENSION | | | | | | | | | | | |
| 70. HEARING | | | | 71. AUDIOMETER | | | | | | 72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score) | | | | | | | | | | | | | |
| RIGHT WV | | /15 SV | | /15 | | 250
256 | | 500
512 | | 1000
1024 | | 2000
2048 | | 3000
2896 | | 4000
4096 | | 6000
6144 | | 8000
8192 | | | |
| LEFT WV | | /15 SV | | /15 | | RIGHT | | | | | | | | | | | | | | | | | |
| | | | | | | LEFT | | | | | | | | | | | | | | | | | |
| 73 NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY | | | | | | | | | | | | | | | | | | | | | | | |

No significant medical or surgical problem since last exam.

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

No physical defects found.

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

See Summary sheet.

76. A. PHYSICAL PROFILE

| | | | | | |
|---|---|---|---|---|---|
| P | U | L | H | E | S |
| | | | | | |

77. EXAMINEE (Check)

A. IS QUALIFIED FOR **full duty.**
 B. IS NOT QUALIFIED FOR

B. PHYSICAL CATEGORY

| | | | |
|---|---|---|---|
| A | B | C | E |
| | | | |

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

79. TYPED OR PRINTED NAME OF PHYSICIAN

M.D.

SIGNATURE b6
b7c

30. TYPED OR PRINTED NAME OF PHYSICIAN

SIGNATURE

31. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)

SIGNATURE

32. TYPED OR PRINTED NAME OR REVIEWING OFFICER OR APPROVING AUTHORITY

SIGNATURE

NUMBER OF ATTACHED SHEETS



**Galter
LifeCenter**

A Swedish Covenant Hospital Affiliate

Noel D. Nequin, M.D.
Medical Director

SUMMARY OF PHYSICAL EXAMINATION RESULTS

Name: O'NEILL, JOHN P. Date of Exam: 1-12-95

MEDICAL HISTORY AND REVIEW OF SYSTEMS:

No significant abnormalities identified.
Comments:

PHYSICAL EXAMINATION ABNORMALITIES:

No significant abnormalities found.
Comments:

24 percent body fat indicates at least 18 lbs over desirable weight.

LABORATORY TEST RESULTS:

No significant abnormalities found.
Comments:

Abnormal lipid profile: total cholesterol of 213 mg (slightly high)
HDL of 35 mg is low. TC to HDL ratio is 6.0 (also high).
LDL of 157 mg is also elevated.

RECOMMENDATIONS:

We recommend stricter adherence to low-fat, low-cholesterol, high-fiber diet, along with some weight reduction. With these, expect some improvement in the abnormal lipid values. If they remain high, please have your physician evaluate need for drug therapy.

The ideal "preventive levels" for blood fats (lipids) are:

Total cholesterol - 160 mg or under.

HDL - as high as possible - will increase with endurance exercise.

TC/HDL ratio - below 4.0

LDL-cholesterol - under 130 mg.



b6
b7c



Swedish Covenant Hospital
 5145 N. California, Chicago, IL 60625
 (312) 878-8200
 Fax No. (312) 275-4950

DEPARTMENT OF LABORATORY MEDICINE
 J. B. McCormick M.D.
 L. E. Dardi M.D.
 P. Guariglia M.D.
 C. A. Mudd M.D., Consultant

PHYSICIANS MEDICAL LABORATORY
 PATIENT REPORT for
 LIFECENTER ON THE GREEN

PAGE 1

0117938 - O'NEILL, JOHN P PML CLOUT 42 M LIFECENTER ON THE GREEN

0112:CO051R - 661220 COMP COLL: 01/12/95 UNK RECD: 01/12/95 1210 LIFECENTER ON
 ORDERED: CHEM 23 , LIPID PROFILE

| [CHEM 23] | | | |
|------------|--------------|------|-----------------------|
| => | GLUCOSE | 87 | mg/dl (65-115) |
| => | BUN | 16 | mg/dl (7-23) |
| => | CREATININE | 1.0 | mg/dl (0.4-1.7) |
| => | SODIUM | 143 | mEq/L (135-147) |
| => | POTASSIUM | 5.1 | mEq/L (3.4-5.3) |
| => | CHLORIDE | 104 | mEq/L (96-108) |
| => | CO2 | 26 | mEq/L (22-32) |
| => | LYTE BALANCE | 13 | mEq/L (0-16) |
| => | URIC ACID | 7.0 | mg/dl (4.0-9.0) |
| => | CALCIUM | 10.2 | mg/dl (8.2-10.5) |
| => | PHOSPHOROUS | 3.5 | mg/dl (2.6-5.0) |
| => | IRON | 104 | mcg/dl (42-135) |
| => | CHOLESTEROL | | 213 H mg/dl (130-200) |
| => | TRIGLYCERIDE | 109 | mg/dl (65-250) |
| => | BILIRUBIN | 0.6 | mg/dl (0.2-1.2) |
| => | PROTEIN | 8.0 | G/dl (6.0-8.0) |
| => | ALBUMIN | 5.0 | G/dl (3.5-5.0) |
| => | CK | 75 | U/L (20-190) |
| => | LD | 146 | U/L (75-200) |
| => | SGOT/AST | 32 | U/L (5.0-50.0) |
| => | GGT | 65 | U/L (0-86) |
| => | HDL | 35 | mg/dl (30.0-70.0) |
| => | HDL RATIO | | 6.0 H RATIO (0-4.5) |
| => | % HDL | 16 | % |
| => | LDL | 157 | mg/dl (0-160.0) |
| => | VLDL | 21 | mg/dl |

| | DESIRABLE | BORDERLINE | HIGH |
|-------|-----------|------------|----------|
| CHOL: | UNDER 200 | 200-240 | OVER 240 |
| LDL: | UNDER 130 | 130-160 | OVER 160 |

GUIDELINES FOR TREATMENT BASED ON CHOLESTEROL AND LDL LEVELS IN ADULTS 20 YEARS OLD AND OVER. (MODIFIED NCEP EXPERT PANEL 1987).

Printed: 01/13/95 0637

O'NEILL, JOHN P

For Date: 01/12/95

Direct Phone Number for Lab Information: (312) 907-1003



Swedish Covenant Hospital
 5145 N. California, Chicago, IL 60625
 (312) 878-8200
 Fax No. (312) 275-4950

DEPARTMENT OF LABORATORY MEDICINE
 J. B. McCormick M.D.
 L. E. Dardi M.D.
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PHYSICIANS MEDICAL LABORATORY
 PATIENT REPORT for
 LIFECENTER ON THE GREEN

PAGE 2

0117938 - O'NEILL, JOHN P PML CLOUT 42 M LIFECENTER ON THE GREEN

0112:CI0020R - 661220 COMP COLL: 01/12/95 UNK RECD: 01/12/95 1210 LIFECENTER ON
 ORDERED: LOGIC-TSH

** THYROID LOGIC PROFILE **
 => TSH

0.63 uIU/ml (0.35-6.00)

 INTERPRETIVE TABLE FOR THYROID LOGIC PROFILE

TSH Normal-----Euthyroid

TSH Low plus:

Free T4 Raised-----Hyperthyroidism
 Free T4 Normal, T3 Raised-----T3 Thyrotoxicosis
 Free T4 Normal, T3 Normal--Subclinical Hyperthyroidism
 Free T4 Low-----Secondary Hypothyroidism

TSH High plus:

Free T4 Low-----Hypothyroidism
 Free T4 Normal-----Subclinical Hypothyroidism
 Recovery from severe illness
 Free T4 Raised-----Secondary Hyperthyroidism

NOTE: There are exceptions to these selected
 interpretations, especially with
 hospitalized patients. If results do
 not correlate with clinical impression
 further investigation may be needed.

0112:H0108R - 661220 COMP COLL: 01/12/95 UNK RECD: 01/12/95 1210 LIFECENTER ON
 ORDERED: CBC

| | | | |
|-------------------|------|--------|----------------------|
| [CBCND] | | | |
| => WBC | 5.64 | | 1000/uL (4.50-11.00) |
| => RBC | 5.10 | | Mil/uL (4.50-6.00) |
| => HEMOGLOBIN | 16.1 | | G/dl (14.0-18.0) |
| => HEMATOCRIT | 49.0 | | % (40.0-54.0) |
| => MCV | | 96.0 H | fL (80.0-94.0) |
| => MCH | | 31.6 H | pg (27.0-31.0) |
| => MCHC | 32.9 | | G/dl (32.0-36.0) |
| => RDW | 12.6 | | % (11.5-14.5) |
| => PLATELET COUNT | 392 | | 1000/uL (130-500) |

Printed: 01/13/95 0637

O'NEILL, JOHN P

For Date: 01/12/95

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PHYSICIANS MEDICAL LABORATORY
 PATIENT REPORT for
 LIFECENTER ON THE GREEN

PAGE 3

0117938 - O'NEILL, JOHN P PML CLOUT 42 M LIFECENTER ON THE GREEN

0112:H0108R (continued)

| [DIFF] | | | |
|--------|------|------|---------------|
| => | NEUT | 61.2 | % (40.0-74.0) |
| => | LYMP | 28.0 | % (19.0-48.0) |
| => | MONO | 5.6 | % (3.4-9.0) |
| => | EO | 2.2 | % (0-7) |
| => | BASO | 0.5 | % (0-1.5) |
| => | LUC | 2.5 | % (0-4.0) |

0112:U0024R - 661220 CMP COLL: 01/12/95 UNK RECD: 01/12/95 1210 LIFECENTER ON
 ORDERED: UA

| [UA] | | | |
|------|-----------------|--------|----------------|
| => | COLOR | YELLOW | |
| => | APPEARANCE | CLEAR | |
| => | GLUCOSE | NEG | NEGATIVE |
| => | BILIRUBIN | NEG | NEGATIVE |
| => | KETONE | NEG | NEGATIVE |
| => | SPECIFIC GRAVIT | 1.030 | (1.003-1.035) |
| => | BLOOD | NEG | NEGATIVE |
| => | PH | 5.0 | (5-8) |
| => | PROTEIN | NEG | NEGATIVE |
| => | UROBILINOGEN | 0.2 | EU/L (0.0-0.2) |
| => | NITRITE | NEG | NEGATIVE |
| => | LEUKOCYTE EST | NEG | NEGATIVE |

Printed: 01/13/95 0637

O'NEILL, JOHN P

For Date: 01/12/95

Direct Phone Number for Lab Information: (312) 907-1003

** END OF PATIENT REPORT **

NAME:

ONEIL JOHN

DATE:

1-12-95

VISION

WITHOUT CORRECTIVE LENSES

WITH CORRECTIVE LENSES

| | DISTANT | NEAR |
|-------|---------|-------|
| RIGHT | 40/20 | 40/20 |
| LEFT | 30/20 | 30/20 |

| | DISTANT | NEAR |
|--|---------|-------|
| | 20/20 | 20/20 |
| | 20/20 | 20/20 |

COLOR: ACCEPTABLE

TONOMETRY: (RIGHT): 20

(LEFT): 19

HEARING

| | 500 | 1000 | 2000 | 3000 | 4000 | 6000 | 8000 |
|-------|-----|------|------|------|------|------|------|
| LEFT | 10 | 0 | 5 | 20 | 30 | 30 | 35 |
| RIGHT | 5 | 5 | 10 | 10 | 25 | 25 | 20 |

COMMENTS:

LEFT EAR: normal hearing sensitivity to 3kHz, with a mild loss @ higher frequencies

RIGHT EAR: Hearing sensitivity WNL.

RECOMMEND: WEAR HEARING PROTECTION WHEN POSSIBLE



alt

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ALL AUDIOMETRIC THRESHOLDS ARE IN dBHL ACCORDING TO ANSI - 1969 STANDARDS

Galter LifeCenter

eight Management Program:
ember Re-test:
sted by:

ame: JOHN O'NEILL Date: 1/12/95
ge: 42 Height: 6'0 1/2" Weight: 223

in Folds:

Men: Chest 23 Thigh 31 Illium 12 Abdomen 31.5 Tricep 21.5 Scapula 21

Women: Thigh Illium Abdomen Tricep Scapula

Results

With the skinfold method, we have calculated your body fat to be 24 percent. Based on the upper limit of 24 % for men, and 22 % for women, your desirable weight should be 205 lbs. At your present weight, 223 lbs., you are at least 18 lbs. over the desired weight.

 Congratulations! Your percent body fat is within the desired upper limits. Keep up the good work!

The body has two basic components: (1) body fat and (2) lean body weight. When the weight of the body fat is subtracted from the total body weight, the remaining portion is called lean body weight. Lean body weight includes the skeletal muscle mass, organs, and other tissues such as bone and skin.

The recommended upper limit of percent body fat for men is 16 percent, and for women 22 percent. Measurements higher than these limits are associated with obesity, a significant health risk factor frequently associated with hypertension, diabetes, coronary artery disease, and other forms of arteriosclerosis.

There are three common methods to determine percent body fat: (1) the skin fold method, (2) the hydrostatic or underwater weighing method, and (3) electrical impedance method.

The skinfold method is the simplest and least expensive of the three methods. The hydrostatic weighing method requires a specially-designed water tank and numerous measurements while the subject is submerged in water. The electrical impedance method is a computerized method that is closely comparable to the other two methods, and is frequently reproducible.

NOTE: The best way to reduce excessive body fat is to combine a lowfat diet with regular endurance-type aerobic exercise. The staff of the Galter LifeCenter will be happy to review your current exercise program with you or refer you to nutritional guidelines.

DESIRABLE WEIGHT RANGES

| MALES | | | | FEMALES | | | |
|--------|-------------|--------------|-------------|---------|-------------|--------------|-------------|
| Height | Small Frame | Medium Frame | Large Frame | Height | Small Frame | Medium Frame | Large Frame |
| 5'4" | 117 - 138 | 123 - 149 | 131 - 163 | 5'0" | 96 - 114 | 101 - 124 | 109 - 138 |
| 5'5" | 120 - 142 | 126 - 153 | 134 - 167 | 5'1" | 99 - 118 | 104 - 128 | 112 - 141 |
| 5'6" | 124 - 146 | 130 - 157 | 138 - 173 | 5'2" | 102 - 121 | 107 - 131 | 115 - 144 |
| 5'7" | 128 - 151 | 134 - 163 | 143 - 178 | 5'3" | 105 - 124 | 110 - 135 | 118 - 149 |
| 5'8" | 132 - 155 | 138 - 167 | 147 - 183 | 5'4" | 108 - 128 | 113 - 139 | 121 - 152 |
| 5'9" | 136 - 161 | 142 - 172 | 151 - 187 | 5'5" | 111 - 132 | 117 - 144 | 125 - 156 |
| 5'10" | 140 - 165 | 146 - 177 | 155 - 193 | 5'6" | 114 - 135 | 120 - 149 | 129 - 161 |
| 5'11" | 144 - 169 | 150 - 183 | 160 - 198 | 5'7" | 118 - 140 | 124 - 153 | 133 - 165 |
| 6' | 148 - 174 | 154 - 188 | 164 - 204 | 5'8" | 122 - 144 | 128 - 157 | 137 - 169 |
| 6'1" | 152 - 179 | 158 - 194 | 169 - 209 | 5'9" | 126 - 149 | 132 - 162 | 141 - 174 |
| 6'2" | 156 - 184 | 163 - 199 | 174 - 215 | 5'10" | 130 - 154 | 136 - 166 | 145 - 179 |
| 6'3" | 160 - 188 | 168 - 205 | 178 - 220 | 5'11" | 134 - 158 | 140 - 171 | 149 - 185 |
| 6'4" | 169 - 198 | 178 - 216 | 188 - 231 | 6'0" | 138 - 163 | 144 - 175 | 153 - 190 |
| 6'5" | 174 - 204 | 182 - 222 | 192 - 238 | | | | |

6-1/2 - 205-

4. Examinee's frame is small medium large
5. Considering the above weight table, the examinee's frame, and other individual physical characteristics, I consider his/her present weight Satisfactory Excessive Deficient
6. Under proper medical supervision, employee should lose _____ pounds
 gain _____ pounds

Remarks: _____

[Signature Box]

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Examiner

1-12-95

Date

SA MEDICAL REPORTS
Personnel File of: ONEILL, JOHN P
Personnel File No. 67-679605

147-42-1004

MEDICAL RECORD

NURSING NOTES

(Sign all notes)

| DATE | HOUR | | OBSERVATIONS
Include medication and treatment when indicated |
|---------|------|------|---|
| | A.M. | P.M. | |
| 7/2/96 | 11 | 10 | TA 0.5cc (R) delta 4
ID 2cc (R) delta 42 4112 8/11/96
[redacted] 1/17/97
[redacted] LH |
| 9/19/96 | | | Received phone call informing
NSU that Mr. O'Neill will be
traveling to Saudi 11/29 - 29, 1996.
Will be inserted during entire trip.
Large city, no disinfection &
[redacted] - no need to administer
Immune Globulin since conditions
& destination are environmentally
controlled for sanitation ^{NO DICK}
Suggest Hep A + B series upon return. ^{epidemic}
- kitchen counter
IG offered, but not necessary |

b6
b7c

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility) REGISTER NO. WARD NO.

NURSING NOTES
Medical Record

O'Neill, John P.
147-42-1004

645 06/28 '96 11:34 ID:CENTEON LLC

610 878 4100

PAGE 2

Michael A. Balady, Ph.D.
Vice President
Worldwide Quality Assurance



Centeon
1020 First Avenue
King of Prussia, PA
19406-1310

810 878-4048
610 878-4182 Fax

URGENT WITHDRAWAL NOTICE

June 24, 1996

**SUBJECT: IMMUNE GLOBULIN (HUMAN) U.S.P., [GAMMAR®]
Rho(D) IMMUNE GLOBULIN (HUMAN), [GAMULIN®Rh]**

Dear Colleague:

Centeon L.L.C. has initiated a voluntary withdrawal of certain lots of its immune globulin products that were manufactured after December 27, 1994. The products being withdrawn bear an Armour Pharmaceutical label. This action is being taken as a precautionary measure in response to the June 13, 1996 letter from the United States Food and Drug Administration (FDA) to all manufacturers of immune globulins for intramuscular administration (Attachment A). In this letter, FDA announced that it recently modified its testing procedure for the detection of Hepatitis C virus ribonucleic acid (HCV-RNA) by Polymerase Chain Reaction (PCR2). Although the FDA states that the new PCR2 test is more sensitive, the FDA also stated that transmission of HCV by products such as Gammar® and Gamulin®Rh has not been documented and that available epidemiologic evidence does not support such transmissions.

This voluntary withdrawal involves all in-date lots of Gammar® and Gamulin®Rh. No other Armour products are affected by this notification.

The product and affected lot numbers subject to this withdrawal are listed in Attachment B.

We request that you inform your customers immediately of this withdrawal. Additionally, we have enclosed a health care provider letter to be disseminated by you to the end user of these products.

Please examine your inventories of Gammar® and Gamulin®Rh. If you have any inventory of Gammar® and Gamulin®Rh lots listed on Attachment B, immediately cease their distribution and use and take the following actions:

URGENT WITHDRAWAL LETTER

June 24, 1996

Page 2

- Complete and return the enclosed *postcard* indicating whether or not you have inventory for Gammar® and Gamulin® Rh.
- Complete the *Returned Goods Form*. Use the enclosed *mailing label* and return the completed *Returned Goods Form* and all affected lots of Gammar® and Gamulin® Rh to the following address:

Rhône-Poulenc Rorer (RPR)
Distribution Center
ATTN: *Returned Goods Processing*
18504 West Creek Drive
Tinley Park IL 60477

Completion of this form will expedite the processing of your credit. Please be advised that customers will be credited for product returned and shipping for only those lot numbers listed in Attachment B. There will be no credit given for returns of any other product you have in your inventory or returned by your customers. If you have any questions concerning product returns, please call 1-800-201-3960.

Please note that this voluntary action by Centeon L.L.C. is being conducted with the knowledge of the U.S. Food and Drug Administration.

Thank you for your cooperation in this matter.

Sincerely,

[Redacted Signature]

[Redacted Name] Worldwide Quality Assurance

MAB/phm

Attachments

b6
b7C

REPORT OF MEDICAL EXAMINATION

| | | | | | | |
|---|---------------------|--|--|--|---|--|
| 1. LAST NAME—FIRST NAME—MIDDLE NAME
O'NEILL, JOHN P. | | | 2. GRADE AND COMPONENT
SPECIAL AGENT | | 3. IDENTIFICATION NO.
147-42-1004 | |
| 4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)
219 So. Dearborn Rd 905 Chgo. Ill. | | | 5. PURPOSE OF EXAMINATION
ANNUAL | | 6. DATE OF EXAMINATION
1/12/95 | |
| 7. SEX
M | 8. RACE
C | 9. TOTAL YEARS GOVERNMENT SERVICE
MILITARY _____ CIVILIAN _____ | | 10. AGENCY
FBI | 11. ORGANIZATION UNIT
CHICAGO | |
| 12. DATE OF BIRTH
2/6/52 | | 13. PLACE OF BIRTH
on record | | 14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
on record | | |
| 15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS
GALTER LIFE CENTER, 5157 NO. FRANCISCO AVE.
CHICAGO, ILLINOIS 60625 | | | | 16. OTHER INFORMATION | | |
| 17. RATING OR SPECIALTY | | | TIME IN THIS CAPACITY (Total) | | LAST SIX MONTHS | |

CLINICAL EVALUATION

| NOR-
MAL | (Check each item in appropriate column, enter "NE" if not evaluated.) | ABNOR-
MAL |
|-------------------------------------|---|---------------|
| <input checked="" type="checkbox"/> | 18. HEAD, FACE, NECK AND SCALP | |
| <input checked="" type="checkbox"/> | 19. NOSE | |
| <input checked="" type="checkbox"/> | 20. SINUSES | |
| <input checked="" type="checkbox"/> | 21. MOUTH AND THROAT | |
| <input checked="" type="checkbox"/> | 22. EARS—GENERAL (INTERNAL CANALS) (Auditory acuity under items 70 and 71) | |
| <input checked="" type="checkbox"/> | 23. DRUMS (Perforation) | |
| <input checked="" type="checkbox"/> | 24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67) | |
| <input checked="" type="checkbox"/> | 25. OPHTHALMOSCOPIC | |
| <input checked="" type="checkbox"/> | 26. PUPILS (Equality and reaction) | |
| <input checked="" type="checkbox"/> | 27. OCULAR MOTILITY (Associated parallel movements nystagmus) | |
| <input checked="" type="checkbox"/> | 28. LUNGS AND CHEST (Include breasts) | |
| <input checked="" type="checkbox"/> | 29. HEART (Thrust, size, rhythm, sounds) | |
| <input checked="" type="checkbox"/> | 30. VASCULAR SYSTEM (Varicosities, etc.) | |
| <input checked="" type="checkbox"/> | 31. ABDOMEN AND VISCERA (Include hernia) | |
| <input checked="" type="checkbox"/> | 32. ANUS AND RECTUM (Hemorrhoids, Fistular) (Prostate, if indicated) | |
| <input checked="" type="checkbox"/> | 33. ENDOCRINE SYSTEM | |
| <input checked="" type="checkbox"/> | 34. G-U SYSTEM | |
| <input checked="" type="checkbox"/> | 35. UPPER EXTREMITIES (Strength, range of motion) | |
| <input checked="" type="checkbox"/> | 36. FEET | |
| <input checked="" type="checkbox"/> | 37. LOWER EXTREMITIES (Except feet) (Strength, range of motion) | |
| <input checked="" type="checkbox"/> | 38. SPINE, OTHER MUSCULOSKELETAL | |
| <input checked="" type="checkbox"/> | 39. IDENTIFYING BODY MARKS, SCARS, TATTOOS | |
| <input checked="" type="checkbox"/> | 40. SKIN, LYMPHATICS | |
| <input checked="" type="checkbox"/> | 41. NEUROLOGIC (Equilibrium tests under item 72) | |
| <input checked="" type="checkbox"/> | 42. PSYCHIATRIC (Specify any personality deviation) | |
| | 43. PELVIC (Females only) (Check how done) | |
| | <input type="checkbox"/> VAGINAL <input checked="" type="checkbox"/> RECTAL | |

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

Reviewed by
Chicago office 3/2/95

6-7-95
Reviewed by

b6
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2/11/95

(Continue in item 73)

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <p>44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)</p> <table style="width:100%; font-size: small;"> <tr> <td style="text-align: center;"> <table style="margin: auto;"> <tr><td>0</td><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td><td></td></tr> <tr><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td></tr> </table> </td> <td style="text-align: center;"> <table style="margin: auto;"> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </table> </td> <td style="text-align: center;"> <table style="margin: auto;"> <tr><td>x</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </table> </td> <td style="text-align: center;"> <table style="margin: auto;"> <tr><td>x</td><td>x</td><td>x</td></tr> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td>x</td><td>x</td><td>x</td></tr> </table> </td> <td style="text-align: center;"> <table style="margin: auto;"> <tr><td>x</td><td>x</td><td>x</td></tr> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td>x</td><td>x</td><td>x</td></tr> </table> </td> <td style="text-align: center;"> <table style="margin: auto;"> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </table> </td> </tr> </table> | <table style="margin: auto;"> <tr><td>0</td><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td><td></td></tr> <tr><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td></tr> </table> | 0 | 1 | 2 | 3 | 32 | 31 | 30 | | | | | | | | | | <table style="margin: auto;"> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </table> | 1 | 2 | 3 | 32 | 31 | 30 | | | | | | | <table style="margin: auto;"> <tr><td>x</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </table> | x | 2 | 3 | 32 | 31 | 30 | | | | | | | <table style="margin: auto;"> <tr><td>x</td><td>x</td><td>x</td></tr> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td>x</td><td>x</td><td>x</td></tr> </table> | x | x | x | 1 | 2 | 3 | 32 | 31 | 30 | x | x | x | <table style="margin: auto;"> <tr><td>x</td><td>x</td><td>x</td></tr> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td>x</td><td>x</td><td>x</td></tr> </table> | x | x | x | 1 | 2 | 3 | 32 | 31 | 30 | x | x | x | <table style="margin: auto;"> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </table> | 1 | 2 | 3 | 32 | 31 | 30 | | | | | | | <p>REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES</p> |
| <table style="margin: auto;"> <tr><td>0</td><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td><td></td></tr> <tr><td></td><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td><td></td></tr> </table> | 0 | 1 | 2 | 3 | 32 | 31 | 30 | | | | | | | | | | <table style="margin: auto;"> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </table> | 1 | 2 | 3 | 32 | 31 | 30 | | | | | | | <table style="margin: auto;"> <tr><td>x</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </table> | x | 2 | 3 | 32 | 31 | 30 | | | | | | | <table style="margin: auto;"> <tr><td>x</td><td>x</td><td>x</td></tr> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td>x</td><td>x</td><td>x</td></tr> </table> | x | x | x | 1 | 2 | 3 | 32 | 31 | 30 | x | x | x | <table style="margin: auto;"> <tr><td>x</td><td>x</td><td>x</td></tr> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td>x</td><td>x</td><td>x</td></tr> </table> | x | x | x | 1 | 2 | 3 | 32 | 31 | 30 | x | x | x | <table style="margin: auto;"> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </table> | 1 | 2 | 3 | 32 | 31 | 30 | | | | | | | | |
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| x | x | x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| LABORATORY FINDINGS | | | |
|---|----------------|---|-----------------|
| 45. URINALYSIS: A. SPECIFIC GRAVITY | | 46. CHEST X-RAY (Place, date, film number and result) | |
| B. ALBUMIN | D. MICROSCOPIC | | |
| C. SUGAR | | | |
| 47. SEROLOGY (Specify test used and result) | 48. EKG | 49. BLOOD TYPE AND RH FACTOR | 50. OTHER TESTS |

MEASUREMENTS AND OTHER FINDINGS

| | | | | | | | | | | |
|---|--------------------------------------|--|-------------------------|---|-------------------------|--------------|--------------|--|--------------|--------------|
| 51. HEIGHT
6' 1/2" | 52. WEIGHT
223 | 53. COLOR HAIR
BROWN | 54. COLOR EYES
HAZEL | 55. BUILD:
<input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM <input checked="" type="checkbox"/> HEAVY <input type="checkbox"/> OBESE | 56. TEMPERATURE
98.4 | | | | | |
| 57. BLOOD PRESSURE (Arm at heart level) | | | 58. PULSE (Heart level) | | | | | | | |
| A. SITTING
SYS. 138
DIAS. 88 | B. RECUMBENT
SYS. 128
DIAS. 78 | C. STANDING (5 min.)
SYS. 120
DIAS. 80 | A. SITTING | B. AFTER EXERCISE | C. [REDACTED] | | | | | |
| 59. DISTANT VISION | | 60. REFRACTION | | 61. NEAR VISION | | | | | | |
| RIGHT 20/ | CORR. TO 20/ | BY | S. | CX | CORR. TO BY | | | | | |
| LEFT 20/ | CORR. TO 20/ | BY | S. | CX | CORR. TO BY | | | | | |
| 62. HETEROPHORIA (Specify distance) | | | | | | | | | | |
| ES* | EX* | R.H. | L.H. | PRISM DIV. | PRISM CONV. CT | | | | | |
| 63. ACCOMMODATION | | 64. COLOR VISION (Test used and result) | | 65. DEPTH PERCEPTION (Test used and score) | | | | | | |
| RIGHT | LEFT | | | UNCORRECTED | CORRECTED | | | | | |
| 66. FIELD OF VISION | | 67. NIGHT VISION (Test used and score) | | 68. RED LENS TEST | | | | | | |
| 69. INTRAOCULAR TENSION | | | | | | | | | | |
| 70. HEARING | | 71. AUDIOMETER | | | | | | 72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score) | | |
| RIGHT WV | /15 SV | /15 | 250
256 | 500
512 | 1000
1024 | 2000
2048 | 3000
2896 | 4000
4096 | 6000
6144 | 8000
8192 |
| LEFT WV | /15 SV | /15 | RIGHT | | | | | | | |
| | | | LEFT | | | | | | | |
| 73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY | | | | | | | | | | |

No significant medical or surgical problem since last exam.

(Use additional sheets if necessary)

| | | | | | | | | | | |
|---|---|---|---|---|---|--|--|--|--|--|
| 74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers) | | | | | | | | | | |
| No physical defects found. | | | | | | | | | | |
| 75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify) | | | | | | | | | | |
| See Summary sheet. | | | | | | | | | | |
| 76. A. PHYSICAL PROFILE | | | | | | | | | | |
| P | U | L | H | E | S | | | | | |
| | | | | | | | | | | |
| 77. EXAMINEE (Check) | | | | | | | | | | |
| A. <input checked="" type="checkbox"/> IS QUALIFIED FOR full duty. | | | | | | | | | | |
| B. <input type="checkbox"/> IS NOT QUALIFIED FOR | | | | | | | | | | |
| 78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER | | | | | | | | | | |
| A | B | C | E | | | | | | | |
| | | | | | | | | | | |

| | | | | | | | | | | | |
|---|--|--|--|-----------|------------|--|--|---------------------------|--|--|--|
| 79. TYPED OR PRINTED NAME OF PHYSICIAN | | | | SIG | [REDACTED] | | | | | | |
| 30. TYPED OR PRINTED NAME OF PHYSICIAN | | | | SIG | [REDACTED] | | | | | | |
| 31. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which) | | | | SIGNATURE | | | | | | | |
| 32. TYPED OR PRINTED NAME OR REVIEWING OFFICER OR APPROVING AUTHORITY | | | | SIGNATURE | | | | NUMBER OF ATTACHED SHEETS | | | |

b6
b7c

**FITNESS FOR DUTY PHYSICAL EXAM CHECKLIST FOR
SPECIAL AGENTS/ELECTRONICS TECHNICIANS/AUTOMOTIVE TECHNICIANS**

NAME John P. O'Neill FBIHQ/FIELD OFFICE Chicago
POSITION A.S.A.C.
D.O.B. 2/6/52 D.O.P. 1/12/95 S.S.N. 147-42-1004

Please place a check mark before each item to ensure completeness of physical. If any items/tests are omitted, obtain results before submitting to FBIHQ. Send a completed FD-277, checklist, and the original physical exam report to the Fitness-for-Duty, Health Care Programs Unit, Room 6344.

REPORT OF MEDICAL HISTORY (SF-88)

- Questions 1 through 16 (by employee)
- Section 18 through 42 (by physician)
- # 48 EKG with interpretation
- # 52 Weight
- # 57 Blood pressure
- # 59 Distant Vision (corr. & uncorr.)
- # 61 Near Vision (corr. & uncorr.)
- # 64 Color Vision (type & test results)
- # 69 Intraocular Tension (IOT)
- # 71 Audiometer-(500hz-8000hz)
- # 77 (Signed by examiner)

REPORT OF MEDICAL HISTORY (SF-93)

- Completed by examinee

FORMS FD-300

- Completed & signed by examiner

TESTS DONE BASED ON AN OCCUPATIONAL EXPOSURE

- N/A Pulmonary Function Test
- N/A Chest x-ray
- N/A Blood Lead Level (when specifically requested by FBI for at risk personnel only)

LABORATORY TESTS

- Urinalysis
- CBC
- Blood Chemistry
- Thyroid Test T-4
- Stool for occult blood (3 slides)

OTHER TESTS

- N/A Exercise Stress Test
- N/A Spect Thallium or stress echocardiogram
- *Give only if abnormal stress test

OPTIONAL INJECTIONS

- Mantoux T.B. Test (Note results on SF-88 # 50 recommend but not mandatory)
- Hepatitis vaccine (at risk personnel only)
- Tetanus Diphtheria (only for specific individuals identified by FBI office being served)

b6
b7c

REVIEWED BY

DATE:

REVISD 6/6/94



TITLE:

Occupational Health Nurse

FEDERAL BUREAU OF INVESTIGATION

Precedence: ROUTINE

Date: 1/20/2000

To: Director, FBI

Att: COMPENSATION UNIT, RM 1008

From: SAC, NEWARK

Handwritten initials

Contact: [Redacted]

ext. 3100

Approved By: [Redacted]

b6
b7c

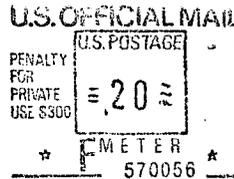
Drafted By: [Redacted]

Case ID #: 020765233

Title: JOHN P ONEILL
SPECIAL AGENT

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

P O BOX 566
NEW YORK NY 10014-0566



Official Business
Penalty for Private Use. \$300

US DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVSTGTN
GATEWAY ONE MARKET ST
PO BOX 1158
NEWARK NJ 07101

CASE NO: 020765233

EMPLOYEE: J P ONEILL

Form CA-89 Rev 9/92 AGENCY: 1502NK

INJURY DATE: 06/01/1992

- 1-Bureau
- 1-Newark(67-O'Neill)
- 1- MJR/qtm
- (2)

~~CONFIDENTIAL~~

FILE & MEDICAL FOLDER
B/you



MEMORANDUM

Dec 4 1 13 PM '00

To: Director, FBI

Date: 11/07/2000

From: ADIC, New York *Burmlagee*Subject: John O'Neill
Special Agent in Charge
Physical Examination Remylet _____ Rebulet _____

- Re Physical examination 06/30/2000
- Dental work was completed on _____
- Vision has been corrected to 20/20 both eyes
Employee specifically instructed on 8/30/2000 by _____ RN
that he/she can operate a Bureau car only when wearing the necessary glasses.
- Results of chest x-ray patch test urinalysis Serology were negative.
- Enclosed physician's statement indicates employee is:
 Qualified for strenuous physical exertion and use of Firearms. Qualified
for firearms, exclusive of defensive tactics. SAC concurs, Yes No. If
answered no, explain under remarks.
- Future participation in firearms is remote and weapon will be returned to the Bureau.
- Enclosed are paid unpaid medical bills.
- Attached are Bureau of Employees' Compensation forms _____
- Time and attendance (T&A) records checked and showed employee was on _____
hours (check one: Continuation of Pay Annual Leave Sick Leave
Leave Without Pay) at time employee sustained injury.
- (THIS MUST AGREE WITH CA-1).** Enclosed is copy of T&A record.
- Physical examination reports are enclosed.
- Employee is scheduled for physical examination on _____
- Physical examination report has been reviewed and initialed.
- Employee returned to active duty _____
- Employee's physical condition is _____
- UACB he/she is being continued on medical mandate.
- UACB he/she is being removed from medical mandate.
- If employee is a Resident Agent, is there a sufficient amount of nonarduous work available to keep him/her fully occupied and are sufficient agents available to handle emergency assignments. Yes No If answer is no, separately and immediately submit your recommendation for the return of this agent to headquarters city.**

b6
b7c1 - Bureau
1 - New York
Enclosures
AFN:alv

#42

REMARKS:

HT: 6'-1/2"

WT: 233 lbs.

FRAME:

DES:

PHYSICAL EXAMINATION REFLECTS:

Physical examination reviewed and copy sent to SAC.

Physical reflects normal labs and all labs and EKG within normal limits.

P.P.D. - Negative - "0" mm induration.

P.E. - co-initialed by HSU nurse RN.

b6
b7c

MEDICAL RECORD

REPORT OF MEDICAL EXAMINATION

DATE OF EXAM
6/30/00

1. LAST NAME-FIRST NAME-MIDDLE NAME: O'Neill, John P.
 2. IDENTIFICATION NUMBER: 147-42-1004
 3. GRADE AND COMPONENT OR POSITION

4. HOME ADDRESS (Number, street or RFD, city or town, state and ZIP code)
 5. EMERGENCY CONTACT (Name and address of contact)
 b6
 b7c

6. DATE OF BIRTH: 2/6/52
 7. AGE: 48
 8. SEX: FEMALE MALE
 9. RELATIONSHIP OF CONTACT

10. PLACE OF BIRTH: VENTNOR, NJ
 11. RACE: WHITE BLACK AMERICAN INDIAN/ALASKA NATIVE HISPANIC WHITE HISPANIC BLACK ASIAN/PACIFIC ISLANDER

12a. AGENCY: FBI
 12b. ORGANIZATION UNIT: New York Office
 13. TOTAL YEARS GOVERNMENT SERVICE:
 a. MILITARY
 b. CIVILIAN: 30

14. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS
 15. RATING OR SPECIALTY OF EXAMINER

16. PURPOSE OF EXAMINATION

17. CLINICAL EVALUATION

| NOR-MAL | (Check each item in appropriate column, enter "NE" if not evaluated.) | ABNOR-MAL | NOR-MAL | (Check each item in appropriate column, enter "NE" if not evaluated.) | ABNOR-MAL |
|-------------------------------------|--|-----------|-------------------------------------|---|-------------------|
| <input checked="" type="checkbox"/> | A. HEAD, FACE, NECK AND SCALP | | <input checked="" type="checkbox"/> | O. PROSTATE (Over 40 or clinically indicated) | |
| <input checked="" type="checkbox"/> | B. EARS-GENERAL (INTERNAL CANALS)
(Auditory acuity under items 39 and 40) | | <input checked="" type="checkbox"/> | P. TESTICULAR | |
| <input checked="" type="checkbox"/> | C. DRUMS (Perforation) | | <input checked="" type="checkbox"/> | Q. ANUS AND RECTUM (Hemorrhoids, Fistulae) (Hemocult Results) | |
| <input checked="" type="checkbox"/> | D. NOSE | | <input checked="" type="checkbox"/> | R. ENDOCRINE SYSTEM | <u>Guaranteed</u> |
| <input checked="" type="checkbox"/> | E. SINUSES | | <input checked="" type="checkbox"/> | S. G-U SYSTEM | |
| <input checked="" type="checkbox"/> | F. MOUTH AND THROAT | | <input checked="" type="checkbox"/> | T. UPPER EXTREMITIES (Strength, range of motion) | |
| <input checked="" type="checkbox"/> | G. EYES-GENERAL (Visual acuity and refraction under items 28, 29, and 36) | | <input checked="" type="checkbox"/> | U. FEET | |
| <input checked="" type="checkbox"/> | H. OPHTHALMOSCOPIC | | <input checked="" type="checkbox"/> | V. LOWER EXTREMITIES (Except feet) (Strength, range of motion) | |
| <input checked="" type="checkbox"/> | I. PUPILS (Equality and reaction) | | <input checked="" type="checkbox"/> | W. SPINE, OTHER MUSCULOSKELETAL | |
| <input checked="" type="checkbox"/> | J. OCULAR MOTILITY (Associated parallel movements nystagmus) | | <input checked="" type="checkbox"/> | X. IDENTIFYING BODY MARKS, SCARS, TATTOOS | |
| <input checked="" type="checkbox"/> | K. LUNGS AND CHEST | | <input checked="" type="checkbox"/> | Y. SKIN, LYMPHATICS | |
| <input checked="" type="checkbox"/> | L. HEART (Thrust, size, rhythm, sounds) | | <input checked="" type="checkbox"/> | Z. NEUROLOGIC (Equilibrium tests under item 41) | |
| <input checked="" type="checkbox"/> | M. VASCULAR SYSTEM (Varicosities, etc.) | | <input checked="" type="checkbox"/> | AA. PSYCHIATRIC (Specify any personality deviation) | |
| <input checked="" type="checkbox"/> | N. ABDOMEN AND VISCERA (Include hernia) | | <input checked="" type="checkbox"/> | BB. BREASTS | |
| | | | <input checked="" type="checkbox"/> | CC. PELVIC (Females only) | |

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 42 and use additional sheets if necessary)

18. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

| Upper Teeth | | | | | | | | | | | | Lower Teeth | | | | | | REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES | | |
|-------------|---|---|------------|---|---|---|----------------------|---|---|---|---------------|-------------|---|---|----------------------|---|---|--|---|------------------------|
| 1 | 2 | 3 | Restorable | 1 | 2 | 3 | Non-restorable teeth | 1 | 2 | 3 | Missing Teeth | X | X | X | Replaced by Dentures | 1 | 2 | | 3 | Fixed Partial Dentures |
| | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |

R I G H T L E F T

19. TEST RESULTS (Copies of results are preferred as attachments)

| | | | |
|--|--------|---|----------------|
| A. URINALYSIS: (1) SPECIFIC GRAVITY | | B. CHEST X-RAY OR PPD (Place, date, film number and result) | |
| (2) URINE ALBUMIN | | (4) MICROSCOPIC | |
| (3) URINE SUGAR | | | |
| C. SYPHILIS SEROLOGY (Specify test used and results) | D. EKG | E. BLOOD TYPE AND RH FACTOR | F. OTHER TESTS |

John

| | | |
|-----------------------------|-----------------------|------------------------|
| NAME
O'Neill John | IDENTIFICATION NUMBER | NO. OF SHEETS ATTACHED |
|-----------------------------|-----------------------|------------------------|

MEASUREMENTS AND OTHER FINDINGS

| | | | | | |
|------------------------------|-----------------------------|--------------------------------|--------------------------------|---|-----------------|
| 20. HEIGHT
6' 1/2" | 21. WEIGHT
233lbs | 22. COLOR HAIR
Brown | 23. COLOR EYES
Hazel | 24. BUILD
<input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM <input type="checkbox"/> HEAVY <input type="checkbox"/> OBESE | 25. TEMPERATURE |
|------------------------------|-----------------------------|--------------------------------|--------------------------------|---|-----------------|

| | | | | | | | | | | |
|---|-----------------|--------------|-------|--------------------------------|-------|------------|--------------|-----------------------|-------------------|------------------|
| 26. BLOOD PRESSURE (Arm at heart level) | | | | 27. PULSE (Arm at heart level) | | | | | | |
| A. SITTING | SYS. 128 | B. RECUMBENT | SYS. | C. STANDING (5 mins.) | SYS. | A. SITTING | B. RECUMBENT | C. STANDING (3 mins.) | D. AFTER EXERCISE | E. 2 MINS. AFTER |
| | DIAS. 90 | | DIAS. | | DIAS. | 64 | | | | |

| | | | | | | | | |
|--------------------|---------------|------------------------|----------------|----|----|-----------------|----------|----|
| 28. DISTANT VISION | | | 29. REFRACTION | | | 30. NEAR VISION | | |
| RIGHT | 20/ 30 | CORR. TO 20/ 20 | BY | S. | CX | 20/ 30 | CORR. TO | BY |
| LEFT | 20/ 30 | CORR. TO 20/ 20 | BY | S. | CX | 20/ 30 | CORR. TO | BY |

| | | | | | | | | |
|-------------------------------------|-----|-----|------|------|------------|----------------|----|----|
| 31. HETEROPHORIA (Specify distance) | ESO | EXO | R.H. | L.H. | PRISM DIV. | PRISM CONV. CT | PC | PD |
|-------------------------------------|-----|-----|------|------|------------|----------------|----|----|

| | | | | | | | | | | |
|---------------------|--------|---|-----------------|-----------|-----------|--|-----------|--|-----------|-----------|
| 32. ACCOMMODATION | | 33. COLOR VISION (Test used and result) | | | | 34. DEPTH PERCEPTION (Test used and score) | | UNCORRECTED <input checked="" type="checkbox"/> | | |
| RIGHT | LEFT | Ishihara's test 14/14 Pass | | | | Stenotest 30 | | CORRECTED | | |
| 35. FIELD OF VISION | | 36. NIGHT VISION (Test used and score) | | | | 37. RED LENS TEST | | 38. INTRAOCULAR TENSION | | |
| RIGHT | LEFT | | | | | | | RIGHT 18 LEFT 15 | | |
| 39. HEARING | | 40. AUDIOMETER | | | | | | 41. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score) | | |
| RIGHT WV | /15 SV | /15 | 250 | 500 | 1000 | 2000 | 3000 | 4000 | 6000 | 8000 |
| | | | 256 | 512 | 1024 | 2048 | 2896 | 4096 | 6144 | 8192 |
| | | | RIGHT 90 | 20 | 10 | 15 | 15 | 15 | 15 | 30 |
| LEFT WV | /15 SV | /15 | LEFT 85 | 20 | 15 | 20 | 30 | 30 | 45 | |

42. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets if necessary)

43. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

| | | | | | | |
|---|-----------------------|---|---|---|---|---|
| 44. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify) | 45A. PHYSICAL PROFILE | | | | | |
| | P | U | L | H | E | S |

| | |
|---|------------------------|
| 46. EXAMINEE (Check) | 45B. PHYSICAL CATEGORY |
| <input checked="" type="checkbox"/> IS QUALIFIED FOR Fall Duty | |
| <input type="checkbox"/> IS NOT QUALIFIED FOR | |

| | | | | |
|---|---|---|---|---|
| 47. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER | A | B | C | E |
|---|---|---|---|---|

| | | |
|---------------------------------------|-----------|---|
| 48. TYPED OR PRINTED NAME OF EXAMINER | SIGNATURE | <div style="border: 1px solid black; width: 100%; height: 100%; display: flex; align-items: center; justify-content: center;"> </div> |
| 49. TYPED OR PRINTED NAME OF EXAMINER | SIGNATURE | |
| 50. TYPED OR PRINTED NAME OF EXAMINER | SIGNATURE | |

| | | |
|---|-----------|---|
| 51. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY | SIGNATURE | AFFILIATED PHYSICIANS
5 WORLD TRADE CTR SUITE 367
NEW YORK, NY 10048-0997
(212) 775-1218 |
|---|-----------|---|

MEDICAL RECORD

REPORT OF MEDICAL HISTORY

DATE OF EXAM

6/30/00

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

| | | | |
|--|-----------|---|--------------------------|
| 1. NAME OF PATIENT (Last, first, middle)
<i>O'Neill, John P.</i> | | 2. IDENTIFICATION NUMBER
<i>147-42-1004</i> | 3. GRADE
<i>SES 5</i> |
| 4a. HOME STREET ADDRESS (Street or RFD; City or Town; State; and ZIP Code) | | 5. EXAMINING FACILITY
<i>Affiliated Physicians
New York City</i> | |
| 4b. CITY | 4c. STATE | 4d. ZIP CODE | |
| 6. PURPOSE OF EXAMINATION
<i>Annual Physical</i> | | | |

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Use additional pages if necessary)

| | | |
|---------------------------------------|---|---|
| a. PRESENT HEALTH
<i>Good</i> | b. CURRENT MEDICATION
<i>Vitamin C</i> | REGULAR OR INTERM.
<i>Daily</i> |
| | c. ALLERGIES (Include insect bites/stings and common foods)
<i>N/A</i> | |
| d. HEIGHT
<i>6'0"</i> | | e. WEIGHT
<i>226</i> |
| 8. PATIENT'S OCCUPATION
<i>FBI</i> | | 9. ARE YOU (Check one)
<input type="checkbox"/> RIGHT HANDED <input checked="" type="checkbox"/> LEFT HANDED |

10. PAST/CURRENT MEDICAL HISTORY

| CHECK EACH ITEM | YES | NO | DON'T KNOW | CHECK EACH ITEM | YES | NO | DON'T KNOW | CHECK EACH ITEM | YES | NO | DON'T KNOW |
|---|-------------------------------------|-------------------------------------|------------|--|-----|-------------------------------------|------------|---|---------------|-------------------------------------|------------|
| Household contact with anyone with tuberculosis | | <input checked="" type="checkbox"/> | | Shortness of breath | | <input checked="" type="checkbox"/> | | Bone, joint or other deformity | | <input checked="" type="checkbox"/> | |
| Tuberculosis or positive TB test | | <input checked="" type="checkbox"/> | | Pain or pressure in chest | | <input checked="" type="checkbox"/> | | Loss of finger or toe | | <input checked="" type="checkbox"/> | |
| Blood in sputum or when coughing | | <input checked="" type="checkbox"/> | | Chronic cough | | <input checked="" type="checkbox"/> | | Painful or "trick" shoulder or elbow | | <input checked="" type="checkbox"/> | |
| Excessive bleeding after injury or dental work | | <input checked="" type="checkbox"/> | | Palpitation or pounding heart | | <input checked="" type="checkbox"/> | | Recurrent back pain or any back injury | <i>Recent</i> | <input checked="" type="checkbox"/> | |
| Suicide attempt or plans | | <input checked="" type="checkbox"/> | | Heart trouble | | <input checked="" type="checkbox"/> | | "Trick" or locked knee | | <input checked="" type="checkbox"/> | |
| Sleepwalking | | <input checked="" type="checkbox"/> | | High or low blood pressure | | <input checked="" type="checkbox"/> | | Foot trouble | | <input checked="" type="checkbox"/> | |
| Wear corrective lenses | <input checked="" type="checkbox"/> | | | Cramps in your legs | | <input checked="" type="checkbox"/> | | Nerve injury | | <input checked="" type="checkbox"/> | |
| Eye surgery to correct vision | | <input checked="" type="checkbox"/> | | Frequent indigestion | | <input checked="" type="checkbox"/> | | Paralysis (including infantile) | | <input checked="" type="checkbox"/> | |
| Lack vision in either eye | | <input checked="" type="checkbox"/> | | Stomach, liver or intestinal | | <input checked="" type="checkbox"/> | | Epilepsy or seizure | | <input checked="" type="checkbox"/> | |
| Wear a hearing aid | | <input checked="" type="checkbox"/> | | Gall bladder trouble or gallstones | | <input checked="" type="checkbox"/> | | Car, train, sea or air sickness | | <input checked="" type="checkbox"/> | |
| Stutter or stammer | | <input checked="" type="checkbox"/> | | Jaundice or hepatitis | | <input checked="" type="checkbox"/> | | Frequent trouble sleeping | | <input checked="" type="checkbox"/> | |
| Wear a brace or back support | | <input checked="" type="checkbox"/> | | Broken bones | | <input checked="" type="checkbox"/> | | Depression or excessive worry | | <input checked="" type="checkbox"/> | |
| Scarlet fever | | <input checked="" type="checkbox"/> | | Adverse reaction to medication | | <input checked="" type="checkbox"/> | | Loss of memory or amnesia | | <input checked="" type="checkbox"/> | |
| Rheumatic fever | | <input checked="" type="checkbox"/> | | Skin diseases | | <input checked="" type="checkbox"/> | | Nervous trouble of any sort | | <input checked="" type="checkbox"/> | |
| Swollen or painful joints | | <input checked="" type="checkbox"/> | | Tumor, growth, cyst, cancer | | <input checked="" type="checkbox"/> | | Periods of unconsciousness | | <input checked="" type="checkbox"/> | |
| Frequent or severe headaches | | <input checked="" type="checkbox"/> | | Hernia | | <input checked="" type="checkbox"/> | | Parent/sibling with diabetes, cancer, stroke or heart disease | | <input checked="" type="checkbox"/> | |
| Dizziness or fainting spells | | <input checked="" type="checkbox"/> | | Hemorrhoids or rectal disease | | <input checked="" type="checkbox"/> | | X-ray or other radiation therapy | | <input checked="" type="checkbox"/> | |
| Eye trouble | | <input checked="" type="checkbox"/> | | Frequent or painful urination | | <input checked="" type="checkbox"/> | | Chemotherapy | | <input checked="" type="checkbox"/> | |
| Hearing loss | | <input checked="" type="checkbox"/> | | Bed wetting since age 12 | | <input checked="" type="checkbox"/> | | Asbestos or toxic chemical exposure | | <input checked="" type="checkbox"/> | |
| Recurrent ear infections | | <input checked="" type="checkbox"/> | | Kidney stone or blood in urine | | <input checked="" type="checkbox"/> | | Plate, pin or rod in any bone | | <input checked="" type="checkbox"/> | |
| Chronic or frequent colds | | <input checked="" type="checkbox"/> | | Sugar or albumin in urine | | <input checked="" type="checkbox"/> | | Easy fatigability | | <input checked="" type="checkbox"/> | |
| Severe tooth or gum trouble | | <input checked="" type="checkbox"/> | | Sexually transmitted diseases | | <input checked="" type="checkbox"/> | | Been told to cut down or criticized for alcohol use | | <input checked="" type="checkbox"/> | |
| Sinusitis | | <input checked="" type="checkbox"/> | | Recent gain or loss of weight | | <input checked="" type="checkbox"/> | | Used illegal substances | | <input checked="" type="checkbox"/> | |
| Hay fever or allergic rhinitis | | <input checked="" type="checkbox"/> | | Eating disorder (anorexia bulimia, etc.) | | <input checked="" type="checkbox"/> | | Used tobacco | | <input checked="" type="checkbox"/> | |
| Head injury | | <input checked="" type="checkbox"/> | | Arthritis, Rheumatism, or Bursitis | | <input checked="" type="checkbox"/> | | | | | |
| Asthma | | <input checked="" type="checkbox"/> | | Thyroid trouble or goiter | | <input checked="" type="checkbox"/> | | | | | |

John P. O'Neill

11. FEMALES ONLY

| CHECK EACH ITEM | YES | NO | DON'T KNOW | DATE OF LAST MENSTRUAL PERIOD | DATE OF LAST PAP SMEAR | DATE OF LAST MAMMOGRAM |
|-------------------------------|-----|----|------------|-------------------------------|------------------------|------------------------|
| Treated for a female disorder | | | | | | |
| Change in menstrual pattern | | | | | | |

CHECK EACH ITEM. IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER.

| ITEM | YES | NO |
|---|-----|----|
| 12. Have you been refused employment or been unable to hold a job or stay in school because of: | | |
| a. Sensitivity to chemicals, dust, sunlight, etc. | | ✓ |
| b. Inability to perform certain motions. | | ✓ |
| c. Inability to assume certain positions. | | ✓ |
| d. Other medical reasons (If yes, give reasons.) | | ✓ |
| 13. Have you ever been treated for a mental condition? (If yes, specify when, where, and give details.) | | ✓ |
| 14. Have you ever been denied life insurance? (If yes, state reason and give details.) | | ✓ |
| 15. Have you had, or have you been advised to have, any operation. (If yes, describe and give age at which occurred.) | ✓ | |
| 16. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) | ✓ | |
| 17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) | | ✓ |
| 18. Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.) | | ✓ |
| 19. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.) | | ✓ |
| 20. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when,) | | ✓ |
| 21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. (If yes, provide details.) | | ✓ |
| 22. Have you ever been diagnosed with a learning disability? (If yes, give type, where, and how diagnosed.) | | ✓ |

15. Tonsils age 6
 appendectomy, Age 10
 16. DeWitt Hospital, Ventnor, NJ, 1958, Tonsils
 [Redacted]
 AT Lanta City Medical Center, Atlanta City NJ 1962. Appendix
 [Redacted]

b6
 b7c

23. LIST ALL IMMUNIZATIONS RECEIVED

✓ (see attached)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment, or service. I understand that falsification of information on Government forms is punishable by fine and/or imprisonment.

| | | |
|---|-------------------------------|----------------------|
| 24a. TYPED OR PRINTED NAME OF EXAMINEE
John P. O'Neill | 24b. SIGNATURE
[Signature] | 24c. DATE
6/30/00 |
|---|-------------------------------|----------------------|

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY".

25. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA (Physician shall comment on all positive answers in Items 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)

- ① Tonsils removed age 6
- ② AP removed age 10
- ③ lower back pain after belt game

b6
 b7c

AFFILIATED PHYSICIANS

| | |
|---|----------------------------------|
| 26a. TYPED OR PRINTED NAME OF PHYSICIAN
1375 BROADWAY SUITE
NEW YORK, NY 10048-0999
(212) 775-1218 | 26c. DATE
[Signature] 6/30/00 |
|---|----------------------------------|

Attachment to Standard Form 88, Report of Medical Examination
For Information and Guidance of Medical Examiner

Age 48

Name of Examinee O'Neill John P.
(Type or print) Last First Middle

The following portions of the attached examination report form need not be completed:

| | | | | |
|---|----|----|----|----|
| 3 | 9 | 17 | 67 | 76 |
| 4 | 11 | 62 | 68 | |
| 8 | 14 | 65 | 72 | |

- 45, 46, 47 and 49; required for all Special Agent and FBI National Academy applicants but not for any other applicant unless the examining physician deems one, two, three or all four of the examinations necessary. 45, 46 and 47 are required in examination of any current employee.
- 48. Required for (1) all Special Agent applicants; (2) all FBI National Academy applicants; (3) all examinees over 35 years of age; (4) any other where examination indicates such as desirable.
- 69. Required for all examinees over 40 years of age.
- 71. Audiometer examinations must be afforded for all Special Agent applicants and Special Agents and decibel readings must be recorded at 500, 1000, 2000, 3000 and 4000 Hertz. Applicants for the Special Agent position will not be accepted if the hearing loss exceeds a 25 decibel average (ANSI) in either ear in the frequency range 1000, 2000, and 3000 Hertz. No single reading in that range may exceed 35 decibels and no applicant will be accepted if found to have a hearing loss exceeding 35 decibels at 500 or 45 decibels at 4000 Hertz.

For All Examinees, Whether Clerical or Special Agent Applicants, National Academy Applicants, or Employees:

The medical examiner should answer the following question:

Examinee is is not qualified for strenuous physical exertion.

To be Answered in the Case of All Special Agents, Special Agent Applicants, and National Academy Applicants:

- 1. Does examinee have any defects restricting or prohibiting his/her participation in defensive tactics and dangerous assignments which might entail the practical use of firearms?

No Yes If "yes" please specify defects. _____

To be Answered in the Case of All Special Agents, Special Agent Applicants, and other Employees who drive Bureau vehicles:

- 1. Does examinee have any defects prohibiting safe operation of motor vehicles?

No Yes If "yes" please specify defects. _____

- 2. For safe driving of motor vehicles, Office of Personnel Management requires distant vision must test at least 20/40 in one eye and 20/100 in the other, corrected or uncorrected. Should examinee wear corrective glasses while operating a motor vehicle? Yes No
If recommendation is based on a factor other than above standard, indicate basis _____

John

DESIRABLE WEIGHT RANGES

| MALES | | | | FEMALES | | | |
|--------|-------------|--------------|-------------|---------|-------------|--------------|-------------|
| Height | Small Frame | Medium Frame | Large Frame | Height | Small Frame | Medium Frame | Large Frame |
| 5'4" | 117 - 138 | 123 - 149 | 131 - 163 | 5'0" | 96 - 114 | 101 - 124 | 109 - 138 |
| 5'5" | 120 - 142 | 126 - 153 | 134 - 167 | 5'1" | 99 - 118 | 104 - 128 | 112 - 141 |
| 5'6" | 124 - 146 | 130 - 157 | 138 - 173 | 5'2" | 102 - 121 | 107 - 131 | 115 - 144 |
| 5'7" | 128 - 151 | 134 - 163 | 143 - 178 | 5'3" | 105 - 124 | 110 - 135 | 118 - 149 |
| 5'8" | 132 - 155 | 138 - 167 | 147 - 183 | 5'4" | 108 - 128 | 113 - 139 | 121 - 152 |
| 5'9" | 136 - 161 | 142 - 172 | 151 - 187 | 5'5" | 111 - 132 | 117 - 144 | 125 - 156 |
| 5'10" | 140 - 165 | 146 - 177 | 155 - 193 | 5'6" | 114 - 135 | 120 - 149 | 129 - 161 |
| 5'11" | 144 - 169 | 150 - 183 | 160 - 198 | 5'7" | 118 - 140 | 124 - 153 | 133 - 165 |
| 6' | 148 - 174 | 154 - 188 | 164 - 204 | 5'8" | 122 - 144 | 128 - 157 | 137 - 169 |
| 6'1" | 152 - 179 | 158 - 194 | 169 - 209 | 5'9" | 126 - 149 | 132 - 162 | 141 - 174 |
| 6'2" | 156 - 184 | 163 - 199 | 174 - 215 | 5'10" | 130 - 154 | 136 - 166 | 145 - 179 |
| 6'3" | 160 - 188 | 168 - 205 | 178 - 220 | 5'11" | 134 - 158 | 140 - 171 | 149 - 185 |
| 6'4" | 169 - 198 | 178 - 216 | 188 - 231 | 6'0" | 138 - 163 | 144 - 175 | 153 - 190 |
| 6'5" | 174 - 204 | 182 - 222 | 192 - 238 | | | | |

4. Examinee's frame is small medium large
5. Considering the above weight table, the examinee's frame, and other individual physical characteristics, I consider his/her present weight Satisfactory Excessive Deficient
6. Under proper medical supervision, employee should lose _____ pounds
 gain _____ pounds

Remarks: _____

AFFILIATED PHY.
 5 WORLD TRADE CTR SUITE 367
 NEW YORK, NY 10048-0997
 (212) 775-1218

6/30/00
 Date

b6
 b7c

**FITNESS-FOR-DUTY PHYSICAL EXAM CHECKLIST FOR
SPECIAL AGENTS/ELECTRONICS TECHNICIANS/AUTOMOTIVE TECHNICIANS**

NAME John P O'Neill FBIHQ/FIELD OFFICE NYO
 POSITION SAC
 D.O.B. 2/6/1950 D.O.P. _____ S.S.N. _____

Please place a check mark before each item to ensure completeness of physical. If any items/tests are omitted, obtain results more submitting to FBIHQ. Send a completed FD-277, checklist, and the original physical exam report to the Fitness-for-Duty, Health Care Programs Unit, Room 6344.

REPORT OF MEDICAL HISTORY (SF-88)

- Questions 1 through 16 (by employee)
- Section 18 through 44 (by physician)
- # 19 EKG with interpretation
- # 20 Height
- # 21 Weight
- # 26 Blood Pressure
- # 28 Distant Vision (corr. & uncorr.)
- # 30 Near Vision (corr. & uncorr.)
- # 33 Color Vision (type & test results)
- # 38 Intraocular Tension (IOT)
- # 40 Audiometer - (500hz-800hz)
- # 48 (Signed by examiner)

REPORT OF MEDICAL HISTORY (SF-93)

- Completed by examinee

FORM FD-300

- Completed & signed by examiner

TESTS DONE BASED ON AN OCCUPATIONAL EXPOSURE

- Pulmonary Function Test
- Chest x-ray
- Blood Lead Level (when specifically requested by FBI for at risk Personnel only)

LABORATORY TESTS

- Urinalysis
- CBC
- Blood Chemistry
- Thyroid Test T-4
- Stool for occult blood (3 slides)

OTHER TESTS

- Exercise Stress Test
- Spect Thallium or stress echocardiogram
- *Give only if abnormal stress test

OPTIONAL INJECTIONS

- Mantoux T.B. Test
(Note results on SF-88 # 19 recommend but not mandatory)
- Hepatitis vaccine (at risk personnel only)
- Tetanus Diphtheria
(only for specific individuals identified by FBI office being served)

b6
b7c

REVIEWED BY:
 DATE: JULY 18, 2000
 REVISED: 7/14/98

TITLE: Employee Relations Clerk



U.S. Department of Justice

Federal Bureau of Investigation

PPD SKIN TESTING

O'Neill John P. AGE: 48
LAST NAME FIRST NAME

STREET APT/FLOOR CITY STATE ZIP

HOME PHONE: WORK PHONE: 212-384-2870

EMPLOYER: FBI

- 1. Do you have a history of positive PPD skin reaction? [] Yes [X] No
- 2. Do you have a history of tuberculosis? [] Yes [X] No
- 3. For women: Are you pregnant? [] Yes [] No
- 4. Have you had a flu shot within the last six weeks? [] Yes [X] No
- 5. In which country were you born? USA

I consent to have the PPD (tuberculosis skin test).

Signature: [Signature] Date: 6/28/00

DATE GIVEN PPD 5TU: 6/28/00 [X] RT FOREARM [] LT FOREARM

NURSE SIGNATURE: [Signature], R.N.

DATE RESULTS: 6/30/00

[X] NEGATIVE [] POSITIVE 0 mm induration

Nurse: [Signature], R.N.

Those with positive skin test results will be referred to a physician and will need a chest x-ray.

b6
b7C

[Signature]

INTERVAL MEDICAL HISTORY

John R. Conwill
Patient Name

1/30/00
Exam Date

Home Address

FBI
~~John R. Conwill~~
Employer Name

City State Zip

(212) 384-2870
Daytime Phone

1. Has there been a significant change in your health since your last examination?
If "Yes," please explain:

NO

2. Do you have any current medical concerns or questions you would like to discuss with the doctor?
If "Yes," please describe:

pain in lower back

Current Medications: *N/A*

Allergies: *None*

Tobacco use:

Never ___ Quit in ___ Smoke ___ per (day/week/month)

Alcohol use:

___ Never ___ Rarely Social Use 2 drinks per day

Exercise:

___ Never ___ Occasional Weekends ___ Regularly ___ times per week

Women:

Date Last Period: ___ Any gynecologic problems: ___

John R. Conwill

PHYSICAL CAPACITIES FORM

Dear Doctor:

Employee's name: _____

Based upon your examination of the client, please check all items where there is a restriction regarding his/her medical condition.

No restrictions/limitations - employee is medically capable of performing the duties of his/her job. The physician must provide documentation regarding medical clearance.

No lifting/carrying 0-20 lbs.

No lifting/carrying 20-50 lbs.

No lifting/carrying 50-100 lbs.

No sitting for long periods of time.

No standing for long periods of time.

No pushing/pulling, including push-ups and pull-ups.

No climbing ladders, poles, etc.

No jumping

No defensive tactics

No kneeling, bending, or twisting

No stretching or working above shoulder

No running

No operating a motor vehicle

No simple grasping

No firearms

No assignments in altitudes over 7,000 ft.

No participation in raids/arrests or any undercover surveillance activities, or reactive squad duty.

No direct assignments or duties that are expected to require the use of firearms.

Current medications

Comments



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AFFILIATED PHYSICIANS
5 WORLD TRADE CTR SUITE 367
NEW YORK, NY 10048-0997
(212) 775-1218

Jan Pen



AFFILIATED PHYSICIANS
Execumed Medical Services, P.C.

5 World Trade Center
Suite 367
New York, N.Y. 10048-0997
Tel (212) 775-1218
Fax (212) 432-0926

18 East 48th Street
2nd Floor
New York, N.Y. 10017
Tel (212) 935-8725
Fax (212) 935-8854

O'Neill

Last Name

John

First Name

DOB

SS #

Home Address

Home Phone

Company Name & Address

Business Phone

3814

Chart #

b6
b7c

| DATE | HISTORY AND PROGRESS NOTES | |
|----------------|----------------------------|--------------|
| WALK-IN | | |
| DATE | 7/15/99 TIME | |
| AGE | CC | |
| MANUF: | Connaught | Im (R) Debid |
| LOT #: | P1382-2 | |
| DATE: | 7/15/99 | |
| NAME: | Typhim Vi | |
| MANUF: | Connaught | Im (R) am |
| LOT #: | P1212 | |
| DATE: | 7/15/99 | |
| NAME: | Inactivated Polio | |
| MANUF: | Connaught | Im (R) Debid |
| LOT #: | 7345AA | |
| DATE: | 7/15/99 | |
| NAME: | T/D | |
| MANUF: | Connaught | Im (R) am |
| LOT #: | 7411AA | |
| DATE: | 7/15/99 | |
| NAME: | Yellow Fever | |

John

Med Rec # _____

Patient Name: _____

DATE

HISTORY AND PROGRESS NOTES

MANUF: Chausoff

LOT #: 6725AA

DATE: 7/15/99

NAME: Meromine

88 (L) an



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b7c

[Faint, illegible markings]

[Handwritten signature]

O'Neill, John

OTHER IMMUNIZATIONS/PROPHYLAXIS RECEIVED
Autres vaccinations/prophylaxies reçues

This space is provided to record immunizations/prophylaxis that are not required for entrance into any country but have been obtained by the traveler for additional health protection (immune globulin, malaria, measles, etc.)

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| Date | Vaccine/prophylactic drug
Vaccin/médicament prophylactique | Dose | Physician's signature
Signature du médecin |
|---------|---|------|---|
| 7/15/88 | TD | .5 | |
| 7/15/88 | Meningococci | .5 | |
| 7/15/88 | Typhim Vi | .5 | |
| 7/15/88 | Inactivated Bho | .5 | |
| 7/15/99 | Hep A H1 | 1cc | |
| 7/15/99 | Hep B H1 | 1cc | |
| 1/20/10 | Hep A H2 | 1cc | |
| 4/4/10 | Hep B H2 | 1cc | |
| 6/28/10 | Hep B H3 | 1cc | |
| | | | |
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| | | | |
| | | | |

MEDICATIONS TAKEN REGULARLY (e.g., insulin, digitals)
Médicaments pris régulièrement (par ex., insuline, digitale)

| Health problem -
Problème de santé | Generic and trade names of medication -
Noms génériques et commerciaux du médicament | Medication dosage -
Dosage du médicament | Physician's remarks -
Remarques du médecin | Physician's signature -
Signature du médecin |
|---------------------------------------|---|---|---|---|
| | | | | |

IMMUNIZATION INFORMATION SHEET

DATE 7/15/99
 NAME John P. O'Neill
 HOME ADDRESS 26 Federal Plaza
 ADDRESS APARTMENT NO.
NY CITY NY STATE ZIP
 SS# 147-42-1004 DATE OF BIRTH 02/06/52
 HOME PHONE (212)384-2870 BUSINESS PHONE () -
 DEPARTURE DATE 7/20/99 LENGTH OF STAY 10 days
 DESTINATION DAR ES SALAM TANZANIA + NAROSBI, Kenya
 ARE YOU PREGNANT? Y [] N [] ^{N/A} ALLERGIES None
 CURRENT MEDICAL CONDITIONS: Excellent

For Official Use Only:

- | | | |
|---|---|--|
| <input type="checkbox"/> Cholera | <input checked="" type="checkbox"/> Menomune | <input checked="" type="checkbox"/> Tetanus/Diphtheria |
| <input type="checkbox"/> Gamma Globulin | <input type="checkbox"/> MMR | <input checked="" type="checkbox"/> Typhoid-Injectable |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid-Oral |
| <input type="checkbox"/> Hepatitis A | <input checked="" type="checkbox"/> Polio-Inactivated | <input checked="" type="checkbox"/> Yellow Fever |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Rubella | |

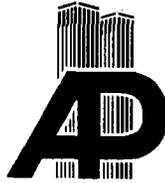
I am requesting the above stated vaccinations from Affiliated Physicians. I understand that if I have any of the following conditions, I will notify the nurse for discussion prior to being vaccinated:

Immune Deficiency, i.e.: HIV, Cancer, currently pregnant or planning pregnancy, other recent or future vaccinations.

Most common side effects associated with vaccinations include tenderness and swelling at injection site, low grade fever, joint aches. This should subside within 2-3 days. Rare allergic reactions can occur.


 Signature

J.P.O.



AFFILIATED PHYSICIANS

5 World Trade Center, Suite 367 New York, N.Y. 10048-0997 • Tel (212) 775-1218 • Fax (212) 432-0926

July 10, 2000

Mr. John P. O'Neill

Dear Mr. O'Neill:

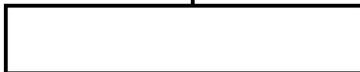
We were pleased that you chose Affiliated Physicians for your physical examination performed on June 30, 2000. We have enclosed full results of all testing from that date.

Your medical history, physical examination, and all laboratory and other tests were normal. Congratulations. I have no specific recommendations other than to continue your good health habits and to follow up routinely as needed.

Please review your physical examination report carefully and discuss it as needed with your private physician. If you do not have a private physician, you may call us so that we can arrange follow-up care at our facility.

Thank you for giving us this opportunity to perform your health evaluation. We look forward to seeing you at your next scheduled physical examination or whenever you have need for general or specialist medical care.

Sincerely



M.D.

KD:jg

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b7c

PHYSICAL EXAMINATION

NAME Mr. John P. O'Neill

DATE OF EXAMINATION 6/30/00

VITAL SIGNS HEIGHT: 6' ½"
WEIGHT: 233 lbs.
BP: 128/90
PULSE: 64 and regular

FAR VISION RT: 20/30 LT: 20/30 w/o correction
RT: 20/20 LT: 20/20 w/correction
Normal vision in both eyes with correction.

NEAR VISION RT: 20/20 LT: 20/30 w/o correction
Normal vision in both eyes with correction.

GLAUCOMA RT: 18 LT: 15 Normal

COLOR TEST Pass

DEPTH PERCEPTION 40 seconds of arc.

HEARING TEST Normal

EKG Normal

OCCULT BLOOD No slides submitted

RECTAL EXAM Guaiac negative

PROSTATE Normal

URINALYSIS Normal

CHOLESTEROL Total cholesterol = 200 (normal).

BLOOD STUDIES Normal

CURRENT MEDICATIONS None

EXERCISE On weekends

ALCOHOL Socially, two drinks a day.

SMOKING Never

John P. O'Neill

AMERICAN MEDICAL LABORATORIES, INC.®

P.O. Box 10841 • 14225 Newbrook Drive

Chantilly, VA 20153-0841

Telephone: (703) 802-6900 • (800) 336-3718

ONEILL, JOHN

50177963/0 (ADULT ASSUMED)

MALE

Page 1 From Chantilly

FOR

X

COLLECTED: 06/30/2000

30953 AFFILIATED PHYSICIANS

RECEIVED: 07/03/2000

C/O WOHA-FBI PROJECT

REPORTED: 07/05/2000

5 WORLD TRADE CENTER #367

2000/0/30953/0/33086940

NEW YORK NY 10048

SAMPLE DATA:SS#147421004

-----TESTS-----RESULTS-FLAG--REF. RANGE-----UNITS

7328/Chantilly

Health Profile #353

CBC with Differential

RBC VALUES

| | | | |
|-------------------|---------|------------|----------------------|
| ERYTHROCYTE COUNT | 4.81 | 4.00-5.60 | x10 ¹² /L |
| HEMOGLOBIN | 16.2 | 12.4-17.23 | g/dL |
| HEMATOCRIT | 48.8 | 37.0-50.0 | % |
| MCV | 101.5 H | 81.0-98.0 | fL |
| MCH | 33.7 | 23.0-34.6 | pg |
| MCHC | 33.2 | 31.0-37.0 | % |
| RDW | 14.0 | 11.0-15.5 | % |

WBC TOTAL AND DIFF

| | | | |
|--------------------|-------|------------|---------------------|
| WBC TOTAL | 5.90 | 4.00-10.60 | x10 ⁹ /L |
| WBC PERCENT COUNTS | | | |
| NEUTROPHILS | 61.1 | 50.0-75.0 | % |
| LYMPHOCYTES | 30.8 | 20.0-45.0 | % |
| MONOCYTES | 2.0 | 0.0-12.0 | % |
| EOSINOPHILS | 5.4 H | 0.0-5.0 | % |
| BASOPHILS | 0.7 | 0.0-3.0 | % |

WBC DIFF ABSOLUTES

| | | | |
|-------------|------|-----------|---------------------|
| NEUTROPHILS | 3.60 | 1.80-7.00 | x10 ⁹ /L |
| LYMPHOCYTES | 1.80 | 1.00-4.00 | x10 ⁹ /L |
| MONOCYTES | 0.10 | 0.10-0.80 | x10 ⁹ /L |
| EOSINOPHILS | 0.30 | 0.00-0.40 | x10 ⁹ /L |

ADDITIONAL FINDINGS

| | | | |
|------------------|------------|---------|---------------------|
| PLATELET COUNT | 313 | 140-440 | x10 ⁹ /L |
| MACROCYTOSIS | SLIGHT | | |
| DECOMPOSED WBC'S | * MODERATE | | |

PROFILE CONTINUED ON NEXT PAGE...

b6
b7c

[Signature Box]

M.D.

DIRECTOR OF LABORATORIES

Jan/En

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-----TESTS-----RESULTS-FLAG--REF. RANGE-----UNITS

7328/Chantilly

Health Profile #353 (CONTINUATION)

Urine with Microscopic

Routine Urinalysis

| | | | |
|--------------------|--------|-------------|--|
| Color | YELLOW | YELLOW | |
| Appearance | CLEAR | | |
| Specific Gravity | 1.018 | 1.001-1.035 | |
| pH | 5.0 | 5.0-8.0 | |
| Leukocyte Esterase | NEG | NEG | |
| Protein | NEG | NEG | |
| Glucose | NEG | NEG | |
| Ketones | NEG | NEG | |
| Bilirubin | NEG | NEG | |
| Occult Blood | NEG | NEG | |
| Nitrite | NEG | NEG | |

Microscopic Urinalysis

| | | | |
|-----------------------|------|-----|------|
| WBC | 0 | 0-4 | /hpf |
| RBC | 0 | 0-4 | /hpf |
| Squamous Epith. Cells | NONE | | |
| Bacteria | NONE | | |

PROFILE CONTINUED ON NEXT PAGE...

b6
b7c

John

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2000/ 0/ 30953/ 0/33086940

NEW YORK NY 10048

SAMPLE DATA:SS#147421004

-----TESTS-----RESULTS-FLAG--REF. RANGE-----UNITS

7328/Chantilly

Health Profile #353 (CONTINUATION)

Chemistry-24

| | | | |
|------------------------|-------|-----------|-------|
| Calcium | 9.3 | 8.4-10.2 | mg/dL |
| Ionized Ca, Calculated | 4.0 | 3.6-4.6 | mg/dL |
| Phosphorus | 4.1 | 2.1-4.5 | mg/dL |
| Glucose | 72 | 70-109 | mg/dL |
| Uric Acid | 6.9 | 3.1-8.8 | mg/dL |
| Urea Nitrogen (BUN) | 17 | 7-26 | mg/dL |
| Creatinine | 0.9 | 0.7-1.3 | mg/dL |
| Creatinine/BUN Ratio | 0.05 | 0.03-0.12 | |
| Total Protein | 7.3 | 6.0-8.1 | g/dL |
| Albumin | 4.5 | 3.6-5.5 | g/dL |
| Globulin | 2.8 | 1.6-3.5 | g/dL |
| A/G Ratio | 1.6 | 1.0-2.9 | |
| Total Bilirubin | 0.5 | 0.2-1.4 | mg/dL |
| ALT (SGPT) | 32 | 0-50 | U/L |
| ALP (Alk. P'tase) | 85 | 30-125 | U/L |
| LD (LDH) | 165 | 110-260 | U/L |
| AST (SGOT) | 19 | 10-50 | U/L |
| GGT | 36 | 11-52 | U/L |
| Sodium | 141 | 133-145 | mEq/L |
| Potassium | 5.1 | 3.2-5.7 | mEq/L |
| Chloride | 104 | 96-112 | mEq/L |
| Carbon Dioxide | 22 | 20-30 | mEq/L |
| Triglycerides | 155 | 25-175 | mg/dL |
| Cholesterol | 200 H | <200 | mg/dL |

PROFILE CONTINUED ON NEXT PAGE...

b6
b7c

Age and sex dependent reference ranges are printed when available
if age and sex are designated. Otherwise, adult values are given.

167086 R 1/00

[Signature Box]

M.D.

DIRECTOR OF LABORATORIES

John

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NEW YORK NY 10048

SAMPLE DATA:SS#147421004

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7328/Chantilly

Health Profile #353 (CONTINUATION)

Coronary Risk Profile

| | | | |
|--------------------------|-------|--------|-------|
| Triglycerides | 155 | 25-175 | mg/dL |
| Cholesterol | 200 H | <200 | mg/dL |
| HDL-Cholesterol | 40 | 35-60 | mg/dL |
| T. Chol./HDL-Chol. Ratio | 5.00 | | |
| VLDL-Chol. Estimated | 31 | 8-32 | mg/dL |
| LDL-Chol. Estimated | 129 | <130 | mg/dL |

| | | | |
|------------------------------------|-------|-------|---|
| * RISK OF CORONARY HEART DISEASE * | | | |
| * TOTAL CHOL./HDL-CHOL. RATIO * | | | |
| | MEN | WOMEN | |
| | ----- | | |
| * 1/2 average risk | 3.4 | 3.4 | * |
| * average risk | 5.0 | 4.4 | * |
| * 2 times average risk | 9.6 | 7.1 | * |
| * 3 times average risk | 23.4 | 11.0 | * |
| * ***** | | | |

Reference ranges for HDL-cholesterol are valid only for persons age 16 and above.

| | | | |
|----|-----|----------|-------|
| T4 | 7.4 | 4.0-10.8 | ug/dL |
|----|-----|----------|-------|

1111/Chantilly

| | | | |
|-----------------------------|-----|----------|---------|
| G-6-Phosphate Dehydrogenase | 8.5 | 4.6-13.5 | U/g Hgb |
|-----------------------------|-----|----------|---------|

10542/Chantilly

| | | | |
|---------------------------|-----|------|-------|
| Prostate Specific Antigen | 1.1 | <4.0 | ng/mL |
|---------------------------|-----|------|-------|

*** FINAL REPORT ***

[P 10249]-[S 2755] Printed 14:55:19 05 JUL 2000

[Redacted] M.D.
Director of Laboratories

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Age and sex dependent reference ranges are printed when available if age and sex are designated. Otherwise, adult values are given.

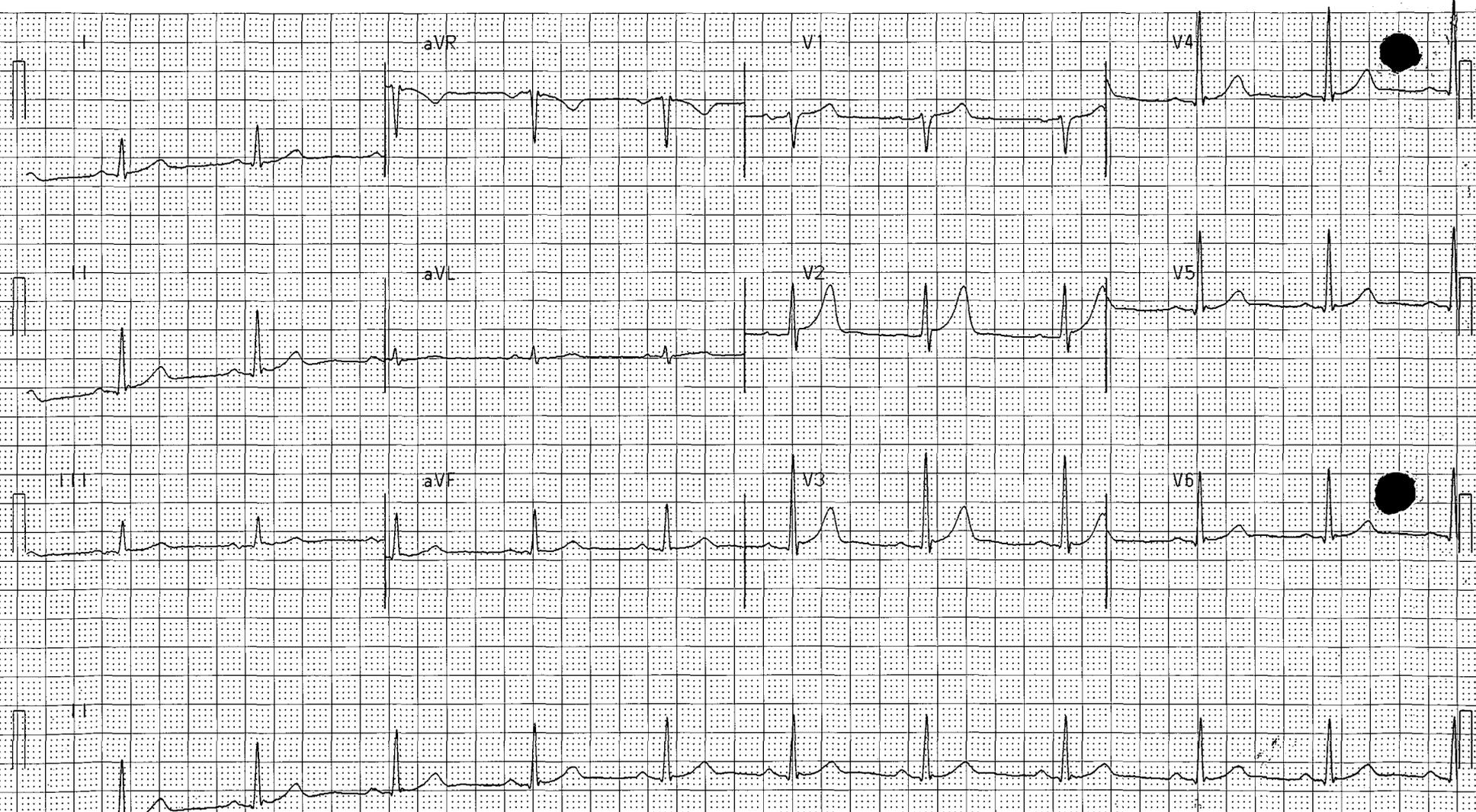
167086 R 1/00

[Redacted] M.D.
DIRECTOR OF LABORATORIES

jm/en

Name: ONEILL, JOHN
ID :
Date: 06/30/00 Time: 07:13

HR: 064



John

Speed 25 mm/s Freq 50 05 - 30Hz
Gain Limb 10 Chest 10 mm/mv

LE Rev 1.56