

REGT NO. 15113

RANK

Sgt

NAME

KALICHUK A

429-488-018

RCAF

SERVICE


3 NOVEMBER 23

R

DENTAL ENVELOPE

FOR THE
CANADIAN FORCES

4.	SOFT TISSUE EXAMINATION	Patient's left	Patient's right	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1
5.	SPECIAL EXAMINATION	Patient's left	Patient's right	18	17	16	15	14	13	12	11	10	9	8	7	6	5	4	3	2	1

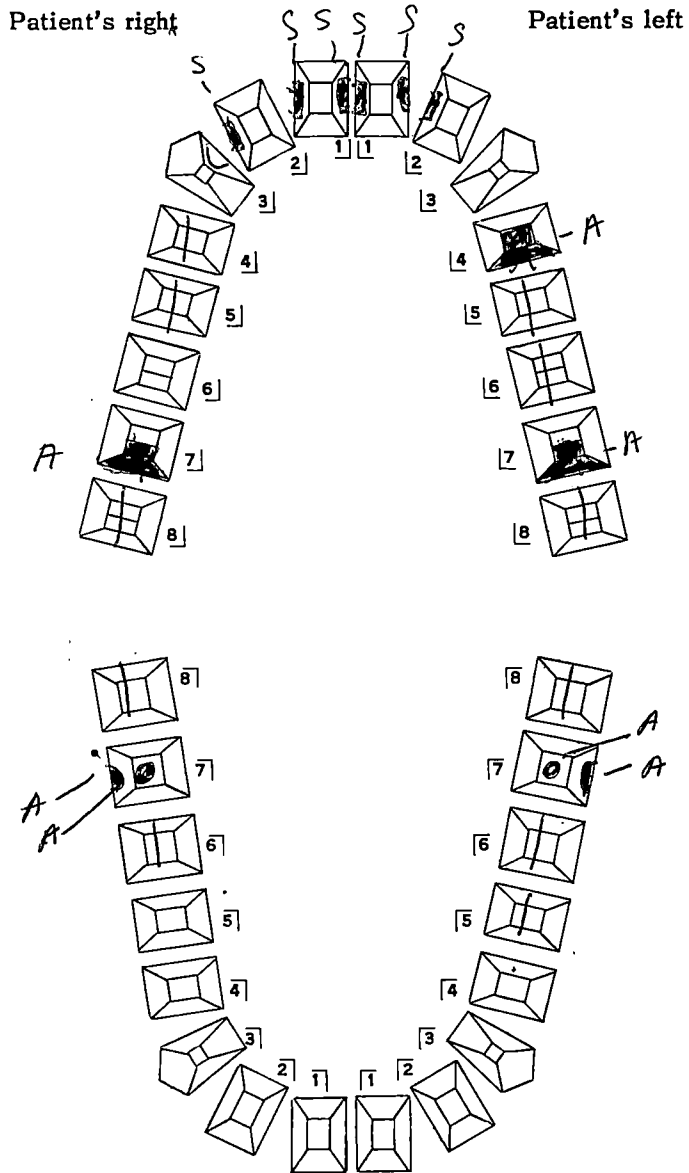
Name and Initials	KALICHUK A	S E R V I C E		Navy	Loc 411	 DEPARTMENT OF NATIONAL DEFENCE ROYAL CANADIAN DENTAL CORPS DENTAL RECORD For the Canadian Forces	
Official Number	15113						Army
Rank	Sgt						
Date of Enrolment	21 Jan 50						
Date of Birth	3 Nov 23		X				

1. CATEGORY AND HYGIENE									
DATE	CAT.	GOOD	FAIR	POOR	DATE	CAT.	GOOD	FAIR	POOR
18-6-55	A		✓						
23 Jun 55				✓					

2. PATIENT HISTORY QUESTIONNAIRE	
A. Have you ever had any of the following?	Circle in Pencil
1 - Heart trouble?	Yes <input type="radio"/> No <input checked="" type="radio"/>
2 - Rheumatic fever, Rheumatism or Arthritis?	Yes <input type="radio"/> No <input checked="" type="radio"/>
3 - Diabetes?	Yes <input type="radio"/> No <input checked="" type="radio"/>
4 - Epilepsy?	Yes <input type="radio"/> No <input checked="" type="radio"/>
5 - Fainting Spells?	Yes <input type="radio"/> No <input checked="" type="radio"/>
6 - Fractured Jaw?	Yes <input type="radio"/> No <input checked="" type="radio"/>
B. Have you ever bled for a long time after a cut or dental extraction?	Yes <input type="radio"/> No <input checked="" type="radio"/>
C. Do you have hay fever, asthma or any allergy?	Yes <input type="radio"/> No <input checked="" type="radio"/>
D. Are you sensitive to any particular medicine Aspirin, Penicillin, Local anaesthetic, etc.?	Yes <input type="radio"/> No <input checked="" type="radio"/>
E. Are you under medical treatment at present?	Yes <input type="radio"/> No <input checked="" type="radio"/>
F. Have you ever been admitted to a hospital?	Yes <input checked="" type="radio"/> No <input type="radio"/>

3. REMARKS

6. CONDITION ON RELEASE



s.19(1)

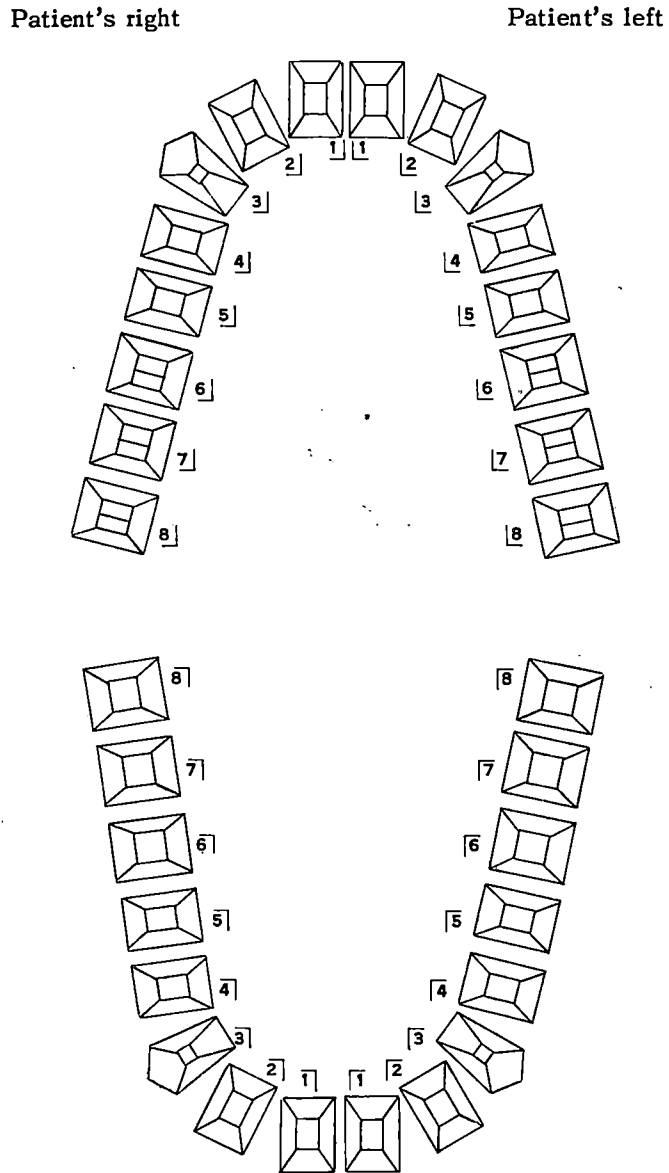
Date of Examination 6 Mar 69

Effective Date of Release 2 Nov 1969

Number, Signature and Rank of Dental Officer [Signature]

Clinic Location #2 Clinic, AFB, Clinton Ont.

7. CONDITION ON ENTRY



Date of Examination _____

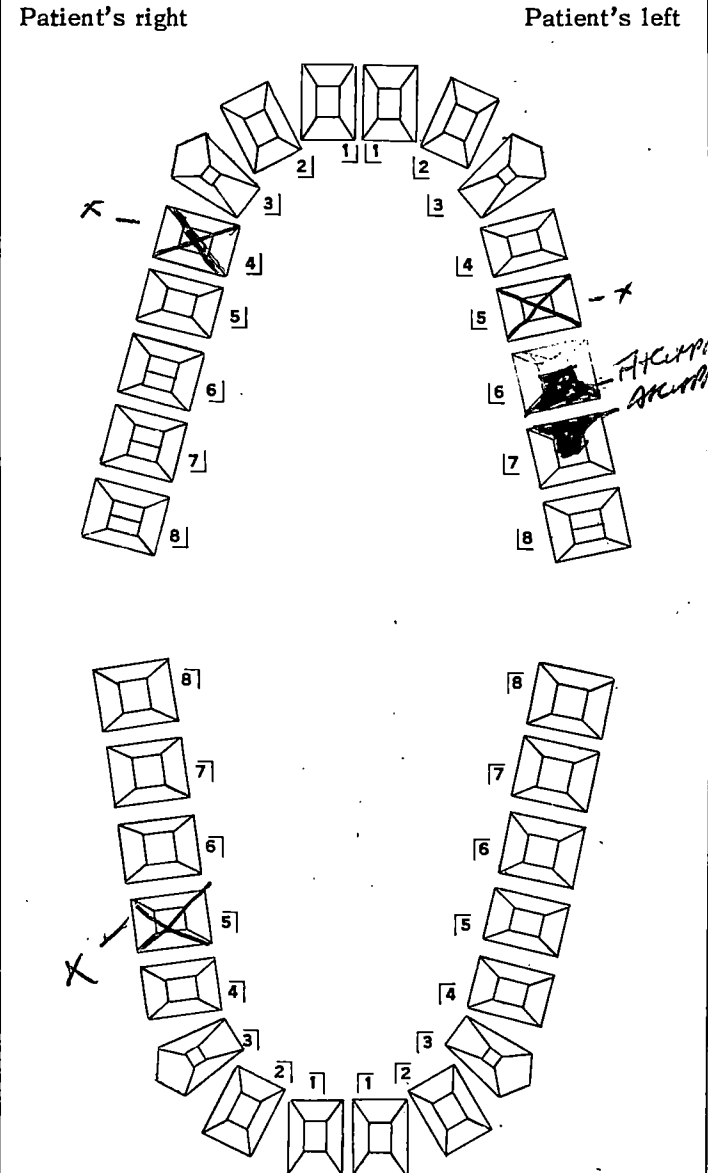
Number, Signature and Rank of Dental Officer _____

Clinic Location _____

ABBREVIATIONS MUST BE USED:

Ac Acrylic	D Distal	La Labial
A Amalgam	En Root Canal	Li Lingual
Br Bridge	F Foil	M Mesial
Bu Buccal	G Gold	NE Not Erupted
CC Chrome Cobalt	Imp Impacted	O Occlusal
Ce Cement	In Incisal	P Porcelain
CG Cast Gold	I Inlay	PC Pulp Cap
Cr Crown	J Jacket	Pe Periodontal

8. TOOTH DIAGRAM



NOTES ON USE OF DIAGRAM:
 Carious defects - Outline only.
 Restorations - Outline and fill in.
 Extraction Required - X over tooth concerned.
 Missing Teeth - MD line through tooth concerned.

GENERAL NOTES:
 Treatment rendered must be described in adequate detail.
 Specify denture materials used.
 Avoid unofficial abbreviations.

DENTURES:

PO Post Operative	CUD Complete upper
Pro Prophylaxis	CLD Complete lower
Ra Radiograph	PUD Partial Upper
S Silicate	PLD Partial Lower
Srg Surgical	TD Treatment Denture
WG Wrought Gold	
X Extraction	

DENTAL TREATMENT

DATE	DESCRIPTION OF TREATMENT	SIGNATURE AND RANK OF DENTAL OFFICER
20 Aug 63	R. Sealing 3211 123. (Requires prophyl.)	[Signature]
9 Sep 63	17 - 170 - Atcctpp	[Signature]
15 Jan 65	16 - Do - Temp 2nd.	[Signature]
10 Feb 65	16 - Do - Atcctpp	[Signature]
14 Jun 65	Linen accept for Pw	
14 June	The 17 has an area below the restoration which indicates trouble. R - Good prophyl and	x [Signature]
23 Jun 65	Sub gingival scaling. OH Very Poor.	[Signature]
28 Jun 65	Further scaling & prophylaxis.	[Signature]
22 Jul 65	Prophylaxis.	[Signature]
6 Aug	17 - X - - - - -	[Signature]
18 Nov 66	5-7 - X - - - - -	[Signature]
30 Jun 68	2 PA'S.	
31 Jul 68	4 1 - x	[Signature]
8 Aug 68	5 PA'S.	[Signature]
10 Aug 68	15 - x.	[Signature]
13 Feb 68	Pee 3 n F 2 Bw	[Signature]
6 MAR 69	Dental check on Release	[Signature]
4 Jul 69		[Signature]

15113
Official Number

LAC
Rank or Rating

KALICHUK A E
Name and Initials

RCAF
Service

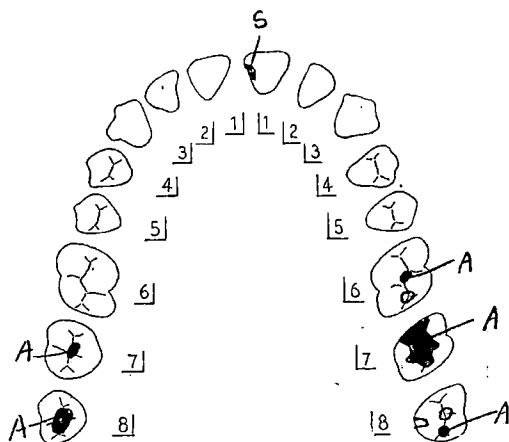
26
Age

TYPE OR PRINT INFORMATION IN BLUE OR BLACK INK

Patient's right

Patient's left

Date 8 Feb 50



REMARKS:

13
Dental Coy. No.

J R Farrell Major
Signature and Rank of Operator

Date	Tooth Treated	Description of Treatment	Operator's Initials and Rank

Caries—Outline defective tissue. Do not fill in space.
Missing teeth—Indicate by a line drawn mesio-distally through diagram.

Use abbreviations, sketch and fill in all restorations.

ABBREVIATIONS:

- M Mesial
- D Distal
- I Incisal
- Ra X-ray
- O Occlusal
- Bu Buccal
- Li Lingual
- A Amalgam
- Ce Cement
- S Synthetic Porcelain
- G Gold
- P Porcelain
- Ac Acrylic

- F Foil
- I Inlay
- C Crown
- J Jacket
- Br Bridge
- X Extraction

DENTURES:

Specify Materials

- PUD Partial upper
- PLD Partial lower
- CUD Complete upper
- CLD Complete lower

TREATMENTS:

Describe Treatment Given

- RC Root Canal
- V's Vincent's Angina
- Pe Periodontia
- Misc. Miscellaneous

Date	Tooth Treated	Description of Treatment	Operator's Initials and Rank	Date	Tooth Treated	Description of Treatment	Operator's Initials and Rank

REMARKS:

Signature of Operator

TYPE OF METALS PRECIOUS	AMOUNT ISSUED	AMOUNT RETURNED	AMOUNT EXPENDED
CASTING.....			
PLATE.....			
SOLDER.....			
WIRE CLASP.....			
WIRE CONNECTOR.....			
WIRE LINGUAL.....			
PLATINUM FOIL.....			
.....			
.....			
.....			
TECHNICIAN'S SIGNATURE.....			

AND
CONDITION ON RELEASE

15113
Official Number

CPL
Rank or Rating

KALICHUK A.
Name and Initials

RCAF
Service

Age

TYPE OR PRINT INFORMATION IN BLUE OR BLACK INK

Patient's right

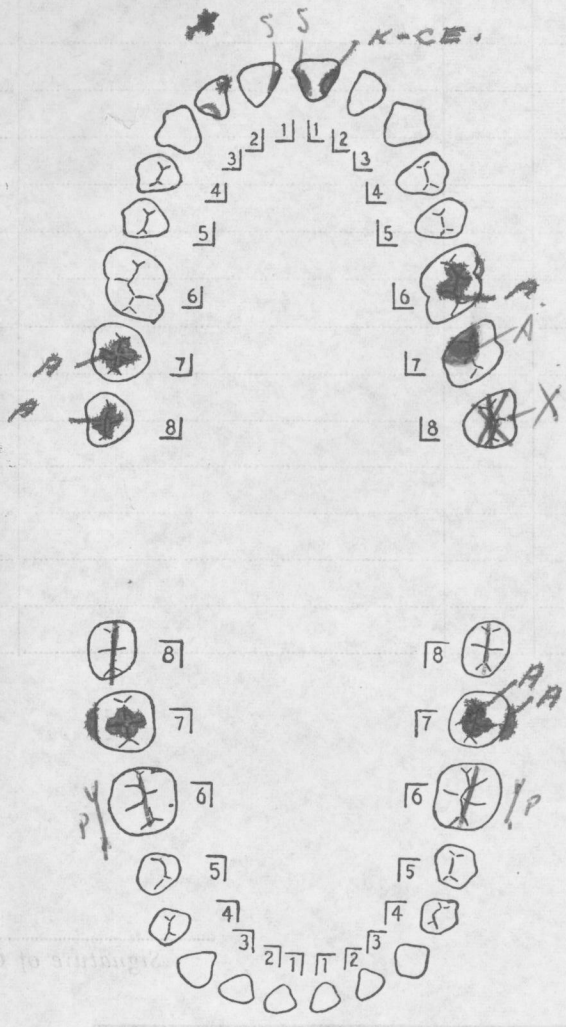
Patient's left

Date 10 Aug 53

Date of Enrolment -- 24 Jan 50

Auth for Release -- ~~QR~~ AIR - 15.01. Item 4(G)

Date of Release ~~PE~~ 23 Jan 55



13
Dental Coy. No. *J. H. Jolly* Capt.
Signature and Rank of Operator

Date	Tooth Treated	Description of Treatment	Operator's Initials and Rank
11 Aug 53	111 - (M) - S ₁₀	Restorations 4 B.W.R.A's	<i>[Signature]</i>
13 Aug 53	18 - X		<i>[Signature]</i>
14 Aug 53	12 - (MO) - A		<i>[Signature]</i>
25 Sep 53	12 - (MO) - Temp. C.C.		<i>[Signature]</i>
29 Oct 53	12 - (MO) A, prophylaxis		<i>[Signature]</i>
9 DEC 54	2 B.W. R.A.S.		<i>[Signature]</i>
	11	D-K-CE	<i>[Signature]</i>
15 DEC 54	21	D-K+CE	<i>[Signature]</i>
	31	M-K+Ce	<i>[Signature]</i>
		Prophylaxis	<i>[Signature]</i>
15113 Cpl A KALICHUK			
Service Signature of Patient & Date			

Caries—Outline defective tissue. Do not fill in space.
Missing teeth—Indicate by a line drawn mesio-distally through diagram.
Use abbreviations, sketch and fill in all restorations.

ABBREVIATIONS:

- M Mesial
- D Distal
- I Incisal
- Ra X-ray
- O Occlusal
- Bu Buccal
- Li Lingual
- A Amalgam
- Ce Ceramic
- S Silver

DENTURES:

- Specify Materials
- Partial upper
- Partial lower
- Complete upper
- Complete lower

TREATMENTS:

- Describe Treatment Given
- RC Root Canal
- V's Vincent's Angina
- Pe Periodontia
- Misc. Miscellaneous

C. A. F. B. 465-6M

DENTAL X-RAY C. A. F. B.

To be attached to Dental Record C.A.F.B. 465

15113
Number

Cpl
Rank/Rating

Kalichuk A
Name and Initials

RCAF
Service

Title or Use of Form

REPORT:

11 Aug 53
Date

Signature of Dental Officer.

C.A.F.B. 1521A
100M-1-52-(5457)
H.Q.4554-B-1521

Date	Tooth Treated	Description of Treatment	Operator's Initials and Rank	Date	Tooth Treated	Description of Treatment	Operator's Initials and Rank

REMARKS:

Signature of Operator

TYPE OF METALS PRECIOUS	AMOUNT ISSUED	AMOUNT RETURNED	AMOUNT EXPENDED
CASTING			
PLATE			
SOLDER			
WIRE CLASP			
WIRE CONNECTOR			
WIRE LINGUAL			
PLATINUM FOIL			
TECHNICIAN'S SIGNATURE			

L 200



000953



000954

① 5768

000955

24-25

DENTAL X-RAY C.A.F.B.

To be attached to Dental Record C.A.F.B. 465

15113

Number

CPL.

Rank/Rating

KALICHUK A

Name and Initials

RCAF.

Service

Title or Use of Form

REPORT:

9 DEC 54 .

Date

Signature of Dental Officer.

C.A.F.B. 1521A
100M-1-52-(5457)
H.Q.4554-B-1521

000956



F.M. 2

000957

000958

000959

000960



000961

15/113
Official Number

Sgt
Rank or Rating

KALICHUK A.
Name and Initials

RCAF
Service

34
Age

TYPE OR PRINT INFORMATION IN BLUE OR BLACK INK

Patient's right

Patient's left

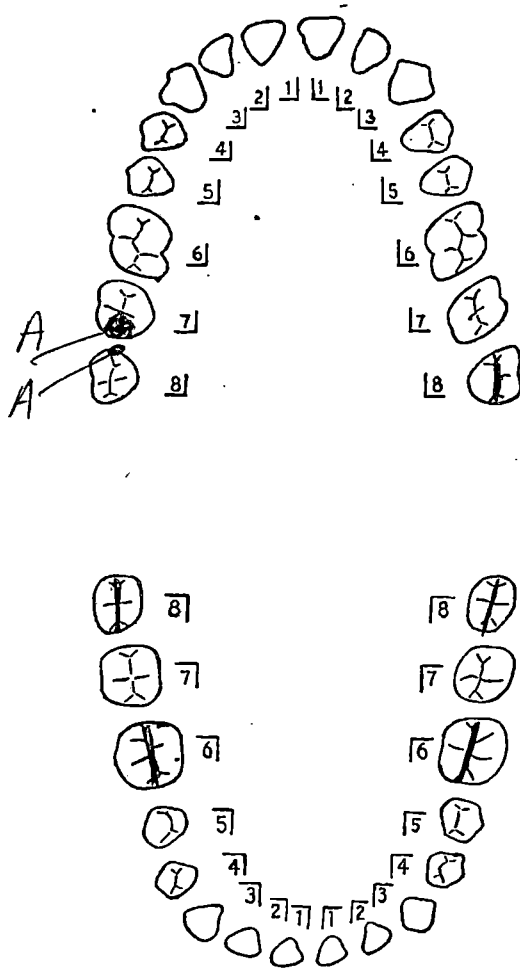
Date 9 Sept '57

REMARKS:

RES Bay (6 mos)

Dental Coy. No. 15

a.c.R. Ramsay Maj
Signature and Rank of Operator



Date	Tooth Treated	Description of Treatment	Operator's Initials and Rank
9 Sept 57		prophyl & scaling	a.c.R. Maj
" " "	7	DO-A + 81-M-A	a.c.R. Maj
10 " "		Exam for complaint. Explained cause of sensitivity after sealing	a.c.R. Maj

[Handwritten signature]

Caries—Outline defective tissue. Do not fill in space.
Missing teeth—Indicate by a line drawn mesio-distally through diagram.
Use abbreviations, sketch and fill in all restorations.

ABBREVIATIONS:

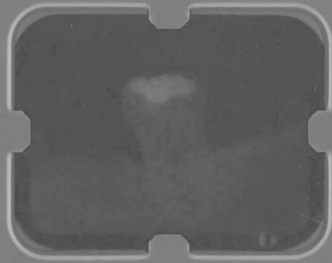
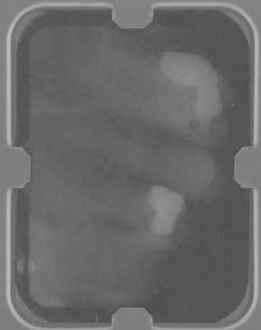
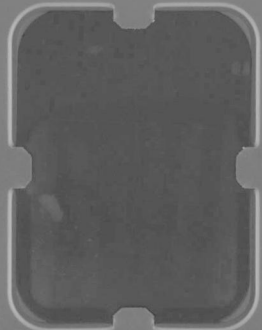
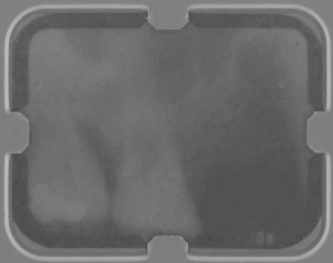
- M Mesial
- D Distal
- I Incisal
- Ra X-ray
- O Occlusal
- Bu Buccal
- Li Lingual
- A Amalgam
- Ce Cement
- S Synthetic Porcelain
- G Gold
- P Porcelain
- Ac Acrylic

DENTURES:

- Specify Materials*
- PUD Partial upper
 - PLD Partial lower
 - CUD Complete upper
 - CLD Complete lower

TREATMENTS:

- Describe Treatment Given*
- RC Root Canal
 - V's Vincent's Angina
 - Pe Periodontia
 - Misc. Miscellaneous



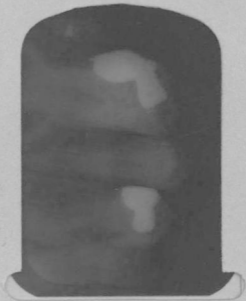
Kalichuf

ap

Ada Products P.O. Box 3630 Milwaukee, Wis. 53217

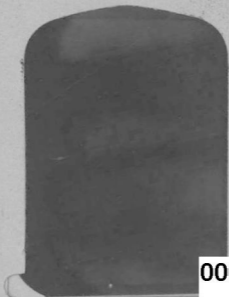
000964

SGT. KALICHNIK



000965

SGT KALICHUK



000966

7: 984974

X RAY INSPECTION OF CHEST

SECTION 1

A radiograph of the chest of

Film No. 625

Rank.....LAC.....Name.....KALICHUK A.....

Reg. No.....15113.....Unit.....RCAF STN. CLINTON ONT.....

Civilian Address as per Registration Card

.....Age.....Height.....Weight.....

Signature of Recruit.....

is reported as follows:—

- (a) Radiological examination does not disclose evidence of tuberculous disease of the lungs of such a nature as to indicate rejection for service in the Canadian Armed Forces except as stated below.
- (b) The transverse diameter of the heart is..... cms. as compared with a transverse diameter of the chest of..... cms.
- (c) Pathological conditions or congenital abnormalities of importance seen in the film are as under-noted. (In each instance an opinion should be expressed as to whether such was present prior to enlistment.)

ANNUAL CHEST X-RAY

**NEGATIVE
APPROVED**

Place.....

Date.....

[Signature]
Radiologist

If a pathological condition or congenital abnormality is not observed by this method of examination, record "negative" after (c).

SECTION 2

Remarks of the Internist, Surgeon or Specialist in Tuberculosis. (State whether in your opinion the lesion present antedated enlistment.)

SECTION 3

Opinion of Consultant Physician and Radiologist as may be indicated by Section 2.

Conclusion.

Place.....

Date.....

Sig.....Sig.....

TREATMENT SERVICES

CASE SHEET

OPHTHALMOLOGY

17-9-69

KALICHUK ALEX 9857
480-488-018 RC 3 NOV25

SURNAME, GIVEN NAMES

CFB CLINTON, ONT.

RECORD NO.

SERVICE NO. OR MARK

HELEN KALICHUK WIFE

527-0095

DATE OF BIRTH

RR 4 WALTON, ONT 15113

See 18 (17-9-69)

Referred to..... BY.....

Reason for Examination.....

History: Mr. Kalichuk has been complaining of diplopia since his lateral rectus was recessed and this is not surprising insofar as he now has to learn to suppress a new corresponding retinal point. He does feel that his distance correction which is +0.50 S OD and +0.75 S OS improves his visual acuity for distance, and also eliminates the diplopia when driving at night. This is not theoretically sound, but insofar as the patient wishes to try these distance glasses for driving, this would seem reasonable.

Anterior Segment } Rt. Lt.

Eye	VISION		REFRACTION				Vision After
	Before	U + 2.50	Sphere	Cylinder	Axis	Prism	
Rt.							
Lt.							

Glasses: { Rt. Sph. +0.50 Cyl. Axis READING
 Prescribed: { Lt. Sph. +0.75 Cyl. Axis READING

Pupils
 Tension: Rt. Lt.
 Cover Test: 20 Ft. 15 Ins.
 Maddox Rod: 20 Ft. 15 Ins.
 Cardinal Positions:

Convergence Cms. Accommodation { Rt. Cms.
 Cms. { Lt. Cms.

Fundi and Media } Rt. Lt.

Fields:

Colour Vision

DIAGNOSIS

Remarks and/or Treatment:

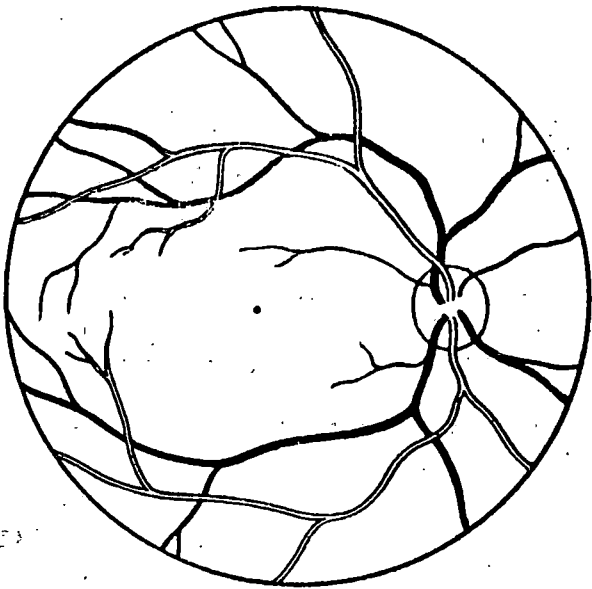
DISTANCE GLASSES AS ABOVE.

James F. Ballantyne
 James F. Ballantyne, M.D., FRCS(C)
 Ophthalmologist

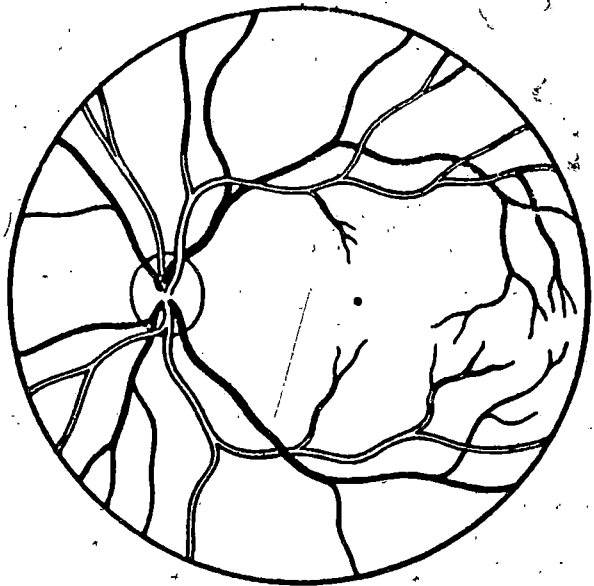
Date 17 Sept 69 /ve

FUNDI

Right Eye

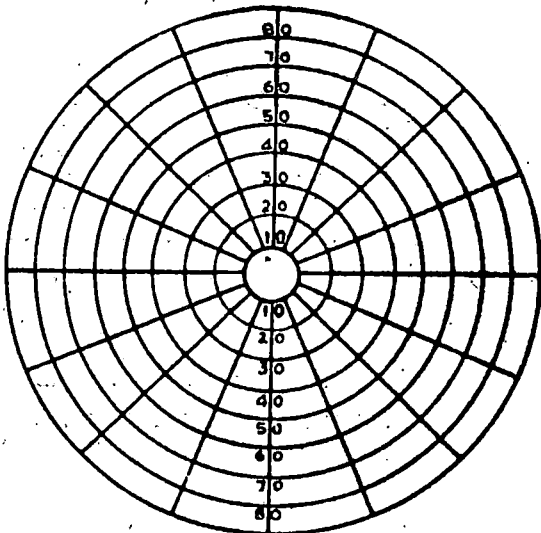


Left Eye



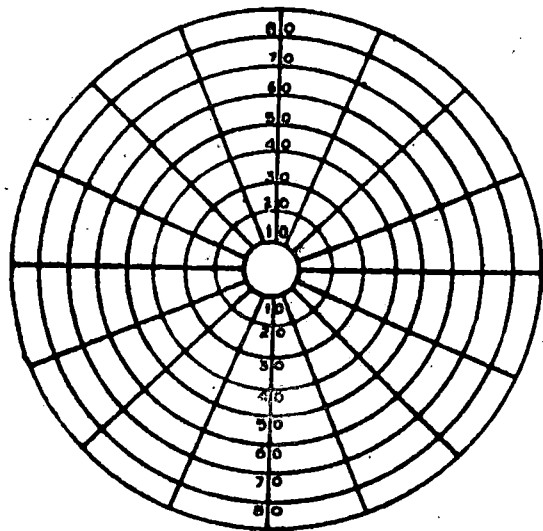
FIELD STUDY

Left Eye



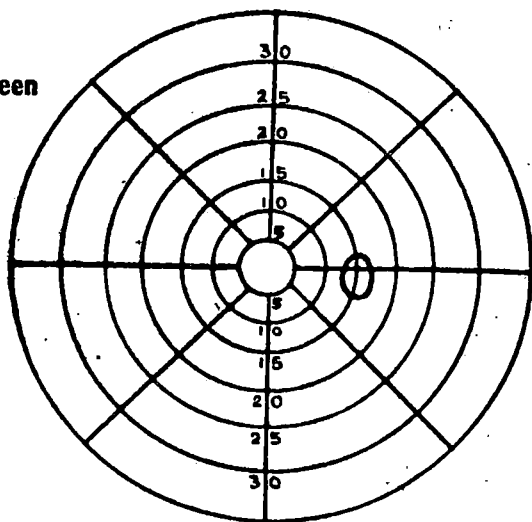
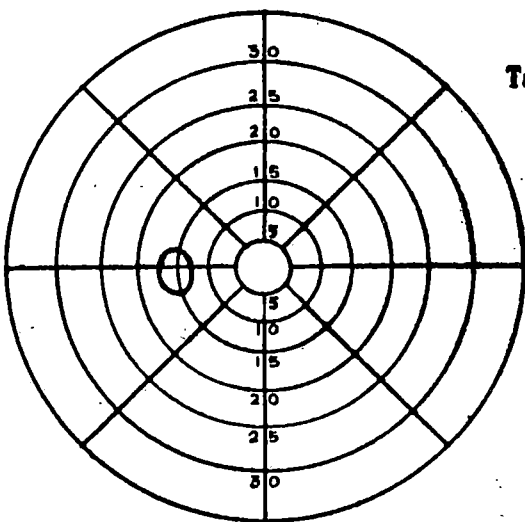
Perimeter

Right Eye



**Colour
Test object, Size
Distance**

Tangent Screen



**Colour
Test object, Size
Distance**

DEPARTMENT OF NATIONAL DEFENCE
Canadian Forces Medical Service
NOTIFICATION OF CHANGE OF MEDICAL CATEGORY

Surname KALICH		Given Names Alexander				Service Number 15113	
Service RCAF (Reg)	Rank Sgt	Trade Sup Tech 911			Year of Birth 1923	Height Ins.	Weight Lbs.
Establishment (if Army include Corps) CFB Clinton Ont				Medical Facility where Board Completed CFB Clinton Ont			

PART I

Service	Prev. Category	Visual Standard							New Category	Visual Standard							DIAGNOSIS - ISC CODE
RCN																	
ARMY		P	U	L	H	E	M	S		P	U	L	H	E	M	S	
RCAF	ALB	V	CV	H	HD	A	L	O		V	CV	H	HD	A	L	O	
		1	1	1	1	1	1	0									

PART II - LIMITATION OF EMPLOYMENT

for conversion to GO factor only.

$$\frac{YOB}{23} \quad \frac{V}{1} \quad \frac{CV}{1} \quad \frac{H}{2} \quad \frac{G}{2} \quad \frac{O}{2} \quad \frac{A}{5}$$

H2 Audiogram

G2 O2 for age

[Handwritten Signature]

D. J. GLADMAN MAJOR

19 Dec 67

N/A

Date to Re-Boarded

Signature of M.O.

Date of Board

PART III - REGIONAL SURGEON'S REMARKS

I concur

[Handwritten Signature]

DJ Gladman Major

Signature

PART IV - ~~CMS ADVISER'S REMARKS~~ BCOMDR'S REMARKS:

CONCUR - RECOMMEND RETENTION IN PRESENT EMPLOYMENT

6 *[Handwritten Signature]*
(E.W. BRYAN) G/C Base Commander

Signature

PART V - COMMAND ADMINISTRATIVE REMARKS

Date

Appointment

Signature

DEPARTMENT OF NATIONAL DEFENCE
REQUISITION ON A CONTRACT

CAF

SERVICE

NO. 20

DDP/QP CONTRACT NO

TO
TAIT GERRARD
381 CLARENCE ST
LONDON ONTARIO

TO THE CONTRACTOR

YOU ARE REQUESTED TO SUPPLY THE FOLLOWING MATERIEL/SERVICES IN ACCORDANCE WITH THE TERMS OF THE ABOVE REFERENCED CONTRACT.

ONLY MATERIEL/SERVICES INCLUDED IN THE CONTRACT SHALL BE SUPPLIED AGAINST THIS REQUISITION.

EACH DELIVERY SHALL BE ACCOMPANIED BY A PACKING NOTE OR DELIVERY SLIP.

PLEASE ADVISE THE UNDERSIGNED IF THE DELIVERY DATE CANNOT BE MET.

INVOICES SHALL BE PREPARED IN ACCORDANCE WITH THE INSTRUCTIONS SET OUT IN THE CONTRACT.

M. Wilton
for BW Wilton Major
Base Surgeon

10 Apr 69

DATE FOR DEPARTMENT OF NATIONAL DEFENCE

DELIVER TO Base Surgeon
CFB Clinton
Adastral Park, Ont

DELIVERY DATE Within 72 hours

CONTRACT ITEM NO	REF./STOCK NO	MATERIEL/SERVICES	QUANTITY	UNIT
	429-488-018	Sgt (AF)		Kalichuk A
	Number	Rank		Name and Initials

1. Please supply the above with:

(a) Spectacles as per accompanying prescription in suitable frames and case, in accordance with DDP contract,

or

(b) Such optical repairs or services as may be required to restore his present spectacles to a fully serviceable condition.

2. One copy of this form signed by the recipient of the spectacles or services performed is to accompany the invoices which you submit monthly under terms of the DDP contract.

3. Please note that personnel are permitted to obtain alternate nonflammable acetate frames of their choice by paying the difference in cost between the frames specified in the contract.

Received in good order:

A. Kalichuk
Signature

Sgt
Rank

21 Apr 69
Date

MLL

WESTMINSTER
HOSPITAL
LONDON ONT
CLINIC CONTROL

KALICHUK, ALEX 9657
15113 RC 03NOV23
CFB CLINTON

TREATMENT SERVICES

REFERRED BY:	READ BY: Dr. N. Dare	DATE:	FILM NUMBER: 6100 - 9.5.69
TYPE OF EXAMINATION:			

~~CLINICAL FINDINGS AND INFORMATION REQUESTED:~~

The esophagus appears normal. There is no evidence of hiatus hernia.

The stomach shows normal motility, peristalsis and mucosal folds with no evidence of gastric ulcer or neoplasm.

The pylorus is essentially normal.

The duodenal bulb is not deformed and no evidence of ulcer crater is recognized. The duodenal loop appears normal.

KJ. DATE 12.5.69

Norman Dare
Norman Dare, M.D. 000973
SIGNATURE OF CONSULTANT R A

**LABORATORY
REQUISITION**

BACTERIOLOGY

429-488-018 (A)

3105
mmw
a

INSTITUTION

WARD

MAJ
CFB CLINTON BASE SURGEON

O.P. 29 Apr, /69

SURNAME, GIVEN NAMES

Sgt. Kalichuk A.

RECORD NO.

SERVICE NO. (OR RANK)

018

DATE OF BIRTH

SERVICE

SPECIMEN: Throat Swab

CLINICAL NOTE OR DIAGNOSIS:

EXAMINATION REQUESTED: C & S

HA

R. L. [Signature]

R. L.

Specimen: THROAT CULTURE

Report:

Normal
flora only

SENSITIVITIES:

5.5.69

ORGANISM	PEN.	STREP.	TETRA	CHLOR.	ERYTH.	NOVO.	BACIT.	NEOM.	POLY.			

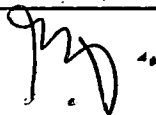
S = Sensitive

R = Resistant

M, R or S = Moderately R or S

Date Received

BACTERIOLOGY



Date Reported
000975

CONSULTANT'S REPORT

[Handwritten initials]

KALICHUK, ALEX 9657
15113 RC 03NOV23
CFB CLINTON

429-488-018 SEC 1 8

KALICHUK A SGT (A) 429 488 018

PENSIONABLE DISABILITY

REFERRED TO:

GASTRO INTESTINAL

DATE

8-5-69

SUMMARY OF COMPLAINTS, PHYSICAL AND LABORATORY EXAMINATION FINDINGS, TREATMENT AND PROGRESS

Burning pain in epigastrium each night at 2-3 am: relieved by food, milk, also occurs before meals, relieved by food. Says his BMs are dark to black often. Recent change in bowel habit with alternating constipation, diarrhea. A long history of excessive intake of "thanal". Large hard liver & fb below RCM. He is being admitted for muscle recession on May 13th. Please proceed with investigation you feel necessary. He is on release in early June.

THIS CASE IS: AMBULATORY STRETCHER WHEELCHAIR BED

SIGNATURE OF M.O. I/C CASE
WILTON B W MAJ

CONSULTANT'S REPORT:

Review of this man's file reveals a diagnosis of psychoneurosis in 1959 with heavy alcohol intake. There is also a story of rather peculiar behaviour and accosting young girls on the roads, although, I gather that he never got into any very serious trouble with the law about this, but did cause considerable concern among the parents, in the locality where he was indulging in this peculiar activities.

He now presents with a classical story of duodenal ulcer characterized by pain in the epigastrium about 2 or 3 am, often waking him from sleep. This began about six months ago and has persisted since that time. The pain is relieved by food and comes on about three hours after a meal associated with hunger. During the same length of time, he has been unable to sleep on his left hand side, it was also initiated when he took a meal including french fried potatoes with a liberal amount of vinegar.

He is to be discharged from the Air Force in the near future and is going to go back to the farm.

He further states that he has had black bowel movements, although, on further inquiry they appear to have been not really black but only dark brown and certainly not to be compared with the black telephone sitting on the desk. He says that his stools are sometimes liquid, although of normal colour, and sometimes small and dark like sheep droppings, sometimes right after a meal he has to rush to the bathroom. These complaints have also gone on for about six months. He says he has had no vomiting. However, he does cough in the early morning when he wakes up and sometimes coughs up a good deal of yellowish stuff and occasionally it is streaked with blood, but this is uncommon and only after a great deal of coughing. I presume, that he will have a chest x-ray when he is admitted to hospital and this should be sufficient to cast some light of this topic. He has never been jaundiced.

DIAGNOSIS:

OVER

RECOMMENDATIONS RESPECTING TREATMENT, CONVALESCENCE, FITNESS FOR GAINFUL EMPLOYMENT, OR DUTY

JLL/pc

May 14/69

SIGNATURE OF CONSULTANT

[Signature]
J. L. Loudon, M.D.

DATE

8-5-69

(USE REVERSE SIDE IF ADDITIONAL SPACE IS REQUIRED)

ON EXAMINATION blood pressure is 160/100. Heart rate 110 per minute and regular. The patient is quite nervous. There is no cardiac enlargement. On abdominal examination there is an old right lower quadrant appendectomy scar. The liver edge is 4 cms. below the right costal margin in the mid-clavicular line. The spleen is not palpable and there are no other masses or enlarged organs. The rectal examination is normal. Prostate is somewhat enlarged, but of normally consistency and there is no occult blood in the stools.

OPINION AND RECOMMENDATIONS: This man probably has a duodenal ulcer. I have arranged for him to have a G.I. series tomorrow morning. If it shows an ulcer then he should be admitted at once to ward 4A. If it does not, I have given him some Gelusil tablets to help with the pain and he can proceed with the plans to be admitted to the Eye Service for correction of one of his extra ocular muscles and when they are through with him, they can then transfer him to the G.I. Service, Ward 4A where I think sigmoidoscopy and barium enema could be performed.

JLL/pc
May 14/69

J. L. Loudon, M.D., FRCP(C)

DEPARTMENT OF NATIONAL DEFENCE
REQUISITION ON A CONTRACT

CAF
SERVICE

NO.

DDP/OP CONTRACT NO
MED5/FE2685AA-165-115-02--
ON DDP Ser TOR8-9819/1 07232

TO
Tait Gerrard Optical Co.,
381 Clarence St.,
London, Ont.

TO THE CONTRACTOR

YOU ARE REQUESTED TO SUPPLY THE FOLLOWING MATERIEL/SERVICES IN ACCORDANCE WITH THE TERMS OF THE ABOVE REFERENCED CONTRACT.

ONLY MATERIEL/SERVICES INCLUDED IN THE CONTRACT SHALL BE SUPPLIED AGAINST THIS REQUISITION.

EACH DELIVERY SHALL BE ACCOMPANIED BY A PACKING NOTE OR DELIVERY SLIP.

PLEASE ADVISE THE UNDERSIGNED IF THE DELIVERY DATE CANNOT BE MET.

INVOICES SHALL BE PREPARED IN ACCORDANCE WITH THE INSTRUCTIONS SET OUT IN THE CONTRACT.

DELIVER TO
Base Commander
CFB Clinton
Adastral Park, Ont.
Attn: Base Surgeon

BK for Base Surgeon
DATE FOR DEPARTMENT OF NATIONAL DEFENCE

DELIVERY DATE Within 72 hours

CONTRACT ITEM NO	REF./STOCK NO	MATERIEL/SERVICES	QUANTITY	UNIT
	<u>159-409-016</u>	<u>Sgt</u>		<u>[Signature]</u>
	Number	Rank		Name and Initials

1. Please supply the above with:

(a) Spectacles as per accompanying prescription in suitable frames and case, in accordance with DDP contract,

or

(b) Such optical repairs or services as may be required to restore his present spectacles to a fully serviceable condition.

2. One copy of this form signed by the recipient of the spectacles or services performed is to accompany the invoices which you submit monthly under terms of the DDP contract.

3. Please note that personnel are permitted to obtain alternate nonflammable acetate frames of their choice by paying the difference in cost between the frames specified in the contract.

Received in good order:

[Signature]
Signature

[Signature]
Rank

30 Sept 69
Date

X RAY REQUISITION AND REPORT

SURNAME: *Kalichuk* FIRST NAME AND INITIALS: *Alexander* SOCIAL INSURANCE NO.: *429468-018*

RANK: *Sgt* SERVICE: *W(A)* AGE: *46* PARENT UNIT: *CFB CLINTON*

X-RAY DEPARTMENT AT: *CLINTON* REPORT TO BE FORWARDED TO: (OFFICE) *HIC CLINTON*

CLINICAL INFORMATION AND DIAGNOSIS:
Vague abd pain - positional
O/C L Abd. aorta easily palpable
seems enlarged - bruit heard
going down to (L) femoral artery

EXAMINATION REQUESTED:
F lat plate abdomen R/L hat
posterior wall shadow

DATE: *Nov 18/69* M.O.'S SIGNATURE: *[Signature]*

IF ROUTINE CHEST	TECHNICIANS USE ONLY
ADMISSION <input type="checkbox"/>	<i>PT Spunk on table for</i>
ENROLMENT <input type="checkbox"/>	<i>14 X 17 2 LAT</i>
RELEASE <input type="checkbox"/>	<i>[Signature]</i>
ANNUAL <input type="checkbox"/>	10 X 12
SERVICE REQ. <input type="checkbox"/>	8 X 10 <i>2E</i>

FILM NO. *8911* DATE OF EXAMINATION *18 Nov 69*

Released

A.P. AND LATERAL VIEWS OF THE ABDOMEN:

intra-

The detail of the/abdominal structures is obscured by grid lines on the films. Questionable linear calcification at the prevertebral region at the level of L2 and 3 and also L5 and S1 is visualized. Linear calcification in the region of the right common iliac artery is suggested. Otherwise the shadow of the abdominal aorta is not clearly demonstrated. The possibility of aneurysm of the abdominal aorta is not conclusive on the present view. No definite evidence of intra-abdominal abnormal mass can be detected. The psoas muscles appear normal on both sides.

Re-examination with A.P., lateral and both oblique views of the abdomen are requested.

[Signature]
Norman Dare, M.D.
 RADIOLOGIST

in 20.11.69

COPY 3

000979

TREATMENT SERVICES

CASE SHEET

(EAR, NOSE AND
THROAT)

INSTITUTION

WARD

Base Surge on

CFB Clinton

KALICHUK ALEX 9657
429-488-018 RG 3 NOV 23
CFB CLINTON, ONT.

SURNAME, GIVEN NAMES Kalichuk Alexander WIFE
HELEN KALICHUK 527-0005
WALTON, ONT RECORD NO.

SERVICE NO. (OR RANK) 429-488-018 15113 Sgt(A) DATE OF BIRTH

21 11 69

3 Nov 23

ENT(throat)

RG Lomas Capt MD.

Referred to

By

Reason for Examination

Ulcer on palate

I. History

Since last may this man has had two non healing shallow ulcers of the hard palate which are painful on eating and drinking.

For biopsy please if you feel it is indicated.

RG Lomas Capt MD.

II. Examination

Stomatitis Gm LeBoldus

This man who is a heavy drinker and smoker, visited us today because of soreness in the mouth.

Examination of the mouth revealed:-

1. the smell of alcohol at 10 o'clock in the morning.
2. two small retention cysts in the palate, and some slight sub-chronic stomatitis involving the rest of the buccal mucosa, and the gingiva.

Indirect laryngoscopy was essentially negative, except for some redness due to chronic irritation.

DIAGNOSES: 1. Stomatitis. 2. Small retention cyst of the palate.

Treatment:- Cut down on smoking and drinking. Lozenges will not help this man.

24 Nov 69
/ve

for

G. M. LeBoldus, M.D., FRCSC(C),
E. N. T. Resident,
Otolaryngologist



Right (A.D.)

Left (A.S.)

Hearing:

- (a) Whispered voice _____
- (b) Conversational voice _____
- (c) Air conduction is greater or less than bone conduction _____
- (d) Weber test _____

Right

Left

Sinus transillumination:

- (a) Frontals _____
- (b) Antra _____

Audiogram — Hearing loss in Decibels:

Date _____

EAR	Type of Conduction	Sound Level	FREQUENCIES											
			128	256	512	1024	2048	2896	4096	5792	8192	11584		
RIGHT	Air	Disappearance												
	Bone	Appearance												
LEFT	Air	Disappearance												
	Bone	Appearance												

III. X-Ray Findings:

IV. Decompression Chamber:

V. Diagnosis:

VI. Remarks and/or Treatment:

Otolaryngologist

Date

Hospital

000981

X-RAY REQUISITION AND REPORT

PR 4

WALTON
ONT

327-0095

SURNAME: Kalichuk
FIRST NAME AND INITIALS: Alexander
SOCIAL INSURANCE NO.: 429488-018

RANK: SGT
SERVICE: C(A)
AGE: 46
PARENT UNIT: CFB CLINTON

X-RAY DEPARTMENT AT: CLINTON
REPORT TO BE FORWARDED TO: (OFFICE) M/R CLINTON

CLINICAL INFORMATION AND DIAGNOSIS:
Vague abd. pain - positional
O/E L Abd. aorta easily palpable
seems enlarged - bruit heard
going down to (L) femoral artery

EXAMINATION REQUESTED:
Flat plate abdomen R/L/ANT
posterior wall shadow

IF ROUTINE CHEST
ADMISSION _____
ENROLMENT _____
RELEASE _____
ANNUAL _____
SERVICE REQ. _____

TECHNICIANS USE ONLY
PT SLEEPING ON TABLE FOR 2 IAT PROJECTION
14 X 17
10 X 12
8 X 10

DATE: Nov. 18/69
M.O.'S SIGNATURE: [Signature]

FILM NO.: 8911
DATE OF EXAMINATION: 18 Nov 69

A.P. AND LATERAL VIEWS OF THE ABDOMEN:

intra-

The detail of the/abdominal structures is obscured by grid lines on the films. Questionable linear calcification at the prevertebral region at the level of L2 and 3 and also L5 and S1 is visualized. Linear calcification in the region of the right common iliac artery is suggested. Otherwise the shadow of the abdominal aorta is not clearly demonstrated. The possibility of aneurysm of the abdominal aorta is not conclusive on the present view. No definite evidence of intra-abdominal abnormal mass can be detected. The psoas muscles appear normal on both sides.

Re-examination with A.P., lateral and both oblique views of the abdomen are requested.

im 20.11.69

[Signature]
Norman Dare, M.D.
RADIOLOGIST

COPY 2

000982

TREATMENT SERVICES

CASE SHEET

(EAR, NOSE AND
THROAT)

ENT(throat)

Base Surge on

CFB Clinton

Kalichuk Alexander

SURNAME, GIVEN NAMES

429-488-018

SERVICE NO. (OR RANK)

21 11 69

INSTITUTION

WARD

KALICHUK ALEX
429-488-018 RC
CFB CLINTON, ONT.
HELEN KALICHUK
WALTON, ONT

9657
3 NOV 23

WIFE
527-0095

15113
Sgt(A)

RECORD NO.

DATE OF BIRTH

3 Nov 23

RD Lomas Capt. MD.

Referred to Ulcer on palate By _____

Reason for Examination _____

I. History

Since last may this man has had two non healing shallow ulcers of the hard palate which are painful on eating and drinking.

For biopsy please if you feel it is indicated.

RD Lomas Capt. MD.

II. Examination

Stomatitis *G. M. LeBaldus*

This man who is a heavy drinker and smoker, visited us today because of soreness in the mouth.

Examination of the mouth revealed:-

1. the smell of alcohol at 10 o'clock in the morning.
2. two small retention cysts in the palate, and some slight sub-chronic stomatitis involving the rest of the buccal mucosa, and the gingiva.

Indirect laryngoscopy was essentially negative, except for some redness due to chronic irritation.

DIAGNOSES: 1. Stomatitis. 2. Small retention cyst of the palate.

Treatment:- Cut down on smoking and drinking. Lozenges will not help this man.

24 Nov 69
/vc

for

H. Hechenan, M.D.,
E. N. T. Resident,
G. M. LeBaldus, M.D., FRCS(C),
Otolaryngologist.



Right (A.D.)

Left (A.S.)

Hearing:

- (a) Whispered voice _____
- (b) Conversational voice _____
- (c) Air conduction is greater or less than bone conduction _____
- (d) Weber test _____

Right

Left

Sinus transillumination:

- (a) Frontals _____
- (b) Antra _____

Audiogram — Hearing loss in Decibels:

Date _____

EAR	Type of Conduction	Sound Level	FREQUENCIES										
			128	256	512	1024	2048	2896	4096	5792	8192	11584	
RIGHT	Air	Disappearance											
	Bone	Appearance											
LEFT	Air	Disappearance											
	Bone	Appearance											

III. X-Ray Findings:

IV. Decompression Chamber:

V. Diagnosis:

VI. Remarks and/or Treatment:

Otolaryngologist

Date

Hospital

000984

X RAY REQUISITION AND REPORT

SURNAME <i>KONICHOV</i>	FIRST NAME AND INITIALS <i>ALEXANDER</i>	SOCIAL INSURANCE NO. <i>429-488-018</i>
----------------------------	---	--

RANK <i>Sgt</i>	SERVICE <i>CPLA 46</i>	AGE	PARENT UNIT <i>EPB GUNTON</i>
--------------------	---------------------------	-----	----------------------------------

X-RAY DEPARTMENT AT: <i>ELWTON</i>	REPORT TO BE FORWARDED TO: (OFFICE) <i>MR GUNTON</i>
---------------------------------------	---

CLINICAL INFORMATION AND DIAGNOSIS:
Abd. pain

EXAMINATION REQUESTED:
Re-examination of abdomen as requested by Radiologist on film report of 8/6/69 18 NOV 69

DATE <i>25 Nov 69</i>	M.O.'S SIGNATURE <i>[Signature]</i>
--------------------------	--

IF ROUTINE CHEST	TECHNICIANS USE ONLY	
ADMISSION <input type="checkbox"/>	<i>14 X 174</i>	
ENROLMENT <input type="checkbox"/>		
RELEASE <input type="checkbox"/>		
ANNUAL <input type="checkbox"/>		<i>10 X 12</i>
SERVICE REQ. <input type="checkbox"/>		<i>8 X 10</i>

FILM NO. <i>8938</i>	DATE OF EXAMINATION <i>25 Nov 69</i>
-------------------------	---

Abdomen:

A.P., lateral and both oblique views show calcification in the lower abdominal aorta and in the iliac arteries.

There is no evidence of an aneurysm radiologically. It should be noted that an aneurysm can only be seen on plain x-rays if it is calcified. If it is not calcified of course it would not be possible to see it on these films.

[Handwritten Signature]

im 26.11.69

J.W.Agnos, M.D. D.M.R. C.R.C.P. (C)
RADIOLOGIST

COPY 2

000985

TREATMENT SERVICES

CASE SHEET

OPHTHALMOLOGY

17-9-69

KALICHUK ALEX 9657
429-488-018 RC 3 NOV23

SURNAME, GIVEN NAMES

CFB CLINTON, ONT.

RECORD NO.

HELEN KALICHUK WIFE

SERVICE NO. (OR RANGE)

RR 4 WALTON, ONT

527-0095

DATE OF BIRTH

15113

(17-9-69)

Referred to..... BY.....

Reason for Examination.....

History: Mr. Kalichuk has been complaining of diplopia since his lateral rectus was recessed and this is not surprising insofar as he now has to learn to suppress a new corresponding retinal point. He does feel that his distance correction which is +0.50 S O and +0.75 S OS improves his visual acuity for distance, and also eliminates the diplopia when driving at night. This is not theoretically sound, but insofar as the patient wishes to try these distance glasses for driving, this would seem reasonable.

Anterior Segment } Rt. Lt.

Eye	VISION		REFRACTION				Vision After
	Before	U + 2.50	Sphere	Cylinder	Axis	Prism	
Rt.							
Lt.							

Glasses: { Rt. Sph. +0.50 Cyl. Axis READING
 Prescribed: { Lt. Sph. +0.75 Cyl. Axis READING

Pupils
 Tension: Rt. Lt.
 Cover Test: 20 Ft. 15 Ins.
 Maddox Rod: 20 Ft. 15 Ins.
 Cardinal Positions:

Convergence Cms. Accommodation { Rt. Cms.
 Cms. { Lt. Cms.

Fundi and Media } Rt. Lt.

Fields:

Colour Vision

DIAGNOSIS

Remarks and/or Treatment:

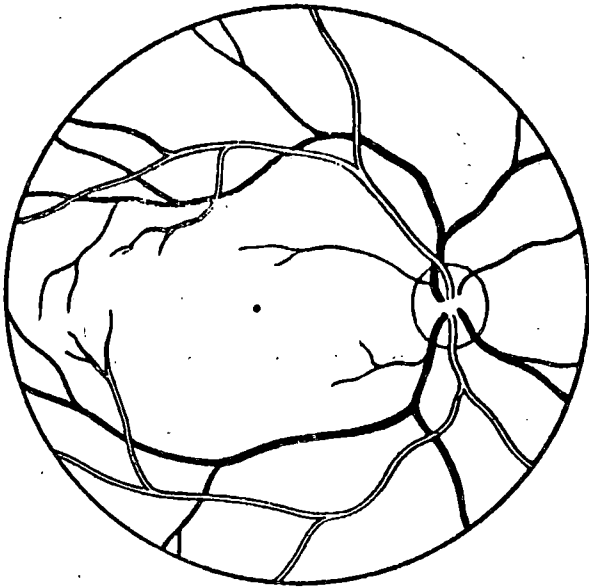
DISTANCE GLASSES AS ABOVE.

James F. Ballantyne
 James F. Ballantyne, M.D., FRCSC(O)
 Ophthalmologist

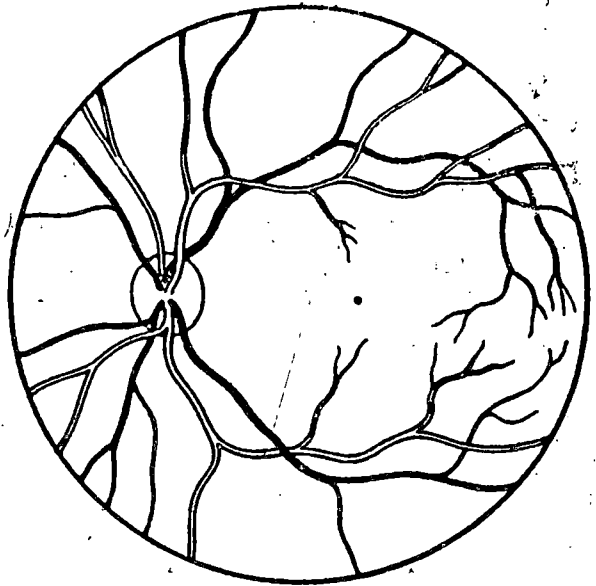
Date 17 Sept 69 /vo

FUNDI

Right Eye

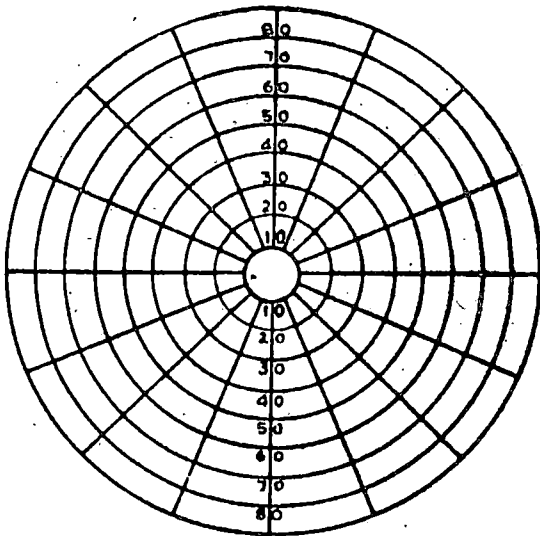


Left Eye



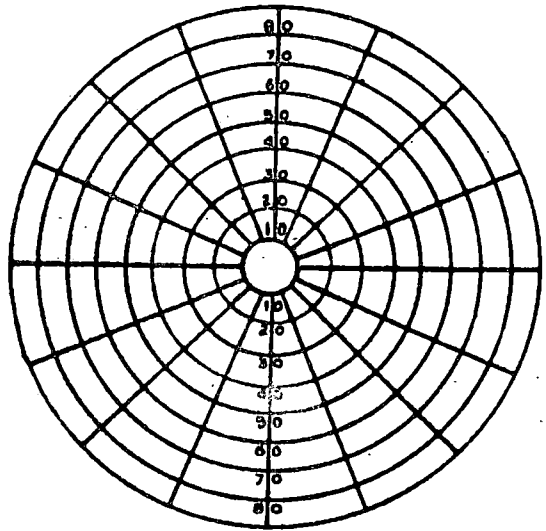
FIELD STUDY

Left Eye



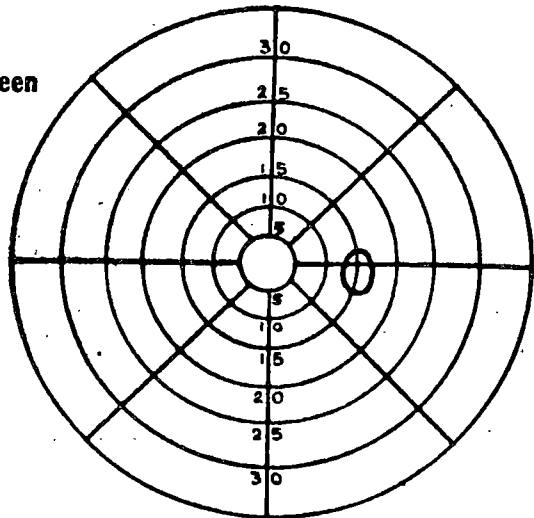
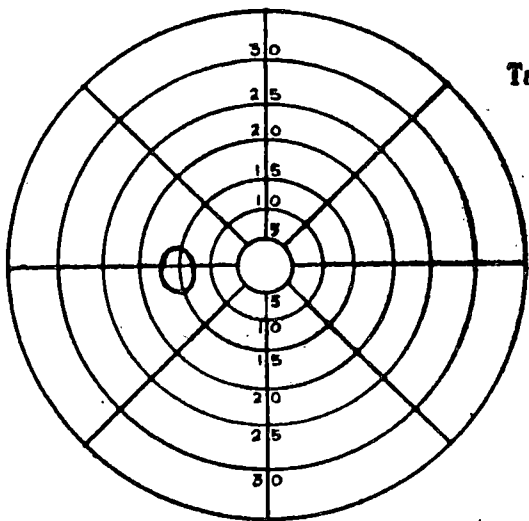
Perimeter

Right Eye



Colour
Test object, Size
Distance

Tangent Screen



Colour
Test object, Size
Distance

CASE HISTORY SHEET

591 (E) KALICHUK, ALEX 9657
 429-489-018 RC 3 NOV 23
 CFB CLINTON, ONT.
 HELEN KALICHUK WIFE
 RR 4 WALTON, ONT 527-0095
 15113

4-A
 MW

RELEASE
 18 5 69

TOS 20.5.69 Sec 18

DATE OF ADMISSION	TRANSFERRED FROM	CONDITION ON ADMISSION ELECTIVE <input type="checkbox"/> SERIOUS <input type="checkbox"/> EMERGENCY <input type="checkbox"/>	REFERRED BY
DATE OF DISCHARGE 30 MAY 29 March, 1969	DAYS IN HOSPITAL	DISPOSAL DUTY <input checked="" type="checkbox"/> OUT PATIENT <input type="checkbox"/> TRANSFER <input type="checkbox"/> HOME <input type="checkbox"/>	
TRANSFERRED TO	CONDITION ON DISPOSAL RECOVERED <input type="checkbox"/> IMPROVED <input checked="" type="checkbox"/> NOT IMPROVED <input type="checkbox"/> DEAD <input type="checkbox"/>		DIAGNOSIS ONLY <input type="checkbox"/>

IF ACCIDENT STATE CIRCUMSTANCES

DIAGNOSIS ON ADMISSION G.I. investigation	SECTION 18
FINAL DIAGNOSES (IN ORDER OF IMPORTANCE)	MORBIDITY CODE
1. Irritable colon	5641
2. Mucosal ulcers of hard palate	5289
3.	
OPERATIONS	DATE
1.	
2.	
3.	

SUMMARY (COMPLAINTS, PHYSICAL AND LABORATORY EXAMINATION FINDINGS, TREATMENT, ETC.)

This 45-year old man was admitted with recurrent epigastric pain and diarrhoea. Previous investigation had shown a normal stomach and oesophagus, and on this admission, investigation showed normal sigmoidoscopy, barium enema, and small bowel follow-through. Stools were negative for occult blood, and ova and parasites. Urinalyses showed slight proteinuria, but a 24-hour urine protein was negative. Creatinine clearance was 68 ml per minute, but the urine volume is only 450ml. B.U.N. Creatinine were normal. The patient had two medium-size ulcers on the hard palate. Cultures from these were negative and Dequadin lozenges helped. The epigastric distress was helped by Amphojel.

MEDICATIONS:

1. Amphojel, as directed.
2. Dequadin lozenges, t.i.d.
3. Triaminic, tabs. 1, t.i.d.

RECOMMENDATIONS: To return to the G.I. Clinic in three weeks.

SURGEON GENERAL
 AUG 29 1969
 STATISTICS SECTION

RECOMMENDATIONS (FURTHER TREATMENT, CONVALESCENCE, LIMITATIONS AS TO WORK, ETC.)

TS 100 (REV. 12/65) 15M-1 RMB/yt	DATE LIKELY FIT FOR WORK	SIGNATURE OF MEDICAL OFFICER I/C CASE R.M. Barr, M.D. for J.L. Loudon, M.D.
-------------------------------------	--------------------------	--

M1

ADMISSION NOTES

Admission recommended by Dr. London
 Chest X-ray completed - Refer to Dental
 Occupation: serviceman
 Employer's Name & Address: Department of National Defence - C.F.B. - London
 Family doctor: none

PROVISIONAL DIAGNOSIS

G.I. investigation

 Section 18
 SIGNATURE OF ADMITTING OFFICER



DATE

CLINICAL NOTES WITH SIGNATURES

20 May 69

T.O.S. THIS DATE:

R.M. Barr,

M.D. - HISTORY AND PHYSICAL EXAMINATION:

HISTORY OF PRESENT ILLNESS:

This 45-year old man states that for the past six months, he has noticed recurrent discomfort in the epigastrium, mainly between meals and at night, and helped by eating almost anything or drinking any fluid. He also noticed a left upper quadrant gaseous pain, when lying on his left side, and has had recurrent diarrhoea with up to four to five bowel movements, occurring in a few hours, followed by constipation for a day or two. The stool is light in colour and watery. He has never had any vomiting, haematemesis or melena. He has no back pain. Coffee seems to precipitate the diarrhoea at times. He has no weight loss.

PAST HISTORY:

Patient has had correction of a squint of the left eye recently, and has some from that, while driving. He has had no other serious illnesses. s.19(1)

FAMILY HISTORY:

No diabetes, tuberculosis or premature heart disease. [REDACTED] has asthma.

FUNCTIONAL ENQUIRY:

Patient has occasional headaches from reading. He had one dizzy spell some months' ago, but none since. Ten days' ago, he was told that he had an ulcer in the roof of his mouth and feels slight burning there on drinking hot liquids. He has a chronic cough due to smoking and coughs up a half-cup of white sputum daily, mainly in the morning. He occasionally has blood streaky sputum after prolonged coughing. He becomes short of breath on running short distances, or climbing stairs quickly. He has no orthopnoea, paroxysmal, nocturnal dyspnoea or ankle oedema. He does complain of a sharp, aching pressure-type of pain, in the anterior chest on exerting himself, lasting only a few minutes and relieved by rest. He has no G.U. complaints or other significant complaints.

PERSONAL HISTORY:

The patient is married with three children, and lives on a farm. He smokes cigarettes and drinks moderately. He is retiring from the Air Force, after 25 years.

PHYSICAL EXAMINATION:

Patient is a round-faced man with a ruddy complexion.

HEAD & NECK:

There is conjunctival injection of the right eye from recurrent surgery. There is no icterus. Fundi are normal and extra ocular movements are normal, with no diplopia. Visual fields are intact. On the posterior portion of the hard palate, there are two ulcerated areas with slight surrounding oedema. There is no exudate, and the ulcer margins are sharp. Remainder Mouth & Throat is negative. There is no jugular venous distention, thyroid enlargement, cervical lymphadenopathy or bruits.

Westminster Hospital - LONDON, Ont.

4A

KALICHUK, Alex

9657

429-483-018

3 Nov 23

page 3

DATE	CLINICAL NOTES WITH SIGNATURES
	<p>CHEST: Clear to percussion and auscultation.</p> <p>C.V.S.: Heart rate: 88 per minute and regular. B.P. 140/90. Heart sounds are essentially normal, with splitting of the second sound on inspiration, and possibly accentuation of the pulmonary component. There is no right ventricular heave or cardiomegaly. There are no murmurs. Pedal pulses are palpable.</p> <p>ABDOMEN: The abdomen is soft and non-tender. There are no organs or masses palpable, but the liver edge percusses at the level of the umbilicus. Rectal Examination: Prostate is small and firm, and there are no masses.</p> <p>EXTREMITIES: No cyanosis, clubbing or oedema.</p> <p>SKIN: Negative.</p> <p>C.N.S.: Motor power sensation and reflexes are normal.</p> <p>IMPRESSION:</p> <ol style="list-style-type: none"> 1. Abdominal pain - sounds like peptic ulcer, but upper G.I. Series is negative. 2. Recurrent diarrhoea - probably irritable colon, but should R/O infectious cause. 3. Palatal ulcers - ? Vincent's angina. 4. Chronic bronchitis. 5. ? angina pectoris. 6. Post-operative corrective surgery for squint. <p>RMB/yt R.M. Barr, M.D.</p>
<p>21 May, 69 R.M. Barr, M.D.</p>	<p>- PROGRESS NOTE:</p> <p>Sigmoidoscopy negative - well prepared.</p> <p>RMB/yt R. M. Barr, M.D.</p>

May, 1969

C.A. Thompson, M.D. - CONSULTANT'S REPORT: Ophthalmology

HISTORY: Recheck as requested by Dr. Thompson.

Patient had a recession of the external rectus of the right eye on May 13th. Today he has an exotropia of 4 prism diopters for distance and 10 P. D. for near. With +0.50 S in each eye, he gets 20/20 vision. No further treatment necessary.

CAT/yt

C.A. Thompson, M.D.
Consultant in Ophthalmology

23 May, 69

J.L. Loudon, M.D. - WARD ROUNDS:

Admitted with history of peptic ulcer. No pathology seen on G.I.'s or barium enema. Should be treated with antacids anyway. Also has ulcers on roof of mouth.

JLL/yt

J.L. Loudon, M.D.
G.I. Consultant

26 May, 69

R.M. Barr, M.D. - PROGRESS NOTE:

Barium enema normal. Will do small bowel follow-through to rule out Crohns. Ulcers in mouth are healing.

RMB/yt

R.M. Barr, M.D.

29 May, 69

S.O.S. THIS DATE:

3 copy

SGT (W)

KALICHUK ALEX 9657
429-488-018 RC 3 NOV23
CFB CLINTON, ONT.
HELEN KALICHUK WIFE
RR 4 WALTON, ONT 527-0095
15113

10-5-69

TO 5-12-5-69 Sec 18

DATE OF ADMISSION <i>12 May 69</i>	TRANSFERRED FROM	CONDITION ON ADMISSION ELECTIVE <input type="checkbox"/> SERIOUS <input type="checkbox"/> EMERGENCY <input type="checkbox"/>	REFERRED BY
DATE OF DISCHARGE <i>15 May 69</i>	DAYS IN HOSPITAL	DISPOSAL DUTY <input type="checkbox"/> OUT PATIENT <input type="checkbox"/> TRANSFER <input type="checkbox"/> HOME <input checked="" type="checkbox"/>	
TRANSFERRED TO	CONDITION ON DISPOSAL RECOVERED <input type="checkbox"/> IMPROVED <input type="checkbox"/> NOT IMPROVED <input type="checkbox"/> DEAD <input type="checkbox"/>		DIAGNOSIS ONLY <input type="checkbox"/>

IF ACCIDENT STATE CIRCUMSTANCES

DIAGNOSIS ON ADMISSION <i>Muscle imbalance, both eyes</i>	SECTION <i>18</i>
FINAL DIAGNOSES (IN ORDER OF IMPORTANCE) 1. <i>Alternating exotropia</i>	MORBIDITY CODE <i>3731</i>
OPERATIONS 1. <i>Recession external rectus O.D. O.S.</i>	DATE <i>106 13 May 69</i>

SUMMARY (COMPLAINTS, PHYSICAL AND LABORATORY EXAMINATION FINDINGS, TREATMENT, ETC.)

Patient seen in the clinic today having had an 8 mm. recession of the external rectus of the right eye two days ago. There is only moderate reaction present. His eyes are looking excellent, but it is too early to give a final result. We would advise that the patient be discharged to use Sodium Sulamyd drops to his right eye four times a day.

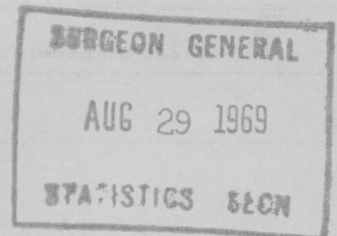
RECOMMENDATIONS:

Return to Clinic in TWO WEEKS' TIME.

Patient need not report back for duty until TUESDAY, 20TH MAY, 1969.

Medications as above.

"SUBJECT TO D.N.D. APPROVAL."



RECOMMENDATIONS (FURTHER TREATMENT, CONVALESCENCE, LIMITATIONS AS TO WORK, ETC.)

TS 100 (REV. 12/65) ISM-1	DATE LIKELY FIT FOR WORK	SIGNATURE OF MEDICAL OFFICER I/C CASE <i>C. A. Thompson, M.D.</i>
------------------------------	--------------------------	--

CAT:vc:jm

ADMISSION NOTES

Admission recommended by Dr. Thompson.
Occupation: D.N.D., Air, CFB, London

PROVISIONAL DIAGNOSIS

Muscle imbalance, both eyes

SIGNATURE OF ADMITTING OFFICER



DATE

CLINICAL NOTES WITH SIGNATURES

12 May 69

Admitted this date.

This 45 year old, well developed, well nourished man entered the hospital for elective repair of squint of eye. Patient noted distortion of vision and fatigue of eye. He could not keep concentration for more than a few seconds.

PAST HISTORY: Appendectomy.
Fracture of nasal bone.

ALLERGIES: Feathers, dust.

B.P. 150/100. Pulse 76.

GENERAL: Well developed, well nourished, not acutely ill, alert man.

HEAD: No trauma.

EYE: Pupils round, equal, reactive to light.
No opacity.
Cornea - No ulcer, no swelling of anterior chamber.
Iris - No rupture. No different pigmentation.
Good accommodation.
Conjunctiva - Not congested.
Sclerae - Not hyperemic. Not icteric.

CONVERSION: Left eye: to lateral side. No nystagmus.
No spot of visual field.
Palpebrae - No ptosis.
Lacrimal gland intact.
Eye tissue - No eczema.
No exophthalmosis.

NOSE: No obstruction. Old fractured.....^{hump} of nasal bone.

EAR: No discharge.

MOUTH: Ulceration of soft palate.

NECK: No mass. No goiter.

CHEST: Lungs clear. Heart normal.

ABDOMEN: Negative.

EXTREMITY: Normal.

G.U.: 40 2 23
Normal testicles and penis.

IMPRESSION: 1. Strabismus
2. Ulcer, soft palate.

/vm (written note)

B.S. Chung, M.D.

KALICHUK, Alexander 9657

429-488-018

15113

DATE	CLINICAL NOTES WITH SIGNATURES
13 May 69	<p><u>RECESSION EXTERNAL RECTUS OD. OS</u> External rectus muscle recessed, 8 mm., and attached to sclera with DA plain cat gut suture. Conj. closed with 3 DA plain catguts. Albucid. /vm (written) C. A. Thompson, M.D.</p>
15 May 69	S.O.S.

*3C
2*

RELEASE

Sgt (L)

KALICHUK ALEX 9657
429-488-018 RC 3 NOV23
CFB CLINTON, ONT.
HELEN KALICHUK WIFE
RR 4 WALTON, ONT 527-0095
15113

NO 5 69

TOS 12-5-69 Dec 18

DATE OF ADMISSION 12 May 69	TRANSFERRED FROM	CONDITION ON ADMISSION ELECTIVE <input type="checkbox"/> SERIOUS <input type="checkbox"/> EMERGENCY <input type="checkbox"/>			REFERRED BY
DATE OF DISCHARGE 15 May 69	DAYS IN HOSPITAL	DISPOSAL DUTY <input type="checkbox"/> OUT PATIENT <input type="checkbox"/> TRANSFER <input type="checkbox"/> HOME <input checked="" type="checkbox"/>			
TRANSFERRED TO		CONDITION ON DISPOSAL RECOVERED <input type="checkbox"/> IMPROVED <input type="checkbox"/> NOT IMPROVED <input type="checkbox"/> DEAD <input type="checkbox"/>			DIAGNOSIS ONLY <input type="checkbox"/>

IF ACCIDENT STATE CIRCUMSTANCES

DIAGNOSIS ON ADMISSION Muscle imbalance, both eyes	SECTION 18
FINAL DIAGNOSES (IN ORDER OF IMPORTANCE)	MORBIDITY CODE
1. Alternating exotropia	
2.	
3.	
OPERATIONS	DATE
1.	
2. Recession external rectus O.D. O.S.	13 May 69
3.	

SUMMARY (COMPLAINTS, PHYSICAL AND LABORATORY EXAMINATION FINDINGS, TREATMENT, ETC.)

Patient seen in the clinic today having had an 8 mm. recession of the external rectus of the right eye two days ago. There is only moderate reaction present. His eyes are looking excellent, but it is too early to give a final result. We would advise that the patient be discharged to use Sodium Sulamyd drops to his right eye four times a day.

RECOMMENDATIONS:

Return to Clinic in TWO WEEKS' TIME.
Patient need not report back for duty until TUESDAY, 20TH MAY, 1969.

Medications as above.

"SUBJECT TO D.N.D. APPROVAL."

RECOMMENDATIONS (FURTHER TREATMENT, CONVALESCENCE, LIMITATIONS AS TO WORK, ETC.)

TS 100 (REV. 12/65)	DATE LIKELY FIT FOR WORK	SIGNATURE OF MEDICAL OFFICER I/C CASE C. A. Thompson, M.D.
15M-1	CAT:vc;vn	

000995

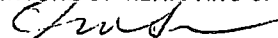
ADMISSION NOTES

Admission recommended by Dr. Thompson.
Occupation: D.N.D., Air, CFB, London

PROVISIONAL DIAGNOSIS

Muscle imbalance, both eyes

SIGNATURE OF ADMITTING OFFICER



DATE

CLINICAL NOTES WITH SIGNATURES

12 May 69

Admitted this date.

This 45 year old, well developed, well nourished man entered the hospital for elective repair of squint of eye. Patient noted distortion of vision and fatigue of eye. He could not keep concentration for more than a few seconds.

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Fracture of nasal bone.

ALLERGIES: Feathers, dust.

B.P. 150/100. Pulse 76.

GENERAL: Well developed, well nourished, not acutely ill, alert man.

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EYE: Pupils round, equal, reactive to light.
No opacity.
Cornea - No ulcer, no swelling of anterior chamber.
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Good accommodation.
Conjunctiva - Not congested.
Sclerae - Not hyperemic. Not icteric.

CONVERSION: Left eye: to lateral side. No nystagmus.
No spot of visual field.
Palpebrae - No ptosis.
Lacrimal gland intact.
Eye tissue - No eczema.
No exophthalmosis.

NOSE: No obstruction. Old fractured..... hump of nasal bone.

EAR: No discharge.

MOUTH: Ulceration of soft palate.

NECK: No mass. No goiter.

CHEST: Lungs clear. Heart normal.

ABDOMEN: Negative.

EXTREMITY: Normal.

G.U.: Normal testicles and penis.

IMPRESSION: 1. Strabismus
2. Ulcer, soft palate.

/vii (written note)

B.S. Chung, M.D.

KALICHUK, Alexander 9657

429-488-018
15113

DATE	CLINICAL NOTES WITH SIGNATURES
<u>RECESSION</u>	<u>EXTERNAL RECTUS OD, OS</u>
13 May 69	<p>External rectus muscle recessed, 8 mm., and attached to sclera with DA plain cat gut suture. Conj. closed with 3 DA plain catguts. Albuclid. /vm (written) C. A. Thompson, M.D.</p>
15 May 69	S.O.S.

CONSULTANT'S REPORT

KALICHUK ALEX 9657
429-488-018 RC 3 NOV23
CFB CLINTON, ONT.
HELEN KALICHUK WIFE
RR 4 WALTON, ONT 527-0095
15113

KALICHUK ALEX SGT(A) 429 488 018 DVA # 9657

PENSIONABLE DISABILITY

119-6-69

REFERRED TO:

GI

DATE

19 Jun 69

SUMMARY OF COMPLAINTS, PHYSICAL AND LABORATORY EXAMINATION FINDINGS, TREATMENT AND PROGRESS

DISCHARGED FROM YOUR HOSP 30 May 69 ASKED TO RETURN GI CLINIC 19 Jun 69

THIS CASE IS: AMBULATORY STRETCHER WHEELCHAIR BED

SIGNATURE OF M.O. I/C CASE

R. JONAS CAPT

CONSULTANT'S REPORT:

This man was discharged from this hospital on May 30, 1969, having been admitted with a good clinical history of duodenal ulcer. However, investigation in hospital failed to reveal any evidence of duodenal ulcer on G.I. Series, and barium enema and sigmoidoscopy were also normal. This is all documented in the account of his last admission. It was also noted at that time that he had ulcers on the roof of his mouth, and his V.D.R.L. was non-reactive. He has a past psychiatric history and has apparently manifested peculiar behaviour toward young girls.

When patient presents today, he says he feels better. He has been treated with Amphogel for his ulcer symptoms, and apparently this has produced some improvement. He is taking this three times a day after meals. He has also been taking Dequadin lozenges, and today the ulcers appear some better. However, he ran out of the Dequadin lozenges and I have ordered a further supply for 10 days, to be taken 1, t.i.d.

He says that he will "have to go on a diet". Apparently this has some special symbolic significance to him and he is quite impressed by the fact that he has decided that he will require a "diet". When I inquired into this it appeared that he had drunk some apple juice his wife gave him and about 1 1/2 hour later he vomited it up. He says that he sometimes has similar trouble with gravy. I advised him to avoid apple juice, gravy, and anything else that upset his stomach.

He need not return to G.I. Clinic unless he has further trouble. He should continue with the Amphojel for about 3 months and should continue with the Dequadin lozenges for another 10 days.

DIAGNOSIS:

RECOMMENDATIONS RESPECTING TREATMENT, CONVALESCENCE, FITNESS FOR GAINFUL EMPLOYMENT, OR DUTY

/bjs

20 Jun 69

J.L. Loudon

SIGNATURE OF CONSULTANT

J.L. Loudon, M.D. FRCP(C)

DATE

19 Jun 69

(USE REVERSE SIDE IF ADDITIONAL SPACE IS REQUIRED)

a

release

KALICHUK ALEX 9657
429-488-018 RC 3 NOV23
CFB CLINTON, ONT.
HELEN KALICHUK WIFE
RR 4 WALTON, ONT 527-0095
15113

KALICHUK ALEX SOT(A) 429 488 018 DVA # 9657

PENSIONABLE DISABILITY

119 - 6 69

REFERRED TO:

GI

DATE

19 Jun 69

SUMMARY OF COMPLAINTS, PHYSICAL AND LABORATORY EXAMINATION FINDINGS, TREATMENT AND PROGRESS

DISCHARGED FROM YOUR HOSP 30 May 69 ASKED TO RETURN GI CLINIC 19 Jun 69

THIS CASE IS: AMBULATORY STRETCHER WHEELCHAIR BED

SIGNATURE OF M.O. I/C CASE

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CONSULTANT'S REPORT:

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DIAGNOSIS:

RECOMMENDATIONS RESPECTING TREATMENT, CONVALESCENCE, FITNESS FOR GAINFUL EMPLOYMENT, OR DUTY

/bjs
20 Jun 69

J.L. Loudon

SIGNATURE OF CONSULTANT
J.L. Loudon, M.D. FRCP(C)

DATE

19 Jun 69

(USE REVERSE SIDE IF ADDITIONAL SPACE IS REQUIRED)

4A

Sgt (L)

KALICHUK ALEX 9657
 429-488-018 RC 3 NOV23
 CFB CLINTON, ONT.
 HELEN KALICHUK WIFE
 RR 4 WALTON, ONT 527-0095
 15113

13 15 69

Tos 20.5.69 Sec 18

DATE OF ADMISSION	TRANSFERRED FROM	CONDITION ON ADMISSION ELECTIVE <input type="checkbox"/> SERIOUS <input type="checkbox"/> EMERGENCY <input type="checkbox"/>	REFERRED BY
DATE OF DISCHARGE 30 MAY 29 March, 1969	DAYS IN HOSPITAL	DISPOSAL DUTY <input type="checkbox"/> OUT PATIENT <input type="checkbox"/> TRANSFER <input type="checkbox"/> HOME <input type="checkbox"/>	
TRANSFERRED TO	CONDITION ON DISPOSAL RECOVERED <input type="checkbox"/> IMPROVED <input checked="" type="checkbox"/> NOT IMPROVED <input type="checkbox"/> DEAD <input type="checkbox"/>		DIAGNOSIS ONLY <input type="checkbox"/>

IF ACCIDENT STATE CIRCUMSTANCES

DIAGNOSIS ON ADMISSION G.I. investigation	SECTION 18
FINAL DIAGNOSES (IN ORDER OF IMPORTANCE)	MORBIDITY CODE
1. Irritable colon	
2. Mucosal ulcers of hard palate	
3.	

OPERATIONS	DATE	A N A E S T H E T I C
1.		
2.		
3.		

SURGEON GENERAL
 JUL 18 1969
 STATISTICS SECR

SUMMARY (COMPLAINTS, PHYSICAL AND LABORATORY EXAMINATION FINDINGS, TREATMENT, ETC.)

This 45-year old man was admitted with recurrent epigastric pain and diarrhoea. Previous investigation had shown a normal stomach and oesophagus, and on this admission, investigation showed normal sigmoidoscopy, barium enema, and small bowel follow-through. Stools were negative for occult blood, and ova and parasites. Urinalyses showed slight proteinuria, but a 24-hour urine protein was negative. Creatinine clearance was 68 ml. per minute, but the urine volume is only 450ml. B.U.N. Creatinine were normal. The patient had two medium-size ulcers on the hard palate. Cultures from these were negative and Dequadin lozenges helped. The epigastric distress was helped by Amphojel.

MEDICATIONS:

1. Amphojel, as directed.
2. Dequadin lozenges, t.i.d.
3. Triaminic, tabs. 1, t.i.d.

RECOMMENDATIONS: To return to the G.I. Clinic in three weeks.

RECOMMENDATIONS (FURTHER TREATMENT, CONVALESCENCE, LIMITATIONS AS TO WORK, ETC.)

Nil

ADMISSION NOTES

Admission recommended by Dr. Loudon
 Chest X-ray completed - Refer to Dental
 Occupation: serviceman
 Employer's Name & Address: Department of National Defence - C.F.B. - London
 Family doctor: none

PROVISIONAL DIAGNOSIS

G.I. investigation

 Section 19
 SIGNATURE OF ADMITTING OFFICER



DATE

CLINICAL NOTES WITH SIGNATURES

20 May 69

T.O.S. THIS DATE:

R.M. Barr,

M.D. - HISTORY AND PHYSICAL EXAMINATION:

HISTORY OF PRESENT ILLNESS:

This 45-year old man states that for the past six months, he has noticed recurrent discomfort in the epigastrium, mainly between meals and at night, and helped by eating almost anything or drinking any fluid. He also noticed a left upper quadrant gaseous pain, when lying on his left side, and has had recurrent diarrhoea with up to four to five bowel movements, occurring in a few hours, followed by constipation for a day or two. The stool is light in colour and watery. He has never had any vomiting, haematemesis or melena. He has no back pain. Coffee seems to precipitate the diarrhoea at times. He has no weight loss.

PAST HISTORY:

Patient has had correction of a squint of the left eye recently, and has some from that, while driving. He has had no other serious illnesses.

FAMILY HISTORY:

No diabetes, tuberculosis or premature heart disease. One asthma. s.19(1)

FUNCTIONAL ENQUIRY:

Patient has occasional headaches from reading. He had one dizzy spell some months' ago, but none since. Ten days' ago, he was told that he had an ulcer in the roof of his mouth and feels slight burning there on drinking hot liquids. He has a chronic cough due to smoking and coughs up a half-cup of white sputum daily, mainly in the morning. He occasionally has blood streaky sputum after prolonged coughing. He becomes short of breath on running short distances, or climbing stairs quickly. He has no orthopnoea, paroxysmal, nocturnal dyspnoea or ankle oedema. He does complain of a sharp, aching pressure-type of pain, in the anterior chest on exerting himself, lasting only a few minutes and relieved by rest. He has no G.U. complaints or other significant complaints.

PERSONAL HISTORY:

The patient is married with three children, and lives on a farm. He smokes cigarettes and drinks moderately. He is retiring from the Air Force, after 25 years.

PHYSICAL EXAMINATION:

Patient is a round-faced man with a ruddy complexion.

HEAD & NECK:

There is conjunctival injection of the right eye from recurrent surgery. There is no icterus. Fundi are normal and extra ocular movements are normal, with no diplopia. Visual fields are intact. On the posterior portion of the hard palate, there are two ulcerated areas with slight surrounding oedema. There is no exudate, and the ulcer margins are sharp. Remainder Mouth & Throat is negative. There is no jugular venous distention, thyroid enlargement, cervical lymphadenopathy or bruits.

Westminster Hospital - LONDON, Ont.

4A

KALICHUK, Alex

9657

429-488-018

3 Nov 23

page 3

DATE	CLINICAL NOTES WITH SIGNATURES
	<p>CHEST: Clear to percussion and auscultation.</p> <p>C.V.S.: Heart rate: 88 per minute and regular. B.P. 140/90. Heart sounds are essentially normal, with splitting of the second sound on inspiration, and possibly accentuation of the pulmonary component. There is no right ventricular heave or cardiomegaly. There are no murmurs. Pedal pulses are palpable.</p> <p>ABDOMEN: The abdomen is soft and non-tender. There are no organs or masses palpable, but the liver edge percusses at the level of the umbilicus. Rectal Examination: Prostate is small and firm, and there are no masses.</p> <p>EXTREMITIES: No cyanosis, clubbing or oedema.</p> <p>SKIN: Negative.</p> <p>C.N.S.: Motor power sensation and reflexes are normal.</p> <p>IMPRESSION:</p> <ol style="list-style-type: none"> 1. Abdominal pain - sounds like peptic ulcer, but upper G.I. Series is negative. 2. Recurrent diarrhoea - probably irritable colon, but should R/O infectious cause. 3. Palatal ulcers - ? Vincent's angina. 4. Chronic bronchitis. 5. ? angina pectoris. 6. Post-operative corrective surgery for squint. <p>RMB/yt R.M. Barr, M.D.</p>
<p>21 May, 69 R.M. Barr, M.D. - PROGRESS NOTE:</p>	<p>Sigmoidoscopy negative - well prepared.</p> <p>RMB/yt R. M. Barr, M.D.</p>

May, 1969

C.A. Thompson, M.D. - CONSULTANT'S REPORT: Ophthalmology

HISTORY: Recheck as requested by Dr. Thompson.

Patient had a recession of the external rectus of the right eye on May 13th. Today he has an exotropia of 4 prism diopters for distance and 10 P. D. for near. With +0.50 S in each eye, he gets 20/20 vision. No further treatment necessary.

CAT/yt

C.A. Thompson, M.D.
Consultant in Ophthalmology

23 May, 69

J.L. Loudon, M.D. - WARD ROUNDS:

Admitted with history of peptic ulcer. No pathology seen on G.I.'s or barium enema. Should be treated with antacids anyway. Also has ulcers on roof of mouth.

JLL/yt

J.L. Loudon, M.D.
G.I. Consultant

26 May, 69

R.M. Barr, M.D. - PROGRESS NOTE:

Barium enema normal. Will do small bowel follow-through to rule out Crohns. Ulcers in mouth are healing.

RMB/yt

R.M. Barr, M.D.

29 May, 69

S.O.S. THIS DATE:

CONSULTANT'S REPORT

KALICHUK, ALEX 9657
15113 RC. 03NOV23
CFB CLINTON

429-488-018 SEC 1 8

KALICHUK A SGT (A) 429 488 018

PENSIONABLE DISABILITY

REFERRED TO:

GASTRO INTESTINAL

DATE

8-5-69

SUMMARY OF COMPLAINTS, PHYSICAL AND LABORATORY EXAMINATION FINDINGS, TREATMENT AND PROGRESS

Burning pain in epigastrium each night at 2-3 am: relieved by food, milk, also occurs before meals, relieved by food. Says his BMs are dark to black often. Recent change in bowel habit with alternating constipation, diarrhea. A long history of excessive intake of "thanal. Large hard liver & fb below RCM. He is being admitted for muscle recession on May 13th. Please proceed with investigation you feel necessary. He is on release in early June.

THIS AMBULATORY STRETCHER
CASE WHEELCHAIR BED

SIGNATURE OF M.O. I/C CASE
WILTON B W MAJ

CONSULTANT'S REPORT:

Review of this man's file reveals a diagnosis of psychoneurosis in 1959 with heavy alcohol intake. There is also a story of rather peculiar behaviour and accosting young girls on the roads, although, I gather that he never got into any very serious trouble with the law about this, but did cause considerable concern among the parents, in the locality where he was indulging in this peculiar activities.

He now presents with a classical story of duodenal ulcer characterized by pain in the epigastrium about 2 or 3 am, often waking him from sleep. This began about six months ago and has persisted since that time. The pain is relieved by food and comes on about three hours after a meal associated with hunger. During the same length of time, he has been unable to sleep on his left hand side, it was also initiated when he took a meal including french fried potatoes with a liberal amount of vinegar.

He is to be discharged from the Air Force in the near future and is going to go back to the farm.

He further states that he has had black bowel movements, although, on further inquiry they appear to have been not really black but only dark brown and certainly not to be compared with the black telephone sitting on the desk. He says that his stools are sometimes liquid, although of normal colour, and sometimes small and dark like sheep droppings, sometimes right after a meal he has to rush to the bathroom. These complaints have also gone on for about six months. He says he has had no vomiting. However, he does cough in the early morning when he wakes up and sometimes coughs up a good deal of yellowish stuff and occasionally it is streaked with blood, but this is uncommon and only after a great deal of coughing. I presume, that he will have a chest x-ray when he is admitted to hospital and this should be sufficient to cast some light of this topic. He has never been jaundiced.

DIAGNOSIS:

OVER

RECOMMENDATIONS RESPECTING TREATMENT, CONVALESCENCE, FITNESS FOR GAINFUL EMPLOYMENT, OR DUTY

JLL/pc

May 14/69

SIGNATURE OF CONSULTANT

J. L. London, M.D.

DATE

8-5-69

(USE REVERSE SIDE IF ADDITIONAL SPACE IS REQUIRED)

ON EXAMINATION blood pressure is 160/100. Heart rate 110 per minute and regular. The patient is quite nervous. There is no cardiac enlargement. On abdominal examination there is an old right lower quadrant appendectomy scar. The liver edge is 4 cms. below the right costal margin in the mid-clavicular line. The spleen is not palpable and there are no other masses or enlarged organs. The rectal examination is normal. Prostate is somewhat enlarged, but of normal consistency and there is no occult blood in the stools.

OPINION AND RECOMMENDATIONS: This man probably has a duodenal ulcer. I have arranged for him to have a G.I. series tomorrow morning. If it shows an ulcer then he should be admitted at once to ward 4A. If it does not, I have given him some Gelusil tablets to help with the pain and he can proceed with the plans to be admitted to the Eye Service for correction of one of his extra ocular muscles and when they are through with him, they can then transfer him to the G.I. Service, Ward 4A where I think sigmoidoscopy and barium enema could be performed.

JLL/pc
May 14/69

J. L. Loudon, M.D., FRCP(C)

CANADIAN FORCES MEDICAL SERVICE
TEMPERATURE-PULSE-RESPIRATION RECORD

FACILITY PROVIDING CARE
CFB CLINTON HOSPITAL

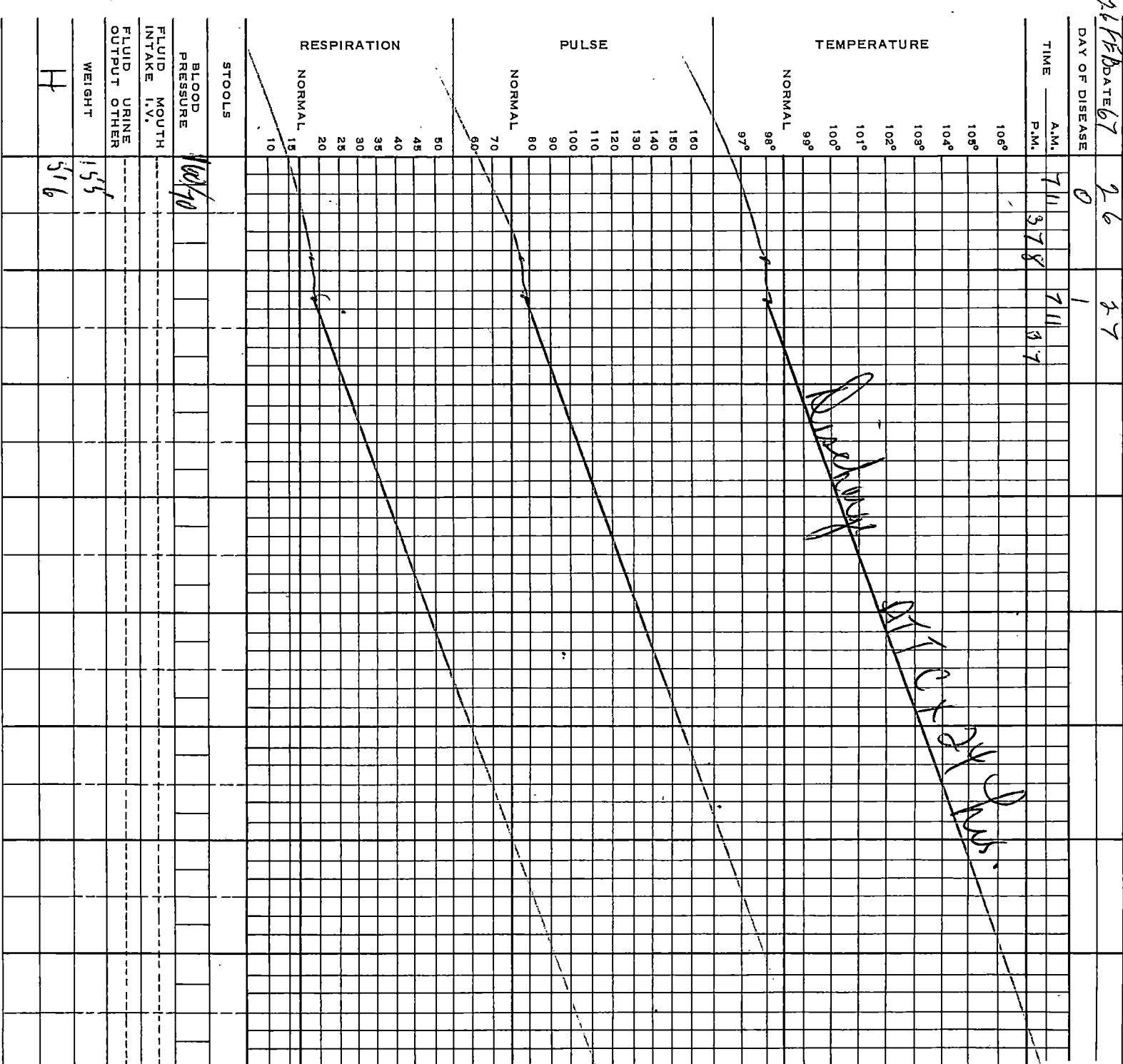
ADMISSION NO. **457** ADMISSION DATE **26/2/67** RELIGION **RC**

SURNAME **KALISHUK** FIRST NAME AND INITIALS **ALEXANDER** SERVICE NO. **15113**

RANK **SGT** FORCE **RCMP** AGE **43** PARENT UNIT **CFB CLINTON ONT**

NEXT OF KIN **WIFE** RELATIONSHIP **WIFE**

ADDRESS OF NEXT KIN **BR # 4 WALTON ONT**



CANADIAN FORCES MEDICAL SERVICE
CASE HISTORY

FACILITY PROVIDING CARE <i>CFB Clinton</i>		
ADMISSION NO. <i>457</i>	ADMISSION DATE <i>26-2-67</i>	RELIGION <i>RC</i>
SURNAME <i>Kalishuk</i>		SERVICE NUMBER <i>15113</i>
FIRST NAME AND INITIALS <i>Alexander</i>		
RANK <i>Sgt</i>	FORCE <i>RCMP</i>	AGE <i>43</i>
PARENT UNIT <i>CFB Clinton</i>		
NEXT OF KIN <i>Wife</i>		RELATIONSHIP <i>Wife</i>
ADDRESS OF NEXT OF KIN <i>RR #4 Walton ONT.</i>		

CONDITION ON ADMISSION ELECTIVE <input checked="" type="checkbox"/> SERIOUS <input type="checkbox"/> EMERGENCY <input type="checkbox"/>	DATE OF DISCHARGE <i>27 Feb 67</i>	TRANSFERRED: FROM: _____ TO: _____	DIAGNOSIS ONLY
IF ACCIDENT, STATE CIRCUMSTANCES			

DIAGNOSIS ON ADMISSION *Cut on left fore head*

FINAL DIAGNOSIS (IN ORDER OF IMPORTANCE)	MORBIDITY CODE
1. <i>Fracture of left forehead</i>	
2.	
3.	

OPERATIONS	SURGEON GENERAL	DATE	ANAESTHETIC
1.			
2.			
3.			
STATISTICS SECN			

SUMMARY (COMPLAINTS, PHYSICAL AND LABORATORY EXAMINATION FINDINGS, TREATMENT, ETC.)

This Sgt was cut on left forehead by a plate of dish thrown to him by his wife.
Reparation of a depth of 1 1/2 ^{inches} depth with 7 stitches with silk 000000

RECOMMENDATIONS (FURTHER TREATMENT, CONVALESCENCE, LIMITATIONS AS TO WORK, ETC.)

DATE LIKELY FIT FOR WORK <i>M.D.</i>	SIGNATURE OF MEDICAL OFFICER I/C CASE <i>A. Stewart RZ</i>	001007
---	---	--------

X-RAY REQUISITION AND REPORT

SURNAME KALICHE		FIRST NAME AND INITIALS Alexander		SERVICE NO. 15113
RANK Sgt	SERVICE RCAF	AGE 44	PARENT UNIT CFB Clinton Ont	
X-RAY DEPARTMENT AT: CFB Clinton Ont		REPORT TO BE FORWARDED TO: (OFFICE)		

CLINICAL INFORMATION AND DIAGNOSIS:

EXAMINATION REQUESTED:

Annual over 40

IF ROUTINE CHEST	TECHNICIANS USE ONLY
ADMISSION <input type="checkbox"/>	14 X 17
ENROLMENT <input type="checkbox"/>	
RELEASE <input type="checkbox"/>	
ANNUAL <input type="checkbox"/>	
SERVICE REQ. <input type="checkbox"/>	10 X 12
	8 X 10

DATE 4 Dec 67	M.O.'S SIGNATURE DJ Gladman Major	FILM NO. 7030	DATE OF EXAMINATION 7 Dec 67
-------------------------	---	-------------------------	--

P.A. Chest

No change in the general appearance of this chest from a film of Oct. 6/66.

No active lung disease. Pleural spaces are clear.

Heart chest ratio is 13.2/31.7.

Wm. L. Teskey
Wm. L. Teskey, M.D.
 RADIOLOGIST

im 8.12.67

COPY 2

NAME 15113 Sgt KALICHUK, A

DATE 7 Dec 67

ADDRESS CFB GLESTON DALT

AGE 44

BY DML

Ambro

Otometer

AUDIOGRAM

67507

150

LEFT EAR

RIGHT EAR

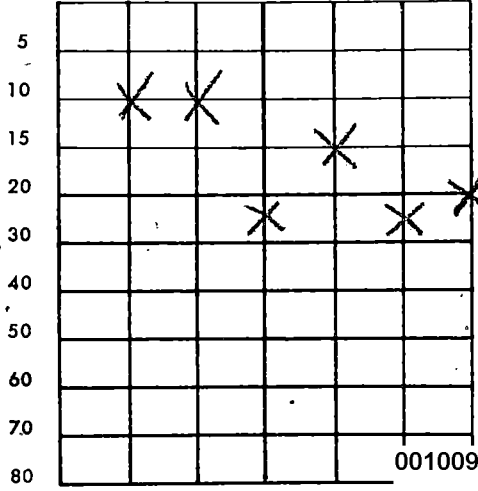
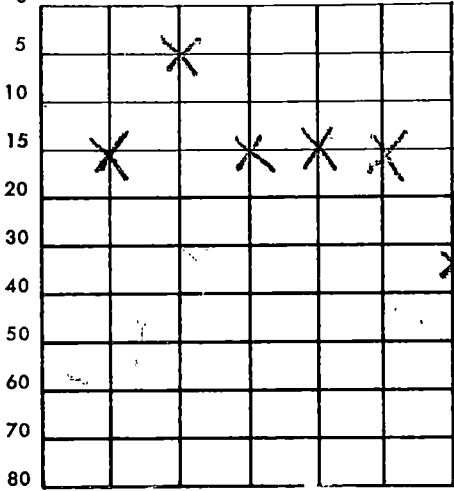
500 1000 2000 3000 4000 6000

500 1000 2000 3000 4000 6000

Normal 0

0

Loss in Decibels



001009

DEPARTMENT OF NATIONAL DEFENCE
LABORATORY REPORT



HOSPITAL, LABORATORIES

NAME (USE BLOCK LETTERS)

KALICHUCK

SERVICE NUMBER

15113

WARD OR SERVICE

OP

LAB. REG. NO.

COLOUR amber

SPEC GRAVITY 1.029

~~TURBID~~ OR CLEAR

ALBUMEN QUALITATIVE Trace

QUANTITATIVE

SUGAR QUALITATIVE neg

QUANTITATIVE

MICROSCOPIC epithelial cells.

pus - 4-8
RBC - 2-6

OTHER TESTS: PH 8

DATE SENT

URINALYSIS

DATE REPORTED

001010

RECORD OF MEDICAL EXAMINATION
(Other than on Enrolment, Release, Annual Flying)

Enclosure Number in
Medical Envelope

Purpose of Examination Annual over 40 & Conversion to GO factor CFB Clinton Ont		Examination Unit CFB Clinton Ont	
PART I - SERVICE PARTICULARS			
Name KALICHUK Alexander	Rank Sgt	Number 15113	
Establishment CFB Clinton Ont	Trade Sup Tech 911		
Date of Enrolment 24 Jan 50	Date of Birth 3 Nov 23	Service RCAF (Reg)	

PART II - HISTORY AND/OR FINDINGS PERTINENT TO EXAMINATION
(consultant's reports to be attached/referred to where indicated)

No complaints at present except occasional chest pain when he gets a cold. This does not sound like angina from his description.
Recent ECG + chest x-ray normal.
Slightly overweight.

Diagnosis:

Slightly overweight

PART III - MEDICAL OFFICER'S RECOMMENDATIONS (State specific limitations)

H₂ audiogram
6202 for off.

Date for next examination/Board

Dec 1968

PART IV

CATEGORY OR PROFILE	RCN		ARMY							RCAF					CATEGORY			
	Cat	Visual Stand	YOB	P	U	L	H	E	M	S	VISION	COLOUR VISION	HEAR-ING	HANDS		ARMS	LEGS	OTHER FACTORS PRESENT
PRESENT											1	1	1	1	1	1	0	AltB
RECOMMENDED																		

YOB 23 V 1 CV 1 H 2 G 2 O 2 A 5

Date

19 Dec 67

Signature Examining Medical Officer

Remarks Approving Medical Officer

A. Lennier

Date

19 Dec 67

Signature and Appointment Approving Medical Officer

001011

PART V - PHYSICAL EXAMINATION

EXAMINATION		Considered normal	See below	EXAMINATION		Considered normal	See below
1	General appearance	✓		15	Lungs	✓	
2	Body Frame: Sm <input checked="" type="checkbox"/> Med <input checked="" type="checkbox"/> Lg <input type="checkbox"/>			16	Heart	✓	
3	Height: 5 ft. 5 ins.			17	Breasts	✓	
4	Weight (Stripped) 150 lbs.			18	Pulse Rate 80		
5	Vision:			19	Blood Pressure: S 124		
	s glasses R 20/15 L 20/15				D 76		
	c glasses R L			20	Abdomen	✓	①
6	Colour Vision: Plates CVN			21	Genitalia	✓	
	Lantern			22	Hemial Orifices	✓	
7	Pupils: Light	✓		23	Anus	✓	
	Acc	✓		24	Rectal Exam (digital)	✓	
8	Visual Field	✓		25	Skin	✓	
9	Fundi	✓		26	Varicosities	✓	
10	Hearing: WV R L H2			27	Lymphatic Glands	✓	
	CV R L Audiogram			28	Thyroid	✓	
11	Ears & Tympani: R	✓		29	Extremities: Upper	✓	
	L	✓			Lower	✓	
12	Mouth & Teeth	✓		30	Spine	✓	
13	Nose & Throat	✓		31	CNS	✓	
14	Chest: Min. Max.			32	Emotional Status	✓	
33	Chest X-Ray: Date Report						
34	Urinalysis: SG Alb 2+ Sugar						
	Microscopic 4-p WBC, 2-6 RBC						
35	Electrocardiogram: Date Report						
36	Other Lab Tests						

POSITIVE FINDINGS AND/OR REMARKS:

① appendectomy scar.

J. J. [Signature]

RECORD OF MEDICAL EXAMINATION
(Other than on Enrolment, Release, Annual Flying)

Enclosure Number in
Medical Envelope

Purpose of Examination Annual over 40	Examination Unit CFB Clinton
--	---------------------------------

PART I - SERVICE PARTICULARS

Name KALICHUK Alexander	Rank Sgt(AF)	Number 429-488-018
Establishment CFB Clinton	Trade Sup Tech 911	
Date of Enrolment 24 Jan 50	Date of Birth 3 Nov 23	Service CAF(AF)

PART II - HISTORY AND/OR FINDINGS PERTINENT TO EXAMINATION
(consultant's reports to be attached/referred to where indicated)

RCAF-M10,
no problem during the last year.
Tenderness @ chest, shoulder when
lying on side at night.
not of significance on examination.

Diagnosis: *As*

PART III - MEDICAL OFFICER'S RECOMMENDATIONS (State specific limitations)

As full duty

Date for next examination/Board *Nov '69*

PART IV

CATEGORY OR PROFILE	RCN		ARMY									RCAF					OTHER FACTORS PRESENT	CATEGORY	
	Cat	Visual Stand	YOB	P	U	L	H	E	M	S	VISION	COLOUR VISION	HEAR-ING	HANDS	ARMS	LEGS			
PRESENT											YOB	V	CV	H	G	O	A		
RECOMMENDED											23	I	I	2	2	2	5		

Date *Jan 29 1969*

YOB	V	CV	H	G	O	A
23	1	1	2	2	2	5

Mulligan MD
Signature Examining Medical Officer

Remarks Approving Medical Officer

Lanceur

Date *Feb 3 1969*

Mulligan MD
Signature and Appointment Approving Medical Officer

PART V - PHYSICAL EXAMINATION

EXAMINATION	Consi- dered normal	See below	EXAMINATION	Consi- dered normal	See below
1 General appearance		①	15 Lungs	✓	
2 Body Frame: Sm _____ Med <u>N</u> Lg _____			16 Heart	✓	
3 Height: ft. <u>5</u> ins. <u>5 1/2</u>			17 Breasts	✓	
4 Weight (Stripped) <u>150</u> lbs.			18 Pulse Rate <u>80</u>		
5 Vision:			19 Blood Pressure: S <u>140</u>		
s glasses R <u>20/20</u> L <u>20/20</u>			D <u>80</u>		
c glasses R _____ L _____			20 Abdomen	✓	② ③
6 Colour Vision: Plates _____	CON		21 Genitalia	✓	
Lantern _____			22 Hemial Orifices	✓	
7 Pupils: Light _____	✓		23 Anus	✓	
Acc _____	✓		24 Rectal Exam (digital)	✓	
8 Visual Field _____	✓		25 Skin	✓	
9 Fundi _____			26 Varicosities	✓	
10 Hearing: WV R _____ L _____			27 Lymphatic Glands	✓	
CV R _____ L _____	H-L		28 Thyroid	✓	
11 Ears & Tympani: R _____	✓		29 Extremities: Upper _____	✓	
L _____	✓		Lower _____	✓	
12 Mouth & Teeth _____	✓		30 Spine	✓	
13 Nose & Throat _____	✓		31 CNS	✓	
14 Chest: Min. _____ Max. _____			32 Emotional Status	✓	
33 Chest X-Ray: Date <u>Nov 12 1968</u> Report <u>Normal.</u>					
34 Urinalysis: SG <u>1020</u> Alb <u>neg</u> Sugar <u>neg</u>					
Microscopic <u>neg.</u>					
35 Electrocardiogram: Date <u>22 Nov 68</u> Report <u>normal.</u>					
36 Other Lab Tests _____					
					<u>Serum cholesterol 245 mg %.</u>

POSITIVE FINDINGS AND/OR REMARKS:

① Very florid countenance.
 ② appendectomy scar.
 ③ Liver firm, down 4 cm below
 RCM.

X-RAY REQUISITION AND REPORT

SURNAME KALICHUK		FIRST NAME AND INITIALS ALEX 42		SERVICE NO. 48018
RANK Sgt.	SERVICE RCM	AGE 45	PARENT UNIT CFB CLINTON	
X-RAY DEPARTMENT AT:		REPORT TO BE FORWARDED TO: (OFFICE)		

CLINICAL INFORMATION AND DIAGNOSIS:

*Productive cough,
fever, chills last few
days.*

EXAMINATION REQUESTED:

PA & lat chest

IF ROUTINE CHEST	TECHNICIANS USE ONLY		
ADMISSION <input type="checkbox"/>	14 X 17 - 2		
ENROLMENT <input type="checkbox"/>			
RELEASE <input type="checkbox"/>			
ANNUAL <input type="checkbox"/>			
SERVICE REQ. <input type="checkbox"/>			
	10 X 12		
	8 X 10		
DATE <i>Nov 22 1967</i>	M.O.'S SIGNATURE <i>[Signature]</i>	FILM NO. <i>8229</i>	DATE OF EXAMINATION <i>12 Nov 67</i>

P.A. & LATERAL VIEWS OF THE CHEST.

Compared with previous films of December 7/67 and October 6/66, no change in the general appearance of the lung fields. No definite evidence of pulmonary infiltration. The pleural spaces are clear. There appears to be a small pericardial fat pad at the left cardio-phrenic angle.

The heart chest ratio 12.5/32.5.

[Signature]

Wm. L. Teskey, M.D., C.R.C.P. (C)
RADIOLOGIST

gb 15-11-68

NAME

429-488-018 Sgt (AF) Kalichuk A

DATE

21 Nov 68

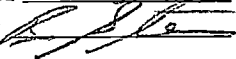
ADDRESS

AFB Clinton

AGE

45

BY



Aml

Otometer

AUDIOGRAM

LEFT EAR

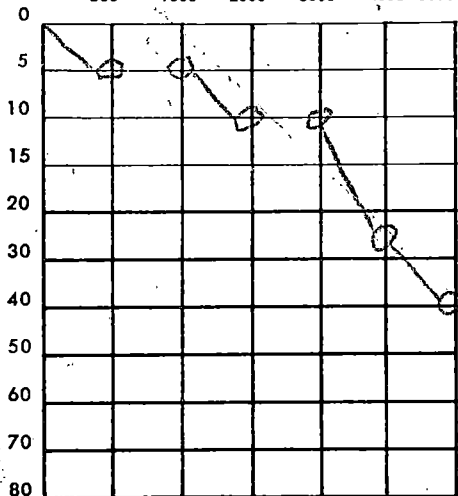
ISO

RIGHT EAR

Normal 0

500 1000 2000 3000 4000 6000

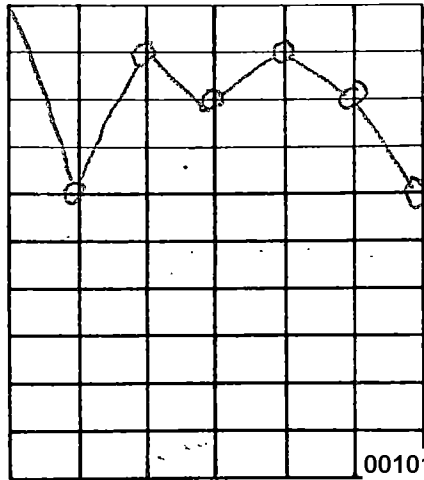
Loss in Decibels



0

500 1000 2000 3000 4000 6000

Loss in Decibels



001016

X-RAY REQUISITION AND REPORT

SURNAME KALICHON		FIRST NAME AND INITIALS Alexander	SERVICE NO. 429-488-018
RANK Sgt	SERVICE CAF(AF)	AGE 45	PARENT UNIT CFB Clinton
X-RAY DEPARTMENT AT: CFB Clinton		REPORT TO BE FORWARDED TO: (OFFICE)	

CLINICAL INFORMATION AND DIAGNOSIS:

Annual over 40

EXAMINATION REQUESTED:

PA Chest

IF ROUTINE CHEST	TECHNICIANS USE ONLY
ADMISSION <input type="checkbox"/>	
ENROLMENT <input type="checkbox"/>	14 X 17 - 1
RELEASE <input type="checkbox"/>	
ANNUAL <input checked="" type="checkbox"/>	10 X 12
SERVICE REQ. <input type="checkbox"/>	8 X 10

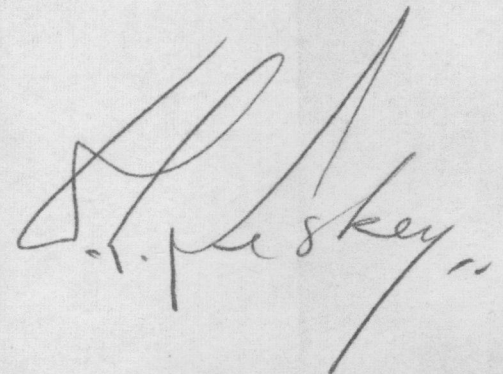
DATE 21 Nov 68	M.O.'S SIGNATURE BW Wilton Major
--------------------------	--

FILM NO. 8257	DATE OF EXAMINATION 21 Nov 68
-------------------------	---

P.A. FILM OF THE CHEST.

No active lung disease. Pleural spaces are clear.

Heart and aorta appear normal.



Wm. L. Teskey, M.D. C.R.C.P. (C)

RADIOLOGIST

im 26.11.68

COPY 2

001017

TREATMENT SERVICES

CASE SHEET

OPHTHALMOLOGY

17-3 69

KALICHUK, ALEX 9657
15113
SURNAME, GIVEN NAME RC 03NOV23
CFB CLINTON
SERVICE NO. (OR RANK)

(10-4-69)
Sec 18

RECORD NO.

DATE OF BIRTH

429-488-018

429-488-018 SGT(AF) KALICHUK Alexander CFB Clinton

Referred to..... eye clinic BY..... BW Wilton Major

Reason for Examination

History: Was seen by you in June for muscle imbalance. Feels it is getting worse.

Also feels glasses not strong enough.

Patient seen in clinic today, and would like stronger glasses for reading.

Anterior Segment	Rt.	Lt.
	normal.	normal.

Eye	VISION		REFRACTION			ADD	Vision After
	Before	\bar{C} + 2.50	Sphere	Cylinder	Axis	Reading	
Rt.	20/20-		+0.50			+2.50	20/20
Lt.	20/20-		+0.75			+2.50	20/20

Glasses: { Rt. Sph. +3.00 Cyl. Axis READING

Prescribed: { Lt. Sph. +3.25 Cyl. Axis READING

Pupils
Tension: Rt. Lt.

Cover Test: 20 Ft. 15 Ins.

Maddox Rod: 20 Ft. Exotropia 35 P. D. for distance. 15 Ins. 25 P. D. for near.

Cardinal Positions:

Convergence Cms. Accommodation { Rt. Cms.
..... Cms. Lt. Cms.

Fundus and Media	Rt.	clear and normal, OU.
	Lt.	

Fields:

Colour Vision

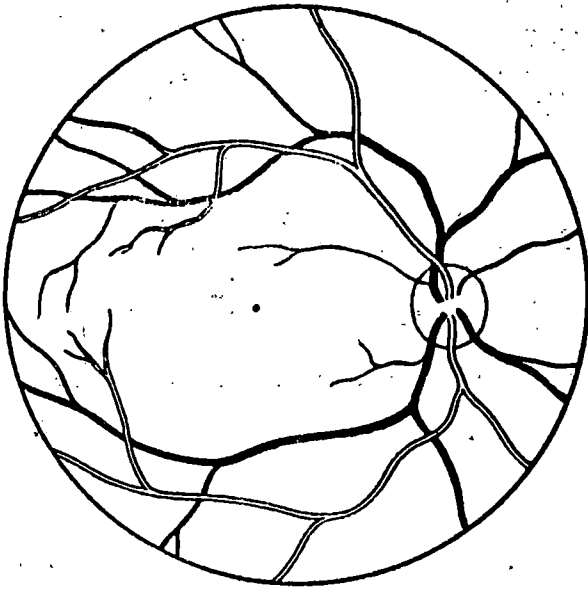
DIAGNOSIS 1. Exotropia, OU.
2. Hyperopia, OU.

Remarks and/or Treatment:
GLASSES AS ABOVE FOR READING. Patient would like to have stronger glasses, and would also like to have his muscle imbalance corrected. Arrangements have been made for this. ADMIT MAY 12th for recession of the external rectus of each eye to be done MAY 13th.

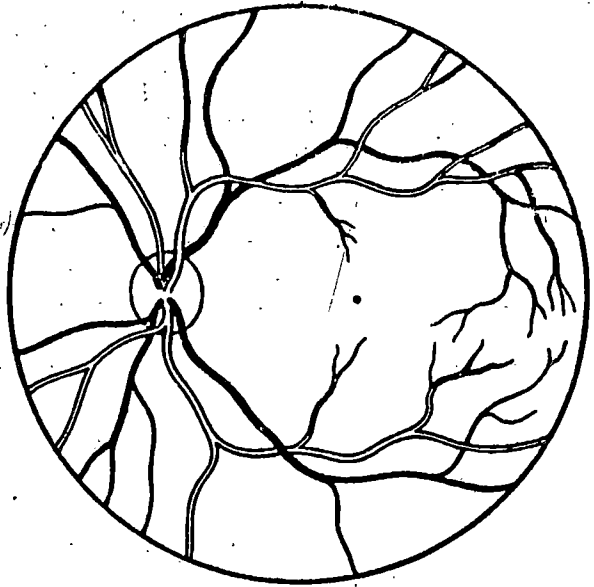
Date 10 April 69 Ophthalmologist C. A. Thompson, M.D.

FUNDI

Right Eye

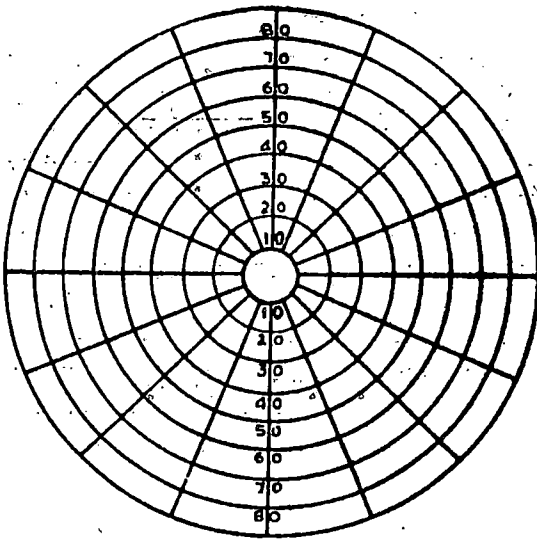


Left Eye



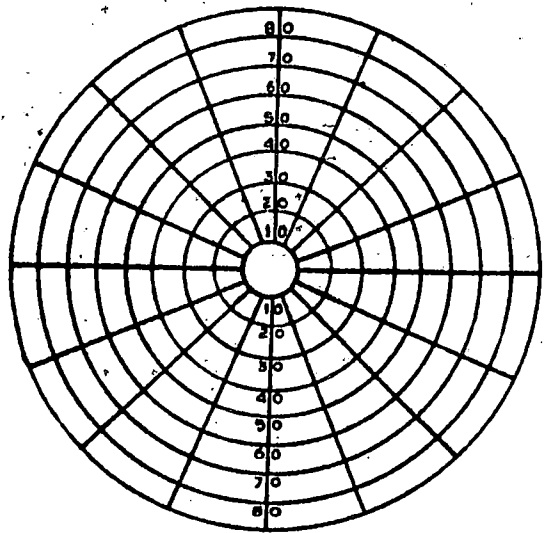
FIELD STUDY

Left Eye



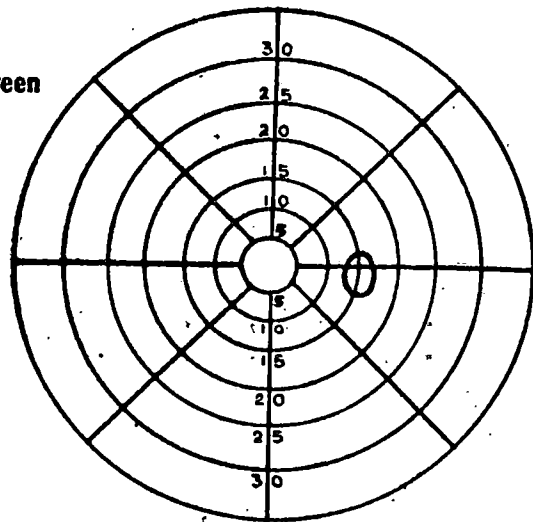
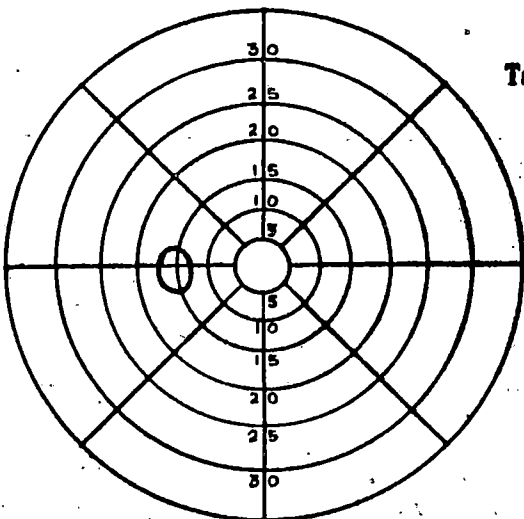
Perimeter

Right Eye



Colour
Test object, Size
Distance

Tangent Screen



Colour
Test object, Size
Distance

**LABORATORY
REQUISITION**

BIOCHEMISTRY

SERVICE

429-488-018

INSTITUTION

WARD

CFB CLINTON BASE SURGEON

OP May/69

SURNAME, GIVEN NAMES

Sgt. Kalichuk A.

RECORD NO.

SERVICE NO. (OR RANK)

018

DATE OF BIRTH

SPECIMEN: Blood

CLINICAL NOTE OR DIAGNOSIS:

EXAMINATION REQUESTED:

Serum Alkaline Phosphatase; Serum Bilirubin

001020

Blood	Glucose, AC	mg %	PC	mg %	Creatinine	mg %
	B.U.N./N.P.N.	mg %	CO ₂ Comb. P.	mEq		
Serum	Sodium	mEq	Potassium	mEq	Chloride	mEq
	Calcium	mg %	Bilirubin	0.6 mg %	Bil. Direct	mg %
	Proteins	g %	Albumin	g %	Globulins	g %
	Phosphate	mg %	Phosph'ase, Alk.	13.0 U.	Phosph'ase, Acid	U.
	Ceph. Chol. Fl.		Thymol Turb	U.	Thymol Fl.	
	B.S.P. Ret'n	%	Cholesterol	mg %	Uric Acid	mg %
	Amylase	U.	Transaminase	U.		
C.S.F.	Glucose	mg %	Chlorides	mg %	Proteins	g %

OTHER TESTS:

S.G.O.T. 82

S.G.P.T. 42

Date Received

BIOCHEMISTRY

Date

001021

**LABORATORY
REQUISITION**

HAEMATOLOGY

SERVICE.....

INSTITUTION

WARD

CFB CLINTON

MAJ
BASE SURGEON

OP 2 May /69

[Handwritten signature]

429488018

SURNAME, GIVEN NAMES

Sgt. Kalichuk A.

RECORD No.

SERVICE No. (OR RANK)

018

DATE OF BIRTH

SPECIMEN: Whole Blood

CLINICAL NOTE OR DIAGNOSIS:

EXAMINATION REQUESTED: HCB; WBC; RBC; Sed. Rate; Differential

HGB 16.25 , HAEMATOCRIT , R.B.C. COUNT: RETICULOCYTES %

SED. RATE 35 S.R. CORRECTED (WINTROBE) m.m./hr

PROTHROMBIN BLEEDING TIME CLOTTING TIME

W.B.C. COUNT 9,000 /cmm. PLATELET COUNT /cmm.

Differential:	Normal	Result	Normal	Result
Neutrophils:—Immature (0)			Eosinophiles (50-400)	
—Band (0-500)			Monocytes (0-600)	2%
—Mature (3-6000)		81%	Lymphocytes:—Large (50-600)	
Basophiles (0-120)			—Small (1, 2-2400)	17%

Other Results or Comments:

RBC's normal. Plat. adeq.

Date Received

HAEMATOTOLOGY

MAY - 6 1969

Date 001023

NAME 429-488-018

Sgt Kalichuk P.

DATE 14 Apr 69

ADDRESS CFB Clinton

AGE 45

BY [Signature]

Ambico Otometer AUDIOGRAM

LEFT EAR

ISO

RIGHT EAR

500 1000 2000 3000 4000 6000

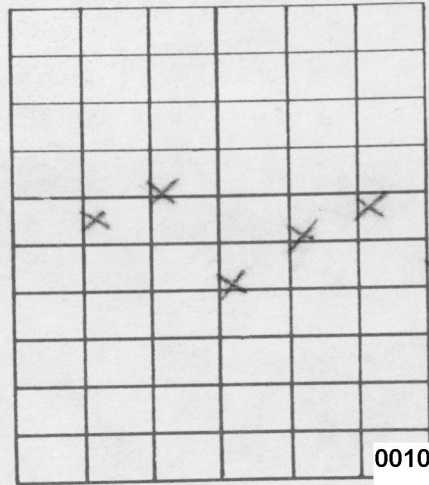
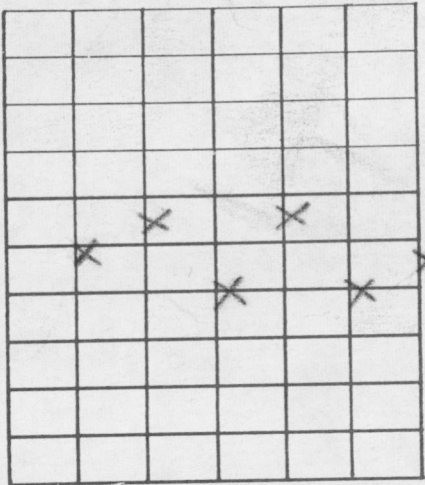
500 1000 2000 3000 4000 6000

Normal 0

Loss in Decibels

0
5
10
15
20
30
40
50
60
70
80

0
5
10
15
20
30
40
50
60
70
80



001024

C. FB Clinton Ont

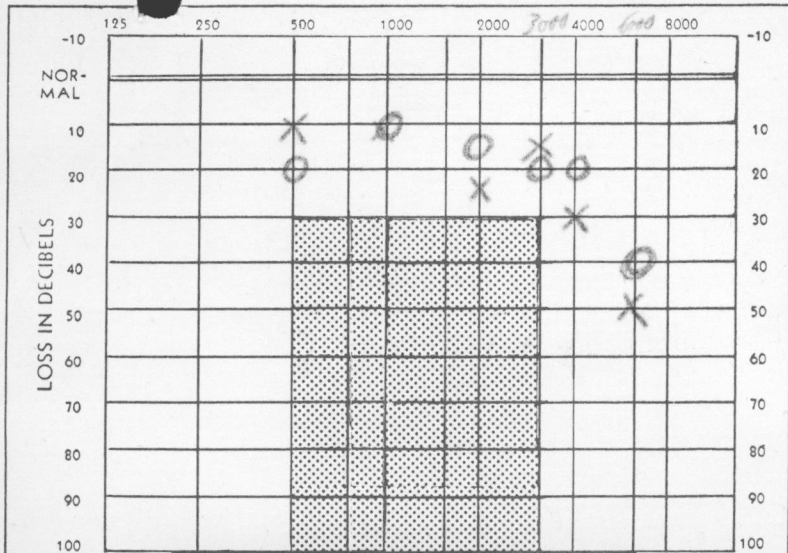
#630

FORM 102 REV.

DATE 6 Oct 66 BY DML

MAICO AUDIOGRAM

15113
15113
Set KALICHUK, A
NAME



	LEFT EAR	RIGHT EAR
	BLUE	RED
AIR	X	O
AIR WITH MASKING	□	△
BONE COND WITH MASKING	<	>
DB INTENSITY OF MASKING		
A. M. A. % HEARING LOSS		
L. _____	R. _____	COMB. _____
	LEFT EAR	RIGHT EAR
S. R. T.		
M. C. L.		
T. D.		

DND 2009U
7530-21-562-7314

DEPARTMENT OF NATIONAL DEFENCE
CANADIAN FORCES MEDICAL SERVICE

LABORATORY REPORT

CFB Clinton

HOSPITAL, LABORATORIES

NAME (use block letters)	SERVICE NO.	WARD OR SERVICE	LAB. REG. NO.
--------------------------	-------------	-----------------	---------------

KALICHUK A

15113

OP

COLOUR *amber*

SPEC GRAVITY *1.018*

~~TURBID~~ OR CLEAR

ALBUMEN - QUALITATIVE *trace*

QUANTITATIVE

SUGAR - QUALITATIVE *neg*

QUANTITATIVE

MICROSCOPIC

pH - 8.

OTHER TESTS:

DATE SENT

6 Oct.

URINALYSIS

DATE REPORTED

6 Oct.

001026

BEDSIDE NURSING NOTES



KALISHUK

SURNAME

GIVEN NAMES

ALEXANDER.

SERVICE NUMBER

15113

RANK

Sgt

ADMISSION DATE

26/2/67

ADMISSION NUMBER

457

UNIT OR SHIP

CFB CLIVTON ONT

INSTITUTION

CFB CLIVTON HOSPITAL

PLACE

CFB ONT

Date and Time

NURSING CARE RECORD

(Irrelevant and insignificant information is NOT to be inserted.)

Signature and Rank

26/2/67 3:00 hrs

BUTTERFLY TO LEFT FORE HEAD
and ADM - for night care
DR to see in am

[Signature]

27 Feb 67

Discharged to ATCS 24 hrs.

[Signature]



DEPARTMENT OF NATIONAL DEFENCE
CANADIAN FORCES MEDICAL SERVICE
CASE SHEET OPTHALMOLOGY

SURNAME Kalichuk		GIVEN NAMES A		SERVICE NUMBER 15113
RANK Sgt	ADMISSION DATE DAY MONTH YEAR			ADMISSION NUMBER
UNIT OR SHIP OFB Clinton Ont				
INSTITUTION				PLACE

Referred to F/L Hain by BMedO Date 23 May 67

Reason for Examination refraction ago 43 years

History: Dr. Thompson N. + 1.25 av N.P.
25° ex. tropia + 37° up at near
bb - " incompensated for his job."

Anterior Segment	Rt.	Lt.
	N	N

Eye	VISION		REFRACTION				Vision After
	Before	+2.50	Sphere	Cylinder	Axis	Prism	
Rt.	20/70	/	+ .50				20/20
Lt.	20/70		+ .50				20/20

Glasses: } Rt. Sph. + .50 Cyl. Axis. READING +1.25 add
 Prescribed: } Lt. Sph. + .50 Cyl. Axis. READING +1.25 add

Pupils N. N.
 Tension: Rt. Lt.

Cover Test: 20 Ft. orth. 15 Ins. no. no. kb

Maddox Rod: 20 Ft. 15 Ins.
 Cardinal Positions: monocular

Full on study *Nov. phoria.*

Convergence Cms. Accommodation { Rt. Cms.
 Cms. { Lt. / Cms.

Fundi and Media } Rt. my
 { Lt. my

Fields: —

Colour Vision

DIAGNOSIS presbyopia + squinter

Remarks and/or Treatment:
Re above in sv
- monocular seg.

Blair (Ophthalmologist)

Date 23/5/67 Hospital

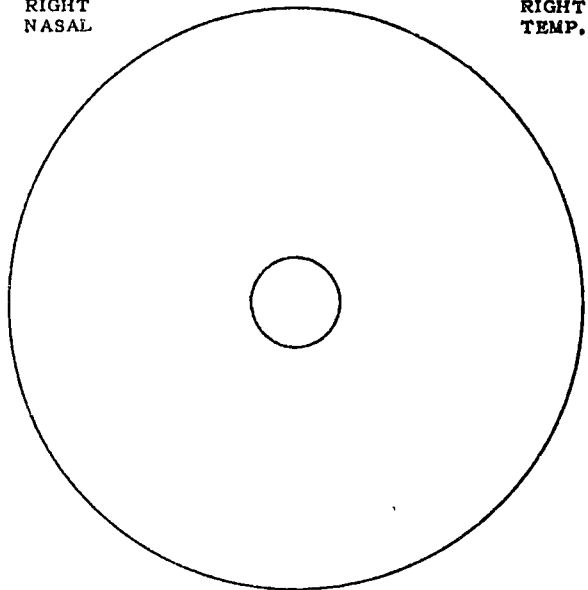
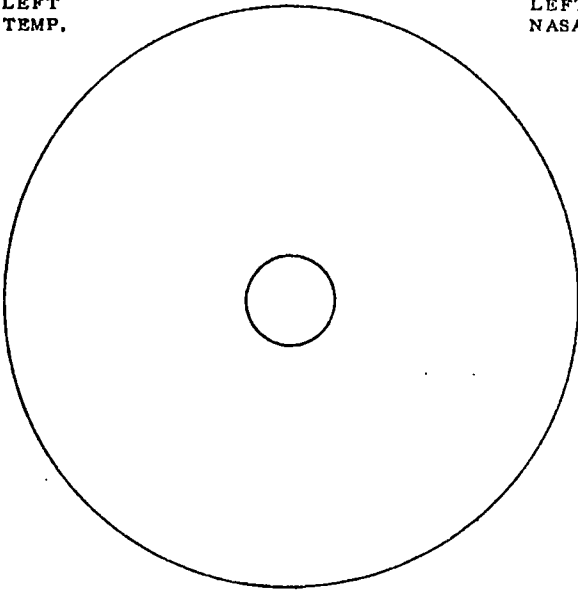
FUNDI

LEFT
TEMP.

LEFT
NASAL

RIGHT
NASAL

RIGHT
TEMP.



Remarks:

FIELD STUDY

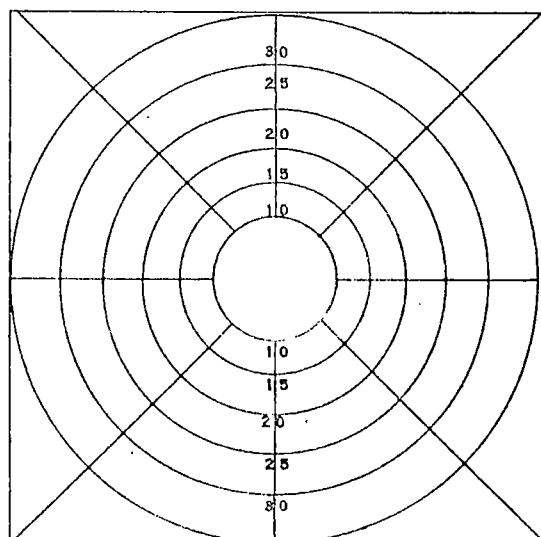
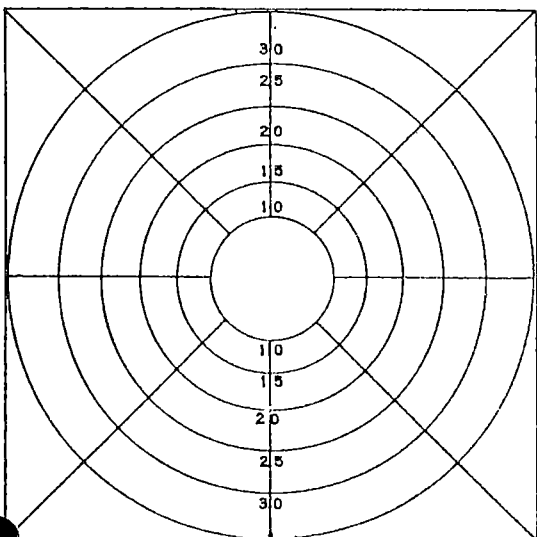
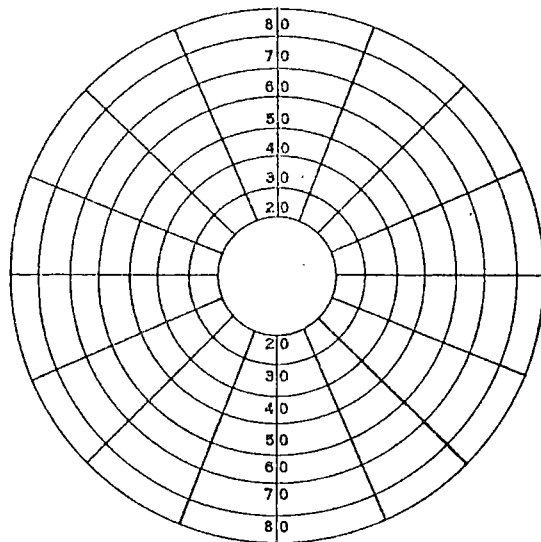
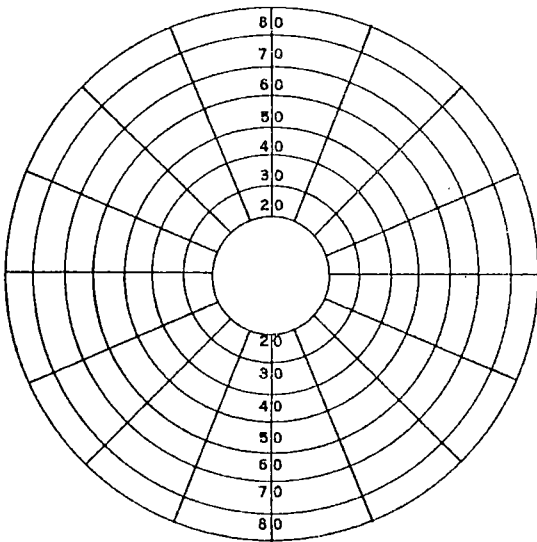
Test Object COLOUR
SIZE
DISTANCE

Illumination

V.O.S.

PERIMETER

V.O.D.



TEST OBJECT

Optometrist

TREATMENT SERVICES

CASE SHEET

OPHTHALMOLOGY

SURNAME, GIVEN NAMES: KALICHUK, ALEX 9657
 SERVICE NO. (OR RANK): 15113 RC 03NOV23
 CFB CLINTON
 RECORD NO.
 DATE OF BIRTH

15113 Sgt Kalichuk Alexander - 3 Nov 23-SupTech-RC-M

Referred to Ophthalmology Clinic BY F/L MacKenzie
 (Wife) Mrs A Kalichuk
 (Address) P.O. Box Adastral Park Ont.

Reason for Examination Original Appt.

History: Referred for Ophthalmology examination on advice of optometrist.

Anterior Segment } Rt. normal. Lt. normal.

Eye	VISION		REFRACTION			ADD	Vision After
	Before	U + 2.50	Sphere	Cylinder	Axis	Prism	
Rt.	20/20		+0.25			+1.00	20/20
Lt.	20/20		+0.25			+1.00	20/20

Glasses: { Rt. Sph. +0.25 Cyl. Axis READING +1.00
 Prescribed: { Lt. Sph. +0.25 Cyl. Axis READING +1.00

Pupils
 Tension: Rt. normal. Lt. normal.
 Cover Test: 20 Ft. Esotropia 25 prism dioptres. 15 Ins. 37 prism dioptres.
 Maddox Rod: 20 Ft. Esotropia 25 prism dioptres. 15 Ins. 37 prism dioptres.
 Cardinal Positions:

While it appears that the patient is able to view on the worth dots, this is not so and he suppresses his left eye.

Convergence Cms. Accommodation { Rt. Cms.
 Cms. { Lt. Cms.

Fundi and Media } Rt. Clear and normal.
 Lt. normal.

Fields:
 Colour Vision

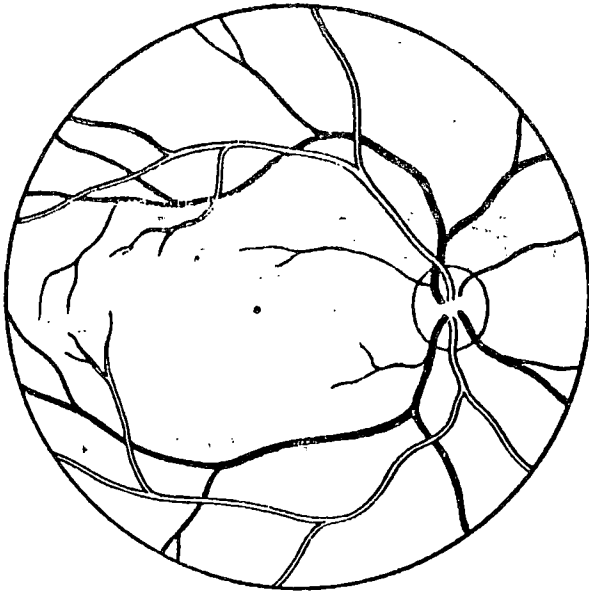
DIAGNOSIS

Remarks and/or Treatment:
GLASSES FOR READING AS ABOVE.

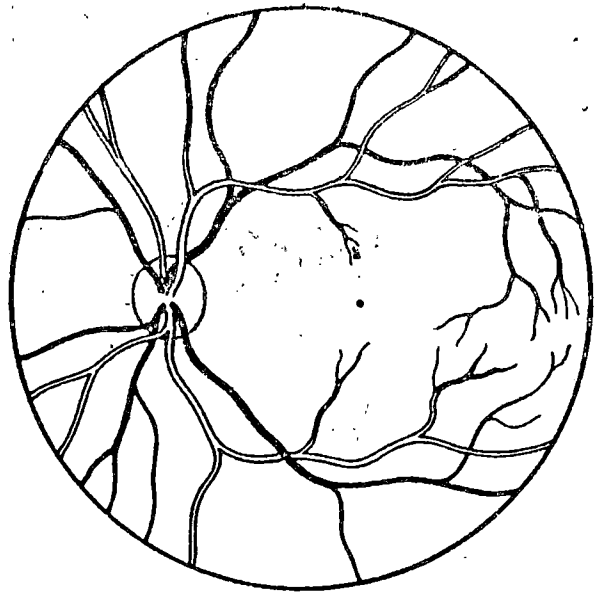
Date 24 Nov 66 Ophthalmologist C. A. Thompson, M.D.

FUNDI

Right Eye

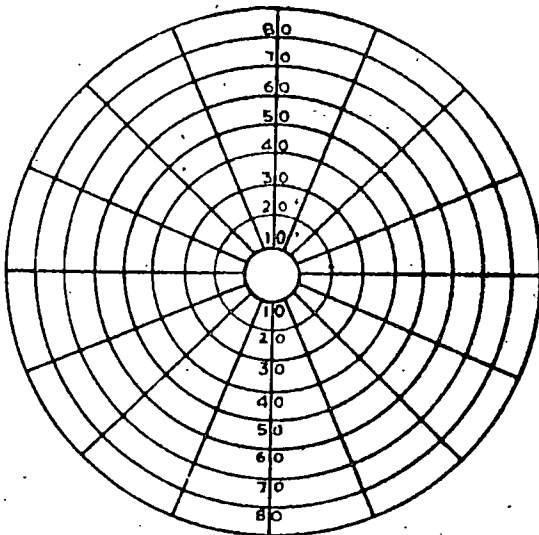


Left Eye



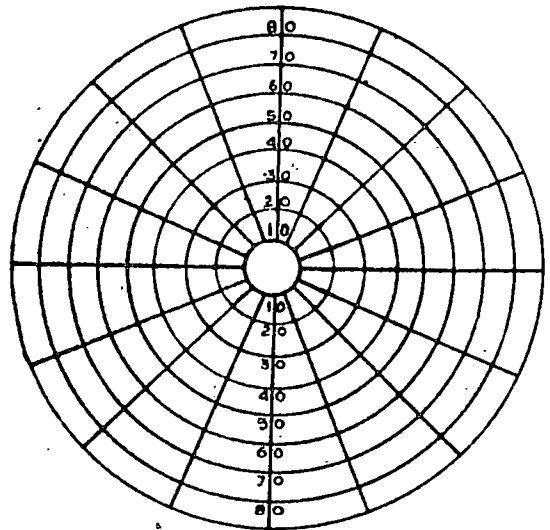
FIELD STUDY

Left Eye



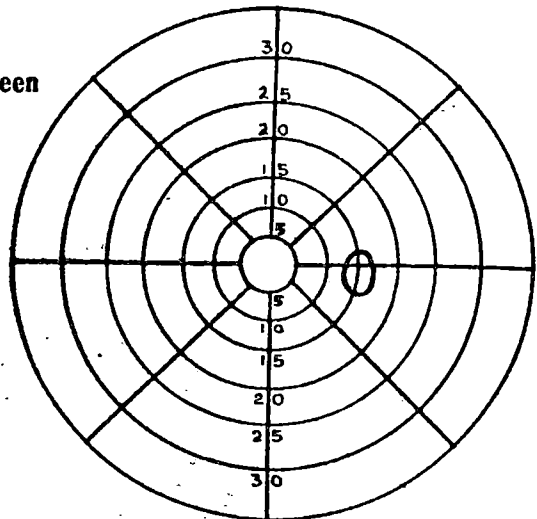
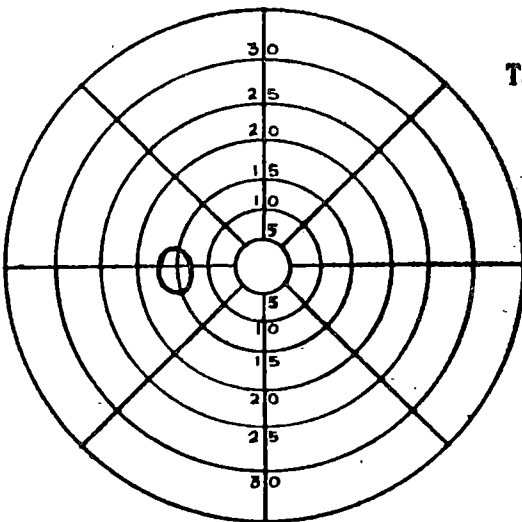
Perimeter

Right Eye



**Colour
Test object, Size
Distance**

Tangent Screen



**Colour
Test object, Size
Distance**

0900 HOURS

DEPARTMENT OF NATIONAL DEFENCE
CANADIAN FORCES MEDICAL SERVICE
CASE SHEET OPTHALMOLOGY



CANADA

SURNAME KALICHUK		GIVEN NAMES A		SERVICE NUMBER 15113
RANK Sgt		ADMISSION DATE DAY MONTH YEAR		ADMISSION NUMBER
UNIT OR SHIP CFB Clinton Ont				
INSTITUTION Base Hospital			PLACE Clinton Ont	

Referred to **F/L Rain Clinton Ont** by **MO Clinton Ont** Date **25 Oct 66**

Reason for Examination **Refraction** **age 43 years**

History: **bb - presbyopic troubles.**
I'm okay on long distance part on the reading portion. O.S. turns out to be prolonged D.P. work.

Anterior Segment } Rt. Lt.
N N

Eye	VISION		REFRACTION				Vision After
	Before		Sphere	Cylinder	Axis	Prism	
Rt.	20/20	+2.50	 plano				20/20
Lt.	20/20		 plano				20/20

Glasses: } Rt. Sph. Cyl. Axis. READING.
Prescribed: } Lt. Sph. Cyl. Axis. READING.

Pupils
Tension: Rt. Lt.
Cover Test: 20 Ft. **orthophoria** 15 Ins. **orthophoria RR**
Maddox Rod: 20 Ft. 15 Ins.
Cardinal Positions:

Convergence Cms. Accommodation { Rt. Cms.
Cms. Lt. Cms.

Fundi and Media } Rt. **central macula** pupils are quite small. takey and it is difficult to view the peripheral area
Lt. **are normal in appearance.**

Fields: **the peripheral area**

Colour Vision

DIAGNOSIS **Squint.**

Remarks and/or Treatment: **Has a squint - alternates. OD is his dominant eye. Recommended referral to see an ophthalmologist in DVA.**
BR Rain O.S. (Ophthalmologist)

Date **25.X.66** Hospital **66**

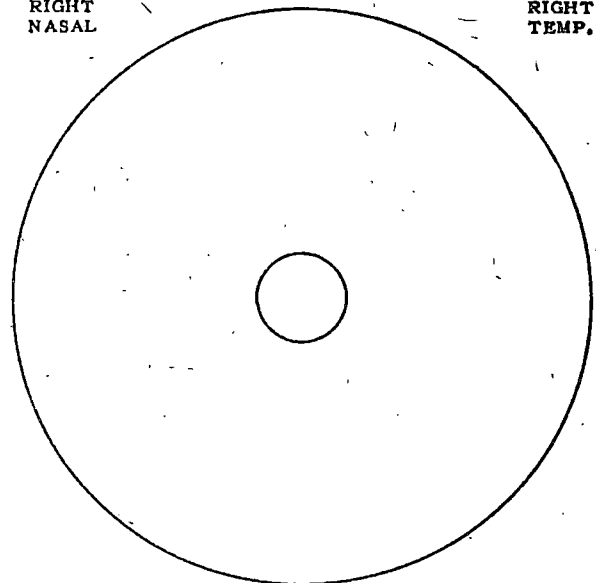
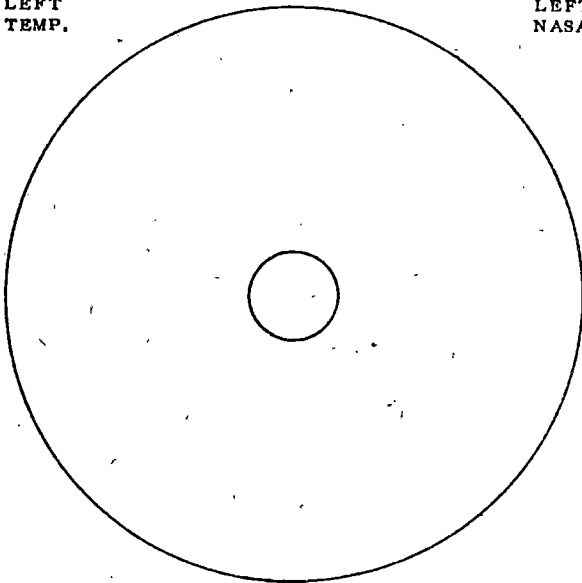
FUNDI

LEFT
TEMP.

LEFT
NASAL

RIGHT
NASAL

RIGHT
TEMP.



Remarks:

FIELD STUDY

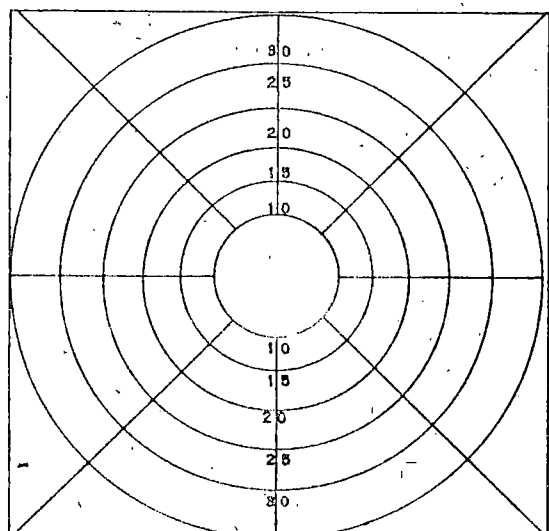
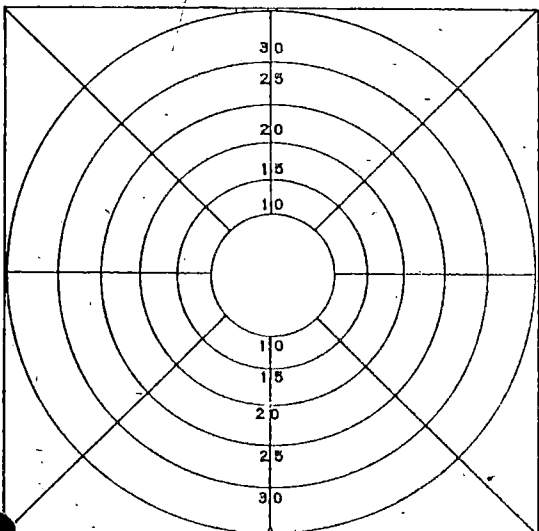
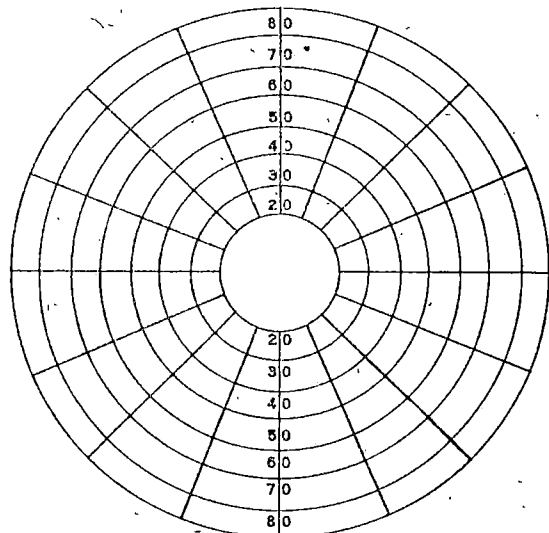
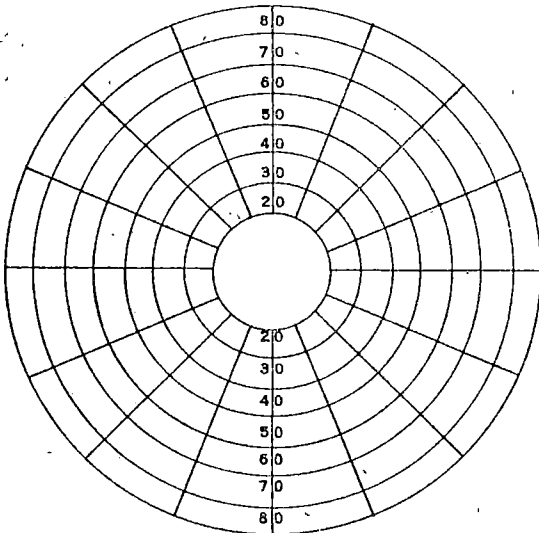
Test Object COLOUR
SIZE
DISTANCE

Illumination

V.O.S.

PERIMETER

V.O.D.



TEST OBJECT

RECORD OF MEDICAL EXAMINATION
(Other than on Enrolment, Release, Annual Flying)

Enclosure Number in
Medical Envelope

Purpose of Examination Annual Over 40 Medical	Examination Unit CFB Clinton Ont
--	-------------------------------------

PART I - SERVICE PARTICULARS

Name KALICHUK Alexander	Rank Sgt	Number 15113
Establishment CFB Clinton Ont	Trade Supply Tech	
Date of Enrolment 24 Jan 50	Date of Birth 3 Nov 23	Service RCAF (REG)

PART II - HISTORY AND/OR FINDINGS PERTINENT TO EXAMINATION
(consultant's reports to be attached/referred to where indicated)

History and Physical examination: Normal

Diagnosis: OVER 40

PART III - MEDICAL OFFICER'S RECOMMENDATIONS (State specific limitations)

Fit over 40

Date for next examination/Board 3 Nov 67

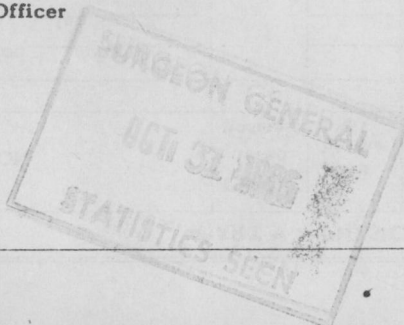
PART IV

CATEGORY OR PROFILE	RCN		ARMY								RCAF					OTHER FACTORS PRESENT	CATEGORY	
	Cat	Visual Stand	YOB	P	U	L	H	E	M	S	VISION	COLOUR VISION	HEAR-ING	HANDS	ARMS			LEGS
PRESENT											/	/	/	/	/	/	0	A4B
RECOMMENDED											/	/	/	/	/	/	0	A4B

Date 20 Oct 66

Hughes Robert PL
Signature Examining Medical Officer

Remarks Approving Medical Officer



Date _____

Signature and Appointment Approving Medical Officer 001035

PART V - PHYSICAL EXAMINATION

EXAMINATION		Consi- dered normal	See below	EXAMINATION		Consi- dered normal	See below
1	General appearance	N		15	Lungs	✓	
2	Body Frame: Sm _____ Med <u>N</u> Lg _____			16	Heart	✓	
3	Height: ft. <u>5</u> ins. <u>7</u>			17	Breasts	✓	
4	Weight (Stripped) <u>155</u> lbs.			18	Pulse Rate <u>80</u>		
5	Vision: s glasses <u>R 20/15 L 20/15</u> c glasses <u>R _____ L _____</u>	①		19	Blood Pressure: S <u>130</u> D <u>88</u>		
6	Colour Vision: Plates _____ Lantern _____	1		20	Abdomen	✓	
7	Pupils: Light _____ Acc _____	N		21	Genitalia	✓	
8	Visual Field	N		22	Hemial Orifices	✓	
9	Fundi			23	Anus	✓	
10	Hearing: WV R <u>N</u> L <u>N</u> CV R <u>N</u> L <u>N</u>	N		24	Rectal Exam (digital)	✓	
11	Ears & Tympani: R <u>N</u> L <u>N</u>	N		25	Skin	✓	
12	Mouth & Teeth	N		26	Varicosities	✓	
13	Nose & Throat	N		27	Lymphatic Glands	✓	
14	Chest: Min. _____ Max. _____	N		28	Thyroid	✓	
				29	Extremities: Upper _____ Lower _____	✓	
				30	Spine	✓	
				31	CNS	✓	
				32	Emotional Status	✓	
33	Chest X-Ray: Date <u>12 OCT 66</u> Report <u>Neg.</u>						
34	Urinalysis: SG _____ Alb <u>Neg</u> Sugar <u>ng</u> Microscopic <u>N</u>						
35	Electrocardiogram: Date <u>6 OCT 66</u> Report <u>Normal.</u>						
36	Other Lab Tests _____						

POSITIVE FINDINGS AND/OR REMARKS:

① - states he has trouble when reading
 afft with the optometrist to see

DEPARTMENT OF NATIONAL DEFENCE
 CANADIAN FORCES MEDICAL SERVICE
 X-RAY REQUISITION AND REPORT



SURNAME KALICHUK		GIVEN NAMES Alexander	
RANK Sergeant	AGE 42	SERVICE NUMBER 15113	
UNIT OR SHIP CFB Clinton Ont			
INSTITUTION Base Hospital			
PLACE Clinton Ont	ADMISSION DATE DAY MONTH YEAR		ADMISSION NUMBER
EXAMINATION REQUESTED Chest XRay - Annual Over 40 Medical			ROUTINE CHEST ADM.....() ENROL.....() RELEASE.....() ANNUAL.....() OTHER
DATE 6 Oct 66			

*CLINICAL INFORMATION

- (*BRIEF HISTORY
- *CLINICAL FINDINGS
- *PREVIOUS X-RAYS)

AMBULATORY.....() WHEEL CHAIR.....() STRETCHER.....() BED.....()	CLINICAL DIAGNOSIS	BW Wilton Capt SIGNATURE OF MEDICAL OFFICER REQUESTING EXAMINATION
RADIOGRAPHERS USE ONLY		STATE OFFICE TO WHICH THIS REPORT IS TO BE FORWARDED

RADIOLOGICAL REPORT	FILM NUMBER 5382	DATE
---------------------	---------------------	------

P.A. CHEST.

No active lung disease.

KJ. 12 Oct 66

W. Wilton
 Norman Wilton, M.D.

11/15/65

RECORD OF MEDICAL EXAMINATION
(Other than on Enrolment, Release, Annual Flying)

Enclosure Number in
Medical Envelope

Purpose of Examination Over 40 Medical	Examination Unit RCAF Stn Clinton Ont
---	--

PART I - SERVICE PARTICULARS

Name KALICHUK Alexander	Rank Sgt	Number 15113
Establishment RCAF Stn Clinton Ont	Trade SupTech	
Date of Enrolment 21 Jan 50	Date of Birth 3 Nov 23	Service RCAF (REG)

PART II - HISTORY AND/OR FINDINGS PERTINENT TO EXAMINATION
(consultant's reports to be attached/referred to where indicated)

History and findings. History nil of note since discharge from Hosp. (25-29 Jan 55) following a bout of alcoholic gastritis when he made a good recovery.

K.A.D.

Diagnosis: Over 40

PART III - MEDICAL OFFICER'S RECOMMENDATIONS (State specific limitations)

Fit over 40.

Date for next examination/Board Dec '66

PART IV

CATEGORY OR PROFILE	RCN		ARMY									RCAF					CATEGORY	
	Cat	Visual Stand	YOB	P	U	L	H	E	M	S	VISION	COLOUR VISION	HEAR-ING	HANDS	ARMS	LEGS		OTHER FACTORS PRESENT
PRESENT											/	/	/	/	/	/	-	A4B
RECOMMENDED											/	/	/	/	/	/	-	A4B

Date 2 Dec 65

(VE Raz) Dr
Signature Examining Medical Officer

Remarks Approving Medical Officer

Date _____

Signature and Appointment Approving Medical Officer

001038

PART V - PHYSICAL EXAMINATION

EXAMINATION		Consi- dered normal	See below	EXAMINATION		Consi- dered normal	See below
1	General appearance	✓		15	Lungs	✓	
2	Body Frame: Sm _____ Med <input checked="" type="checkbox"/> Lg _____			16	Heart	✓	
3	Height: ft. <u>5</u> ins. <u>7</u>			17	Breasts		
4	Weight (Stripped) <u>150</u> lbs.			18	Pulse Rate <u>84</u>		
5	Vision:			19	Blood Pressure: S <u>100</u> D <u>80</u>		
	s glasses R <u>20/15</u> L <u>20/15</u>			20	Abdomen		Ⓚ
	c glasses R <u>15</u> L <u>15</u>			21	Genitalia	✓	
6	Colour Vision: Plates _____ Lantern _____	✓		22	Hemial Orifices	✓	
7	Pupils: Light _____ Acc _____	✓		23	Anus	✓	
8	Visual Field _____	✓		24	Rectal Exam (digital)	✓	
9	Fundi _____	✓		25	Skin	✓	
10	Hearing: WV R <u>See audiology</u>	✓		26	Varicosities	✓	
	CV R _____ L _____			27	Lymphatic Glands	✓	
11	Ears & Tympani: R _____ L _____	✓		28	Thyroid	✓	
12	Mouth & Teeth	✓		29	Extremities: Upper _____ Lower _____	✓	
13	Nose & Throat	✓		30	Spine	✓	
14	Chest: Min. _____ Max. _____	✓		31	CNS	✓	
33	Chest X-Ray: Date <u>30 Nov 61</u> Report <u>neg</u>			32	Emotional Status	✓	
34	Urinalysis: SG _____ Alb _____ Sugar _____ Microscopic _____						
35	Electrocardiogram: Date <u>30 Nov 61</u> Report <u>normal</u>						
36	Other Lab Tests _____						

POSITIVE FINDINGS AND/OR REMARKS:

Ⓚ dull heard non-symptomatic appendicitis.

DEPARTMENT OF NATIONAL DEFENCE
 CANADIAN FORCES MEDICAL SERVICE
 X-RAY REQUISITION AND REPORT



SURNAME KALICHUK		GIVEN NAMES Alexander	
RANK Sgt	AGE 42	SERVICE NUMBER 15113	
UNIT OR SHIP RCAF Stn Clinton Ont			
INSTITUTION RCAF Infirmary			
PLACE Clinton Ont	ADMISSION DATE DAY MONTH YEAR		ADMISSION NUMBER

*CLINICAL INFORMATION

- (*BRIEF HISTORY
- *CLINICAL FINDINGS
- *PREVIOUS X-RAYS)

EXAMINATION REQUESTED Over 40 Medical	ROUTINE CHEST ADM.....() ENROL.....() RELEASE.....() ANNUAL.....() OTHER
DATE 30 Nov 65	

AMBULATORY.....() WHEEL CHAIR.....() STRETCHER.....() BED.....()	CLINICAL DIAGNOSIS <div style="text-align: right;"> (J MacKenzie) F/L SIGNATURE OF MEDICAL OFFICER REQUESTING EXAMINATION </div>
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RADIOGRAPHERS USE ONLY	STATE OFFICE TO WHICH THIS REPORT IS TO BE FORWARDED
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RADIOLOGICAL REPORT	FILM NUMBER 4499	DATE 3 Dec 65
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P.A. CHEST.

The heart is not enlarged. There is no evidence of active pulmonary disease or pleural effusion.

W.A. BLOOMFIELD, M.D.
 RADIOLOGIST

CASE HISTORY



CANADA

Buyer made

SURNAME KALICHUK		GIVEN NAMES ALEC		SERVICE NUMBER 15113	
RANK SGT	TRADE SUPPLY	FORCE RCAF	DATE OF BIRTH 30 Nov 23	AGE 40	
SHIP OR UNIT RCAF STN CENTRALIA,		RELIGION RC	ADMISSION NUMBER 11		
CIVILIAN ADDRESS RR4 WANTON ONT			PREVIOUS ADMISSION DATES		
NEXT OF KIN AND ADDRESS MRS A. KALICHUK - (WIFE) (as above)					
INSTITUTION Infirmity		PLACE R.C.A.F. STATION CENTRALIA, ONT.	WARD OR WING		
DATE OF ADMISSION 25 Jan 65	TRANSFERRED FROM	CONDITION ON ADMISSION ELECTIVE <input type="checkbox"/> SERIOUS <input type="checkbox"/> EMERGENCY <input type="checkbox"/>		REFERRED BY Dr R. G. Alure	

HEADQUARTERS USE ONLY	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
-----------------------	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----

DATE OF DISCHARGE 29 Jan 65	DAYS IN HOSPITAL 4	DAYS SICK LEAVE	DISPOSAL DUTY <input type="checkbox"/> EXCUSED DUTY <input type="checkbox"/> 1 day OUT PATIENT <input checked="" type="checkbox"/> TRANSFER <input type="checkbox"/> HOME <input type="checkbox"/>		47
TRANSFERRED TO		CONDITION ON DISPOSAL RECOVERED <input type="checkbox"/> IMPROVED <input type="checkbox"/> NOT IMPROVED <input type="checkbox"/> DEAD <input type="checkbox"/> DIAGNOSIS ONLY <input type="checkbox"/>			48

IF ACCIDENT STATE CIRCUMSTANCES

49

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DIAGNOSIS ON ADMISSION
Acute alcoholic gastritis

52

FINAL DIAGNOSES (IN ORDER OF IMPORTANCE)

1. **11** **11** **11**

53

SURGEON GENERAL
 APR 6 1965
STATISTICS SECN

MORBIDITY CODE	54
55	
56	
OPERATIONS	
1.	
2.	
3.	
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SUMMARY (COMPLAINTS, PHYSICAL AND LABORATORY EXAMINATION FINDINGS, TREATMENT, ETC.)

Admitted with epigastric pain, nausea and vomiting following heavy week-end drinking. Patient had some tenderness in the epigastrium. It was felt he had an acute alcoholic gastritis. He recovered on Rx with soft diet, alcohol, and bed rest. On discharge his symptoms had subsided.

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RECOMMENDATIONS (FURTHER TREATMENT, CONVALESCENCE, LIMITATIONS AS TO WORK, ETC.)

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DVA-TS (REV.-9-51) 71	DATE LIKELY FIT FOR WORK	SIGNATURE OF MEDICAL OFFICER I/C CASE JAM Alure
-----------------------	--------------------------	---

ADMISSION NOTES

Drinking heavily ~~to~~ all week end. Last evening unable to eat supper then sudden onset of sharp epigastric pain about 9:00 PM. Nausea & vomiting since then - specks of blood in vomitus. Pain has persisted

PROVISIONAL DIAGNOSIS

SIGNATURE OF ADMITTING OFFICER

DATE

CLINICAL NOTES WITH SIGNATURES

O/E.

- HR 124 BP 155/90
- Very red complexion
- Slight cyanosis

CVS - Heart sounds regular, clear
 - Grade I/II systolic ejection (m)
 heard best at apex - no radiation

Abdomen -

- Soft, slightly obese
- Tender epigastrium
- Readily palpable pulsation in epigastrium (most likely transmitted from the cardiac)
- No masses, bowel sounds normal.

Impress Acute alcoholic gastritis

J.A. McDerm.

26 Jan 65.

Feeling better today. Appetite still poor and still having some epigastric pain

J.A.M.

TREATMENT RECORD



SURNAME <i>KANICHUK</i>	GIVEN NAMES <i>A/NEC</i>	SERVICE NUMBER <i>15113</i>
RANK <i>Sgt</i>	ADMISSION DATE <i>25 Jan 65</i>	ADMISSION NUMBER
UNIT OR SHIP <i>RCMP Det Centralia Ont.</i>		
INSTITUTION <i>Infirmary</i>		PLACE <i>R.C.A.F. STATION - CENTRALIA, ONT.</i>

ORDER GIVEN		DIET	ORDERS, TREATMENT, MEDICATIONS, ETC.	ORDER DISCONTINUED	
DATE	BY WHOM			DATE	BY WHOM
<i>25 Jan 65</i>	<i>Dr McClure</i>		<ol style="list-style-type: none"> ① Soft diet ✓ ② Milk ad lib. ✓ ③ Bed rest & BRP ✓ ④ Diiodol 1 tbs. q4h ✓ except at night ⑤ Second gr 1/2 hs prn. ✓ ⑥ APC: C gr 1/2 1 or 2 tbs q4h prn for pain ✓ 		
			<i>J.A. McClure</i>		
<i>26 Jan 65</i>			<ol style="list-style-type: none"> ① May repeat second gr 1/2 hs once. 		
			<i>J.A. McClure</i>		
<i>29 Jan 65</i>			<ol style="list-style-type: none"> ② Discharge on Diiodol 		
			<i>J.A.M.</i>		

BEDSIDE NURSING NOTES



SURNAME KALICHUK	GIVEN NAMES ANEC	SERVICE NUMBER 15113
RANK Sgt	ADMISSION DATE 25 Jan 65	ADMISSION NUMBER
UNIT OR SHIP RCAF 2 Str Centralia Ont.		
INSTITUTION Infirmary.		PLACE CENTRALIA, ONT.

Date and Time	Medication, nursing care and any abnormal signs and symptoms are to be recorded and signed. Irrelevant and insignificant information is NOT to be inserted.	Signature
25 Jan 65 0600	Reported to M.R. 4/0 abdominal pain & vomiting. No rest - put to bed & to be seen by M.D. in am. Seen by Dr. McRae - to be admitted.	
1400	APC + C tabs 1/2 for abdominal pain. Dioval 3/5s.	
1800 hrs	Dioval 3/5s - APC + C tabs 1/2 for pain.	
2200 hrs	Dioval 3/5s - Seconal grs 1/5s Po. Abdominal pain cont's APC + C not effective.	
26 Jan 65 0730	Pt spent a fair night. Appetite poor.	
1000 hrs	DIOVAL 3/5s - APC + C TABS 1/2 for pain.	
1400 hrs	DIOVAL 3/5s - APC + C TABS 1/2 for pain.	
1800 hrs	Dioval 3/5s	
2200 hrs	Dioval 3/5s Po. Seconal grs 1/5s Po.	
27 Jan 65 1200	Dioval 3/5s.	
1600	Abdominal pain improving.	
1800	Dioval 3/5s Po.	
2200 hrs	Dioval 3/5s Po.	
2300 hrs	Seconal grs 1/5s Po.	
28 Jan 65 1000 hrs	Dioval 3/5s Po.	
1400 hrs	Dioval 3/5s Po.	
1800 hrs	DIOVAL 3/5s Po.	
29 Jan 65 0930	Discharge to M.D.	

LABORATORY REPORT SHEET



SURNAME <i>KALICHUK</i>	GIVEN NAMES <i>ALEC</i>	SERVICE NUMBER <i>15113</i>
RANK <i>Sgt</i>	ADMISSION DATE <i>25 JAN 68</i>	ADMISSION NUMBER
UNIT OR SHIP <i>RCAF Stn Centralia, Ont.</i>		
INSTITUTION <i>Infirmery</i>		PLACE <i>R.C.A.F. STATION - CENTRALIA, ONT.</i>

REPORTS

AFFIX 15TH REPORT HERE

330. 150 standard RCAF
30/Nov/68 BY *Stelabsh* MAICO
AUDIOGRAM *KALICHUK* NAME *A.*

15113 SGT FORM 102 REV.

	LEFT EAR	RIGHT EAR
	BLUE	RED
AIR	X	O
AIR WITH MASKING	□	△
BONE COND WITH MASKING	◁	▷
DB INTENSITY OF MASKING		
A. M. A. % HEARING LOSS		
L. _____	R. _____	COMB. _____
	LEFT EAR	RIGHT EAR
S. R. T.		
M. C. L.		
T. D.		

850 Yonge Street - 924-2317

AFFIX 3RD REPORT HERE

ISM-9U (4-58)
7530-21-562-7314

LABORATORY REPORT

Sp. Chlora HOSPITAL, LABORATORIES

NAME (USE BLOCK LETTERS) <i>Kalichuk A</i>	SERVICE NUMBER <i>15113</i>	WARD OR SERVICE <i>US9</i>	LAB. REG. No.
COLOUR <i>Shon</i>	SPEC GRAVITY <i>US9</i>	TURBID OR CLEAR <u>CLEAR</u>	
ALBUMEN - QUALITATIVE <i>ng</i>	QUANTITATIVE		
SUGAR - QUALITATIVE <i>ng</i>	QUANTITATIVE		
MICROSCOPIC			
OTHER TESTS: <i>Perid</i>			
DATE SENT <i>30 Nov 68</i>		URINALYSIS DATE REPORTED	

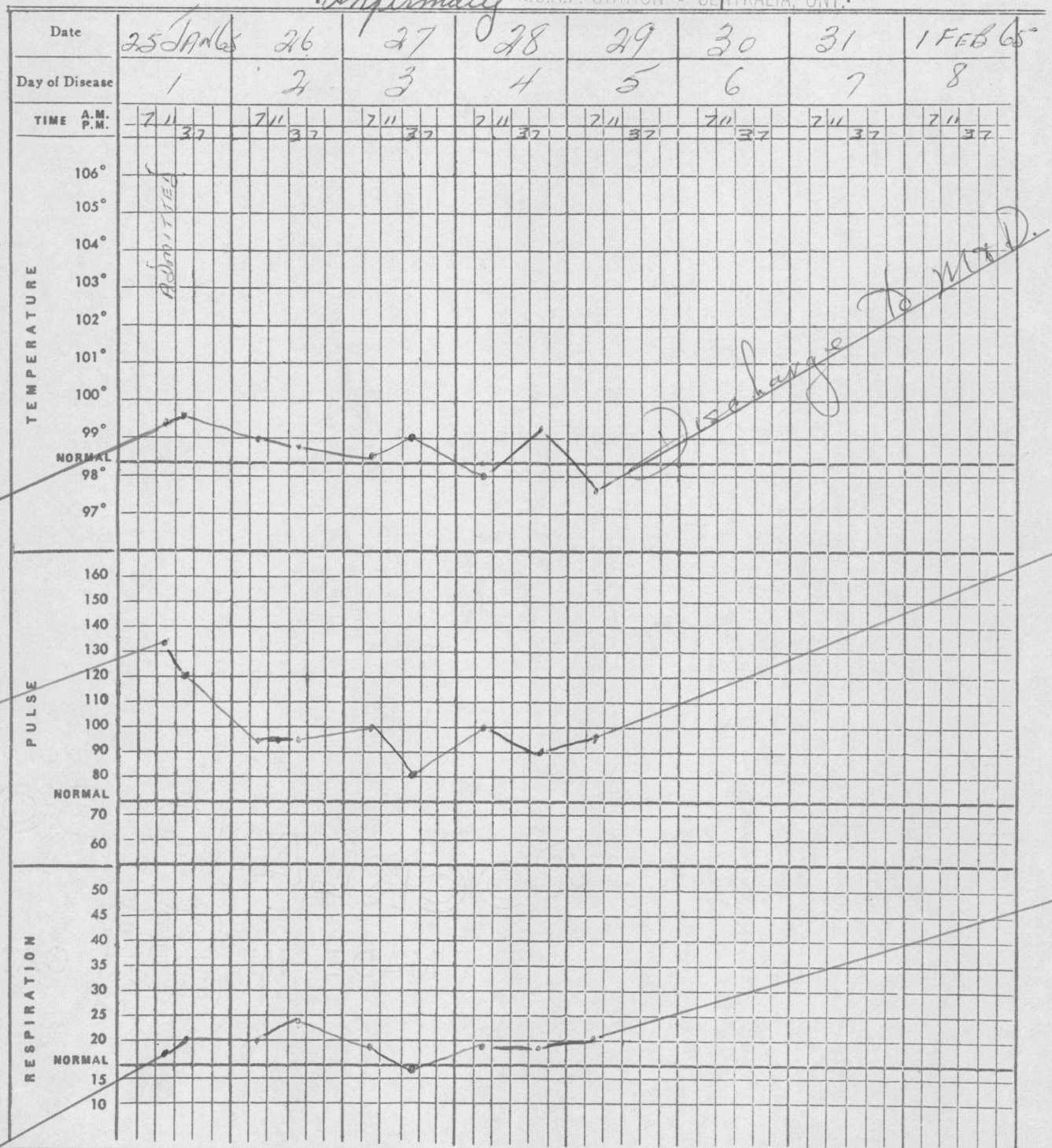
FIRMLY AFFIXED



CANADA

TEMPERATURE — PULSE — RESPIRATION — RECORD

SURNAME <i>KALICHUK</i>		GIVEN NAMES <i>ALFRED</i>		SERVICE NUMBER <i>15113</i>
RANK <i>SGT</i>		ADMISSION DATE <i>25 JAN 65</i> DAY MONTH YEAR		ADMISSION NUMBER
INSTITUTION <i>Infirmary R.C.A.F. STATION - CENTRALIA, ONT.</i>			PLACE	RECORD NUMBER



STOOLS									
BLOOD PRESSURE	<i>175/72</i>								
FLUID Mouth INTAKE I.V.	---	---	---	---	---	---	---	---	---
FLUID Urine OUTPUT Other	---	---	---	---	---	---	---	---	---
WEIGHT									

DEPARTMENT OF NATIONAL DEFENCE
CANADIAN FORCES MEDICAL SERVICE
X-RAY REQUISITION AND REPORT



SURNAME KALICHUK		GIVEN NAMES ALEC	
RANK Sgt	AGE 40	SERVICE NUMBER 15113	
UNIT OR SHIP CENTRALIA			
INSTITUTION X-RAY DEPARTMENT RCAF STN CENTRALIA			
PLACE CENTRALIA	ADMISSION DATE DAY MONTH YEAR 25 Jan 65		ADMISSION NUMBER

*CLINICAL INFORMATION

- (*BRIEF HISTORY
- *CLINICAL FINDINGS
- *PREVIOUS X-RAYS)

EXAMINATION REQUESTED	ROUTINE CHEST
① CHEST	ADM.....()
② FLAT PLATE - ABDOMEN	ENROL.....()
DATE 25 JAN 65	RELEASE.....()
	ANNUAL.....()
	OTHER

Heavy drinker. ~~Now~~ drinking all week-end. Last night developed sharp epigastric pain. Has had nausea & vomiting since - specks of blood in vomitus. ^{under} Pulsating mass in epigastrium. ^{Heart} appears enlarged.

AMBULATORY.....() WHEEL CHAIR.....() STRETCHER.....() BED.....()	CLINICAL DIAGNOSIS Alcoholic gastritis
---	--

J.A. McClure
SIGNATURE OF MEDICAL OFFICER REQUESTING EXAMINATION

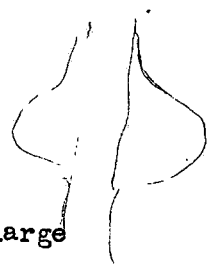
RADIOGRAPHERS USE ONLY

2-14217
Way

STATE OFFICE TO WHICH THIS REPORT IS TO BE FORWARDED
SMO RCAF STN CENTRALIA

RADIOLOGICAL REPORT	FILM NUMBER 1947	DATE JAN 25 1965
---------------------	----------------------------	----------------------------

P.A. CHEST AND FLAT PLATE OF THE ABDOMEN.
Chest: Lung fields and pleural spaces are clear.
Heart chest ratio is 11.7 to 31.0.



Flat film of the abdomen shows small amount of gas in the small and large bowel, not abnormal. No abnormal shadows noted in the KUB tract.

H.L. Teskey
Hm.L. Teskey, M.B.
RADIOLOGIST

RECORD OF MEDICAL EXAMINATION
(Other than on Enrolment, Release, Annual Flying)

Enclosure Number in
Medical Envelope

Purpose of Examination <i>Over 40 Medical</i>	Examination Unit <i>RCAF Stn CENTRALIA ONT</i>
--	---

PART I - SERVICE PARTICULARS

Name <i>KALICHUK ALEXANDER</i>	Rank <i>Sgt</i>	Number <i>15113</i>
Establishment <i>Stn CENTRALIA</i>	Trade <i>SUPPLY TECH</i>	
Date of Enrolment <i>21 JAN 50</i>	Date of Birth <i>3 NOV 23</i>	Service <i>RCAF (REG)</i>

PART II - HISTORY AND/OR FINDINGS PERTINENT TO EXAMINATION
(consultant's reports to be attached/referred to where indicated)

Healthy individual with no complaints.

Diagnosis: *Over 40*

PART III - MEDICAL OFFICER'S RECOMMENDATIONS (State specific limitations)

Fit

Date for next examination/Board *1 yr.*

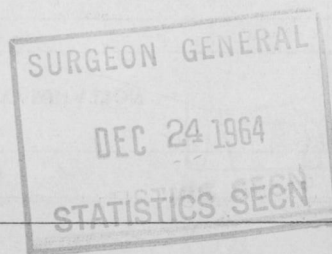
PART IV

CATEGORY OR PROFILE	RCN		ARMY							RCAF					OTHER FACTORS PRESENT	CATEGORY		
	Cat	Visual Stand	YOB	P	U	L	H	E	M	S	VISION	COLOUR VISION	HEAR-ING	HANDS			ARMS	LEGS
PRESENT											/	/	/	/	/	/	-	<i>A4B</i>
RECOMMENDED											/	/	/	/	/	/	-	<i>A4B</i>

Date *10 Nov 64*

R. Amet.
Signature Examining Medical Officer

Remarks Approving Medical Officer



Date _____

Signature and Appointment Approving Medical Officer _____

PART V - PHYSICAL EXAMINATION

EXAMINATION		Consi- dered normal	See below	EXAMINATION		Consi- dered normal	See below
1	General appearance			15	Lungs		
2	Body Frame: Sm <u> </u> Med <u> </u> Lg <u> </u>			16	Heart		
3	Height: ft. <u>5</u> ins. <u>6</u>			17	Breasts		
4	Weight (Stripped) <u>154</u> lbs.			18	Pulse Rate <u>78</u>		
5	Vision: s glasses R <u>20/20</u> L <u>20/20</u> c glasses R <u> </u> L <u> </u>			19	Blood Pressure: S <u>120</u> D <u>80</u>		
6	Colour Vision: Plates <u> </u> Lantern <u> </u>			20	Abdomen		
7	Pupils: Light <u> </u> Acc <u> </u>			21	Genitalia		
8	Visual Field <u> </u>			22	Hernial Orifices		
9	Fundi <u> </u>			23	Anus		
10	Hearing: WV R <u> </u> L <u> </u> CV R <u> </u> L <u> </u>			24	Rectal Exam (digital)		
11	Ears & Tympani: R <u> </u> L <u> </u>			25	Skin		
12	Mouth & Teeth <u> </u>			26	Varicosities		
13	Nose & Throat <u> </u>			27	Lymphatic Glands		
14	Chest: Min. <u> </u> Max. <u> </u>			28	Thyroid		
				29	Extremities: Upper <u> </u> Lower <u> </u>		
				30	Spine		
				31	CNS		
				32	Emotional Status		

33 Chest X-Ray: Date 10 Nov 64 # 1833 Report Negative

34 Urinalysis: SG 1.028 Alb neg Sugar neg
Microscopic Occ'l WBC / HPF Mucous threads

35 Electrocardiogram: Date 13 Nov 64 Report Category 2. H.A. Sears MD
to the file no 29169

36 Other Lab Tests Audiogram

POSITIVE FINDINGS AND/OR REMARKS:

ROYAL CANADIAN AIR FORCE

RCAF M58A

AUDIOGRAM

NUMBER 15113 RANK SGT NAME KALICHUK, A.
 AGE LAST BIRTHDAY 42 TRADE SUP/TECH DATE ENLISTED _____

EAR TESTED	THRESHOLD	HEARING LOSS (DECIBELS RE NORMAL THRESHOLD)						
		FREQUENCY (CYCLES PER SECOND)						
		256	512	1024	2048	2896	4096	5192 <u>6000</u>
RIGHT	DISAPPEARANCE	0	5	-5	-5	-5	0	0
	APPEARANCE	5	10	0	0	0	5	5
LEFT	DISAPPEARANCE	0	-5	-5	-5	-5	0	0
	APPEARANCE	5	0	0	0	0	5	5

OPERATOR'S NUMBER 122316 RANK CPL NAME HALL, W.S.

AUDIOMETER SERIAL NUMBER 4691

PLACE TESTED 1msd Centalca DATE TESTED 10 NOV 64

DEPARTMENT OF NATIONAL DEFENCE
 CANADIAN FORCES MEDICAL SERVICE
 X-RAY REQUISITION AND REPORT

REGULAR



SURNAME KALICHUK		GIVEN NAMES Alexander	
RANK SGT	AGE 41	SERVICE NUMBER 15113	
UNIT OR SHIP RCAF STN CENTRALIA			
INSTITUTION RCAF INFIRMARY			
PLACE CENTRALIA	ADMISSION DATE DAY MONTH YEAR		ADMISSION NUMBER
EXAMINATION REQUESTED PA Chest			ROUTINE CHEST ADM.....() ENROL.....() RELEASE.....() ANNUAL.....() OTHER Over 40 X
DATE 10 Nov 64			

*CLINICAL INFORMATION

- (*BRIEF HISTORY
- *CLINICAL FINDINGS
- *PREVIOUS X-RAYS)

AMBULATORY.....() WHEEL CHAIR.....() STRETCHER.....() BED.....()	CLINICAL DIAGNOSIS 	(R Arnot) F/L SIGNATURE OF MEDICAL OFFICER REQUESTING EXAMINATION
RADIOGRAPHERS USE ONLY <i>1-14417</i> <i>W. J. [Signature]</i>		STATE OFFICE TO WHICH THIS REPORT IS TO BE FORWARDED SMO RCAF STN CENTRALIA
RADIOLOGICAL REPORT		FILM NUMBER 1 F33
		DATE 10 Nov 64

NEGATIVE

[Signature]
 Wm L. TESKEY, M.D.
 RADIOLOGIST

CONSULTANT'S REPORT



SURNAME Kalichuk	GIVEN NAMES Alexander	SERVICE NUMBER 15113
RANK Sgt	ADMISSION DATE	ADMISSION NUMBER
INSTITUTION RCAF Station Aylmer, Ontario		PLACE

REFERRED TO: Psychiatric Clinic	DATE
------------------------------------	------

SUMMARY OF COMPLAINTS, PHYSICAL AND LABORATORY EXAMINATION FINDINGS, TREATMENT AND PROGRESS.
All the pertinent details are included in attached referral to W/C Beach, his findings and recommendation of a period of in hospital management.

INFORMATION REQUIRED:

THIS AMBULATORY CASE IS:	WHEELCHAIR	STRETCHER	BED	SIGNATURE OF M.O. IIC CASE (D V Catton) F/L
--------------------------	------------	-----------	-----	--

CONSULTANT'S REPORT:
This man's problem and history well outlined on attached report from W/C Beach.

DIAGNOSIS:
In Abeyance

RECOMMENDATIONS RESPECTING TREATMENT, CONVALESCENCE, FITNESS FOR GAINFUL EMPLOYMENT, OR DUTY
ADMIT TO D-3&4 FOR FURTHER INVESTIGATION

/ss	SIGNATURE OF CONSULTANT G.E. Hobbs, M.D.	DATE 21.7.59.
-----	---	------------------

(USE REVERSE SIDE IF ADDITIONAL SPACE IS REQUIRED)

CONSULTANT'S REPORT



SURNAME <i>KALICHUK</i>	GIVEN NAMES <i>ALEXANDER</i>	SERVICE NUMBER <i>15113</i>
RANK <i>Sgt.</i>	ADMISSION DATE DAY MONTH YEAR	ADMISSION NUMBER
UNIT OR SHIP <i>R.C.A.F. Stn. Aylmer, Ontario</i>		
INSTITUTION <i>R.C.A.F. Stn. Infirmary</i>		PLACE <i>Aylmer</i>

REFERRED TO: *10/6 Beach - Psychiatry* DATE *9 Jun 59*

SUMMARY OF COMPLAINTS, PHYSICAL AND LABORATORY EXAMINATION FINDINGS, TREATMENT AND PROGRESS.

Referred at request of CO for evaluation of personality.

He has recently been charged with aiding the delinquency of a juvenile in St. Thomas, but was extremely lucky to have the charge dismissed. After some afternoon drinking, he tried to entice a 10 year old female into the car by showing her some gifts. However the girl's father happened along, and the charge was not.

INFORMATION REQUIRED:

THIS AMBULATORY STRETCHER CASE IS: WHEELCHAIR <input type="checkbox"/> BED <input type="checkbox"/>	SIGNATURE OF M.O. I/C CASE? <i>[Signature]</i>
--	---

CONSULTANT'S REPORT:

This 35 yr old NCO was interviewed and his pertinent documents reviewed. He comes from a Polish family and is the 3rd of 3 boys. He has been accused of minor sexual misdemeanors. His family life at present is complicated by his [redacted]

s.19(1) *On interview he was well controlled but evasive at times and there was a definite paranoid tinge to his thinking. Psychological testing revealed no particular sexual psychopathology as the record was swamped by love.*

DIAGNOSIS:
 ① Sexual deviation 320.6 ② Anxiety reaction 310

RECOMMENDATIONS RESPECTING TREATMENT, CONVALESCENCE, FITNESS FOR GAINFUL EMPLOYMENT, OR DUTY.
Admit to West Hosp.

SIGNATURE OF CONSULTANT <i>[Signature]</i>	DATE <i>7 Jul 59</i>
---	-------------------------

In 1950 he had a civil conviction for unlawful exposure in Denton.

Recently he has been drinking to excess with increased frequency. He has family problems as well. A civil suit against a [redacted] is pending as a result of a playground accident. And a second [redacted] [redacted].

s.19(1)

This source work record on a Supply Dept is satisfactory.

He has his own home in Beaufort and is anxious to be posted to [redacted] or [redacted] (from where he came here). A transfer is due, as his job has been deleted from the Supply School establishment.

I think it would be for you to talk with this man.

overwhelming anxiety, tension, depression and guilt. This is indicative more of a danger of an attack on himself than any further acting out in the sexual sphere.

I feel the family court's recommendation of treatment is a good one and it may be possible to relieve him of some of his anxiety etc.

Recommend referral to West Hosp. for treatment & send along a copy of this report with the patient to Psychiatric Clinic, West Hosp.

It could be that we are dealing with the acute emotional disturbance so often seen in people with character disorders when they get caught.

001054

1 AM

DEPARTMENT OF NATIONAL DEFENCE

X RAY INSPECTION OF CHEST

SECTION 1

A radiograph of the chest of

Film No. 3409

Rank Sgt Name Kalichuk Alexander

Reg. No. 15113 Unit Clinton

Civilian Address as per Registration Card

Age 33 Height Weight
26 Aug 57

Signature of Recruit

is reported as follows:—

- (a) Radiological examination does not disclose evidence of tuberculous disease of the lungs of such a nature as to indicate rejection for service in the Canadian Armed Forces except as stated below.
- (b) The transverse diameter of the heart is.....cms. as compared with a transverse diameter of the chest of.....cms.
- (c) Pathological conditions or congenital abnormalities of importance seen in the film are as undernoted. (In each instance an opinion should be expressed as to whether such was present prior to enlistment.)

Isolation Medical

Place.....

Date.....

[Handwritten Signature]
Radiologist

If a pathological condition or congenital abnormality is not observed by this method of examination, record "negative" after (c).

SECTION 2

Remarks of the Internist, Surgeon or Specialist in Tuberculosis. (State whether, in your opinion the lesion present antedated enlistment.)

113

SECTION 3

Opinion of Consultant Physician and Radiologist as may be indicated by Section 2.

Conclusion.

Place.....

Date.....

Sig. Sig. 001056

CANADIAN ARMED FORCES

MEDICAL BOARD PROCEEDINGS

PART I

Station or Place..... RCMP STN. CLINTON Date..... 21 DEC 54
 Reason for Medical Board Proceedings..... Q.R. AIR ARTICLE 15:01 ITEM 4(G)
 Force..... RCMP REG Rank..... CPL. Service No..... 15113
 Surname..... KALICHUK Christian Names..... ALEXANDER
 Ship, Unit (or Establishment)..... RCMP STN CLINTON Present Trade..... SUPP. TECH
 Date of Birth..... 3 NOV. 1923 Former Civilian Trade..... FARMER
 Profession or Occupation.....
 Permanent Home Address..... R.R.# 4 WALTON ONT.

RECORD OF ALL SERVICE (RECORD CHRONOLOGICALLY)

Force	Number	Rank	DATE		Theatre of Operations
			From	To	
<u>ARMY REG</u>	<u>77067</u>	<u>PTE</u>	<u>23 MAY 41</u>	<u>10 MAR 43</u>	<u>CANADA</u>
<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>11 MAR 43</u>	<u>5 DEC 45</u>	<u>GR. BRITAIN - CONTINENT</u>
<u>✓</u>	<u>✓</u>	<u>✓</u>	<u>6 DEC 45</u>	<u>23 JAN 46</u>	<u>CANADA</u>
<u>RCMP REG</u>	<u>15113</u>	<u>CPL</u>	<u>23 JAN 50</u>	<u>PRESENT</u>	<u>CANADA</u>

No. _____ NAME _____
 NAVY: ARMY: AIR FCE. SOS 22-1-55
 BRD REC'D WSR 24-1-55 ON N. ROLL DATED
21-1-55 COPY TO H. O. 26-1-55
 CHECKER'S INITIALS ER

History of Service obtained from: Man's Statement..... Service Documents..... Both

PART II—PRESENT DISEASES OR INJURIES (to be filled in by the President of the Board)

Present Diseases or Injuries (If multiple, list in order of importance)	International Code No.	Place of Origin	Date of Origin
<u>NONE</u>			

PART III.—STATEMENT OF PRESENT COMPLAINTS (Individual's own words)

Have you any trouble resulting from any disease or injury. If so, state what it is, when it started, and what you think was the cause.

I have no complaints

Previous to joining the service did you suffer from any disease or injury mentioned in the above answer? If so, give details and dates as to hospital and doctor.

OKalichuk *CPH*

PART IV—HISTORY OF PRESENT DISABILITY

This section should contain a detailed history of the origin of all diseases and injuries described in PART III or otherwise discovered. Past history and family history, if relevant, is to be included.

It is found that M10 does not contain a copy of form M1 Medical Examination Record.

Rather than initiating tracing action at this time the M10 and M227 are forwarded for further action.

M10 Enclosure #5 Hospitalization Westminster Hospital

4-8 Feb 51.

*Diagnosis - nose fracture
no operation.*



ONTARIO

ATO *RO*

ONTARIO DEPT. OF HEALTH, DIVISION OF LABORATORIES
SERODIAGNOSIS (S.T.S.)

50826

LAB. NO.

PATIENT

LAST NAME

FIRST NAME

MIDDLE NAME

3420-15113 Cpl KALICHUK A.

AGE 31 SEX M TREATEDDATE 21 Dec 1954 PREVIOUS RESULT

(SPECIMEN COLLECTED)

REMARKS W.R. (Release)

THIS REPORT CANNOT
BE IDENTIFIED EXCEPT
BY LAB. NO.

Dr.

NAME OF PHYSICIAN

S.M.O

STREET AND NO.

R.C.A.F. STN

TOWN OR CITY

CLINTON

Ontario

DO NOT USE THIS SPACE

SEROLOGIC REPORT
NO REACTION

DEC 30 1954

W.M. Wilson
M.D.

LONDON

001059

TELEPHONE INQUIRY REGARDING REPORTS NOT PERMITTED

50881
All specimens are tested with the Presumptive Kahn test. Those failing to show a reaction are reported as "Reaction (Negative)"

0210107
All specimens reported "Reaction Present (Positive)" have been found to show a reaction with both the Standard Kahn test and Kolmer Complement Fixation test.

1210107
The method of reporting the Quantitative Kahn test may be compared to Kahn units by multiplying the serum dilution named by four (4X).

RO

X RAY INSPECTION OF CHEST

X63290

SECTION 1

A radiograph of the chest of

Film No.

Rank CPL Name KALICHUK, A

Reg. No. 15113 Unit RCAF STN CLINTON, ONT.

Civilian Address as per Registration Card

Age 31 Height Weight

Signature of Recruit

is reported as follows:—

- (a) Radiological examination does not disclose evidence of tuberculous disease of the lungs of such a nature as to indicate rejection for service in the Canadian Armed Forces except as stated below.
- (b) The transverse diameter of the heart is cms. as compared with a transverse diameter of the chest of cms.
- (c) Pathological conditions or congenital abnormalities of importance seen in the film are as under-noted. (In each instance an opinion should be expressed as to whether such was present prior to enlistment.)

Routine chest x-ray for release.

P.A. FILM OF CHEST.

Negative

Place Westminster Hospital

Radiologist

Date 23.12.54

Wm.L. Teskey, M.D.

If a pathological condition or congenital abnormality is not observed by this method of examination, record "negative" after (c).

SECTION 2

Remarks of the Internist, Surgeon or Specialist in Tuberculosis. (State whether in your opinion the lesion present antedated enlistment.)

SECTION 3

Opinion of Consultant Physician and Radiologist as may be indicated by Section 2.

Conclusion.

Place.....

Date.....

Sig.....Sig.....

PART V

PHYSICAL EXAMINATION—Before completing this section, the subject of the survey will be stripped and given a complete physical examination. All defects must be recorded and if indicated specialist's opinion obtained and attached hereto.

Height: Ft. 5 Ins. 6 Weight 141 lbs. Weight on enlistment.....lbs.

EXAMINATION	NEG	POSITIVE FINDINGS AND REMARKS
Vision: s Glasses R <u>20/20</u> L <u>20/20</u>	✓	
c Glasses R <u>/</u> L <u>/</u>		
c + 2.50 R <u>/</u> L <u>/</u>		
c + 1.50 R <u>1.3. LUR</u> L <u>1.3. LUR</u>	✓	
Colour Vision: Plates <u>CUN</u>	✓	
Lantern.....		
Hearing: WV-R <u>20</u> L <u>20</u>	✓	
CV-R..... L.....		
Ears: Tymp. Mem. R <u>N</u> L <u>N</u>	✓	
Nose.....	✓	<i>Slight deviation of lower 2/3 of nose to the right.</i>
Mouth and Teeth.....	✓	
Throat.....	✓	
Head and Neck.....	✓	
Spine.....	✓	
Extremities Upper.....	✓	
Lower.....	✓	
Hernia..... <u>NONE</u>	✓	
Genitalia.....	✓	
Anus and Haemorrhoids.....	✓	
Varicosities..... <u>NONE</u>	✓	
Abdomen.....	✓	
Joints.....	✓	
Chest: Min. <u>33</u> Max. <u>35 1/2</u>	✓	
Lungs.....	✓	
Heart.....	✓	
Blood Pressure: S <u>138</u> D <u>84</u>	✓	
Pulse Rate..... <u>76</u>	✓	
Lymphatic Glands.....	✓	
Ductless Glands.....	✓	
Skin.....	✓	
Tremors..... <u>NONE</u>	✓	
Pupils: L and A.....	✓	
Reflexes.....	✓	
CNS Including Emotional Status.....	✓	

Chest X-ray No..... Report Chest X-Ray Westminster London

Serological Test No..... Type ant Prox Rab Report.....

Urinalysis: Sugar NEG Albumin NEG Microscopic.....

Other Laboratory or X-ray Reports (specify).....

Canadian Pension Commission,
Daly Building,
Ottawa, Canada.

Summary of Positive Findings:

N/A.

The subject of this Board has been struck off strength the

RCAF eff. *23 Jan 55*

Auth: QH (Air) Art 15.01 Item *4/9*

Honourably Released

Checked by *J. C. M.* Release Sec RCAF (RO)

Grade or Category

A4B

Considered by Examining MO

21 Dec 54

(Date)

H. H. Haily Jr

(Signature of MO Bringing Board Forward)

PART VI—RECOMMENDATION OF MEDICAL BOARD (Treatment required and disposal)

If treatment required specify nature and probable duration.

Fit for Hon medical release.

PART VII NAVY	ARMY								R.C.A.F.						
	Profile on Enlistment								Profile on Enlistment						
Category on Enlistment	YOB	P	U	L	H	E	M	S	Vision	Colour Vision	Hearing	Hands	Arms	Legs	Other Factors Present
Category Recommended by Medical Board	Present Profile								Recommended by Medical Board						
	Recommended by Medical Board								Recommended by Medical Board						
	Recommended by Medical Board								Recommended by Medical Board						

Place *RCAF S/W CHINTON*

H. H. Haily Jr President

Date *21 DEC 54*

PART VIII
Certified True Copy. Date..... Signature.....

PART IX
Approved By: Confirmed By: *H. H. Haily Jr*
Date..... Date: *27 Dec 54*

PART X
RE-EXAMINED AND CATEGORY (OR PROFILE) CONFIRMED:
REMARKS:
Date..... Signature.....

PART XI
Date of Release..... Signature.....
(To be filled in by unit/ship effecting release)

4

DEPARTMENT OF VETERANS AFFAIRS

TREATMENT SERVICES

CASE
HISTORY
SUMMARY

SURNAME (USE CAPITAL LETTERS) K A L I C H U K				SERVICE NUMBER 15113
GIVEN NAMES IN FULL ALEXANDER				RANK LAC
CIVILIAN ADDRESS SIFTON, Manitoba				ADMISSION DATE 4-2-51
IF NOW SERVING—ADDRESS OF UNIT R.C.A.F. Bn., CLINTON, Ont.				ADMISSION NUMBER 3827/50
AGE 27	DATE OF BIRTH 3-11-23	RELIGION R.C.	NATIONALITY Polish	PREVIOUS ADMISSION Nil
INSTITUTION Westminster Hospital, "Lo" District				WARD OR WING ATP-2

DIAGNOSES ON ADMISSION

Fractured Nose

REFERRED BY

CONDITION ON ADMISSION

ELECTIVE SERIOUS EMERGENCY

SUMMARY (COMPLAINTS, PHYSICAL AND LABORATORY EXAMINATION FINDINGS, TREATMENT AND END RESULT)

This man was admitted to Hospital 4 February, 1951, following blow on his nose. X-rays revealed fracture, but ear, nose and throat consultant did not recommend any treatment. There is still slight periorbital hematoma, but airways are clear and Patient is ready for discharge.

FINAL DIAGNOSES

1. Fractured nasal bone

NOMENCLATURE CODE

2160-410

OPERATIONS

A
N
E

S
T
H

E
T
I

C

DISPOSAL DATE

8-2-51

CONDITION AT DISPOSAL

RECOVER-
ED IMPROV-
ED NOT
IMPROVED DIED DIAGNO-
SES ONLY

DISPOSAL

HOME UNIT OUT-
PATIENT

TRANSFERRED TO

RECOMMENDATIONS FOR FURTHER TREATMENT, CONVALESCENCE, LIMITATIONS AS TO WORK, ETC.

He can return to Duty.

DATE LIKELY FIT FOR WORK

SIGNATURE OF PHYSICIAN

(Sgd.) L.P. Salden, M.D. 001065

LPM:C

DEPARTMENT OF VETERANS AFFAIRS

TREATMENT SERVICES

CASE HISTORY SHEET

PATIENT'S NAME (USE BLOCK LETTERS) KARLOVUK			SERVICE NUMBER 32110
GIVEN NAMES IN FULL Alexander			RANK LAC
CIVILIAN ADDRESS Clinton, Manitoba			ADMISSION DATE 4 FEB 51
IF NOW SERVING—ADDRESS OF UNIT RCMP Det., Clinton			ADMISSION NUMBER 5017/50
AGE 28	DATE OF BIRTH 5.11.23	RELIGION R.C.	NATIONALITY Polish
INSTITUTION Westminster Hospital, "10"			PREVIOUS ADMISSION nil
			WARD OR WING ATF 2

PENSIONABLE DISABILITY

nil

DIAGNOSIS ON ADMISSION

Fractured nose

ADMISSION NOTE

Referred in by Dr Addison, Clinton when Station H.O. not available.

CLASS

101

Occupation..... **Supply Technician**
Employer..... **RCMP Det**

Please X-RAY Chest

Please refer to HISTORY

DEPARTMENTAL DISTRICT MEDICAL OFFICER

ADMITTING MEDICAL OFFICER

DATE

CLINICAL NOTES WITH DOCTORS' SIGNATURES

5-2-51

CASE SHEET (EAR, NOSE AND THROAT):

This Patient was kicked in the nose Sunday morning.
On Examination: There is some deviation of the nose to the left. X-Rays show some depression of the right nasal bone. Using some 4% Cocaine in right side of nose, Patient commenced to faint. Whether this is just vasomotor instability or Cocaine reaction it is difficult to say. However, I feel any local measures to adjust this fracture will not be possible in this Patient.

Please have Dr. Babb look at his nose tomorrow afternoon, and if he thinks it requires reduction, this can be arranged then.

(Sgd.) W.H. Burnett, M.D.
Otolaryngologist

6-2-51

CASE SHEET (EAR, NOSE AND THROAT):

There is very little deformity of this man's nose today, externally. He has good nasal airways on each side.

When the swelling has entirely reduced on the left side, I do not think there will be any marked deformity of his nose, and for that reason I do not think Operative interference is indicated.

(Sgd.) W.H. Burnett, M.D.
Otolaryngologist

7-2-51

This man was admitted to Hospital 4 February, 1951, following blow on his nose. X-rays revealed fracture, but Ear, Nose and Throat Consultant did not recommend any treatment. There is still slight periorbital hematoma, but airways are clear and Patient is ready for discharge. He can return to Duty.

Final Diagnosis: 1. Fractured nasal bone 2160-416
L.P.C. L.P. Walden, M.D.

KALICHUK ALEXANDER
15113 *Sgt* RC

9657
3 NOV 23

RCAF STN AYLMER ONT
MRS H KALICHUK WIFE
RR 4 WALTON ONTARIO

21JUL59
834-R-24

SEC 18



CANADA

WESTMINSTER HOS.
LONDON, ONT.

D% (N.P.)
21 JULY 59

HEADQUARTERS USE ONLY																																		
	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46							
DATE OF DISCHARGE <i>31-7-59</i>	DAYS IN HOSPITAL						DAYS SICK LEAVE						DISPOSAL														47							
														DUTY <input type="checkbox"/>				EXCUSED DUTY <input type="checkbox"/>				OUT PATIENT <input type="checkbox"/>				TRANSFER <input type="checkbox"/>				HOME <input checked="" type="checkbox"/>				48
TRANSFERRED TO														CONDITION ON DISPOSAL														49						
														RECOVERED <input type="checkbox"/>				IMPROVED <input checked="" type="checkbox"/>				NOT IMPROVED <input type="checkbox"/>				DEAD <input type="checkbox"/>				DIAGNOSIS ONLY <input type="checkbox"/>				50
IF ACCIDENT STATE CIRCUMSTANCES																												51						
DIAGNOSIS ON ADMISSION																												52						
FINAL DIAGNOSES (IN ORDER OF IMPORTANCE)																												53						
1. <i>Psychoneurosis Anxiety Reaction</i>																								310		MORBIDITY CODE <i>000.X01</i>		54						
2.																												55						
3.																												56						
OPERATIONS																								DATE	A	N	A	57						
1.																												58						
2.																												59						
3.																												60						
SUMMARY (COMPLAINTS, PHYSICAL AND LABORATORY EXAMINATION FINDINGS, TREATMENT, ETC.)																												61						
<p><i>This 35 year old man was admitted to US/B 22-7-59. On admission he was tense and nervous, and anxiety and depression were obvious. He settled down well in hospital and had a short course of Tofranil plus psychotherapy in the course of which some of his problems were ironed out. He is now asymptomatic, is cheerful and friendly and keen to leave hospital and return to duty.</i></p> <p><i>He will be S.O.S. as of this afternoon.</i></p>																												62						
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RECOMMENDATIONS (FURTHER TREATMENT, CONVALESCENCE, LIMITATIONS AS TO WORK, ETC.)																												77						
<i>See above.</i>																												78						
																												79						
DVA-TS 100 (REV. 9-51)														DATE LIKELY FIT FOR WORK										SIGNATURE OF MEDICAL OFFICER I/C CASE <i>[Signature]</i> for H.B. Garscadden, M.D.				80						
IBM-1 (BRADMA)																												81						

Pensionable Disability

None

Handwritten notes

Admission Notes

Admission recommended by Dr. Hobbs

~~Please X-Ray Chest~~/Chest X-Ray Completed - Refer to Dental

Occupation Airman

Employer's Name & Address

Family Doctor

Name

Address

Provisional Diagnosis

IP HD

Section

Signature of Admitting Officer

DATE

CLINICAL NOTES WITH SIGNATURES

21-7-59

NEUROPSYCHIATRIC CLINIC

This man's problem and history well outlined on attached report from W/C Beach. Admit to D3/4 for further investigation.

/ss

G.N.Hobbs, M.D.

/ek

20-7-59

HAEMATOLOGY: Hgb 17.1 gms%, Hct 50, WBC 14,800, Hct 8, Neut. 83%, Lymphs 10%, Monoc. 7%, RBC's normal. Plat. adeq.

20-7-59

BIOCHEMISTRY: AG 92 mgs%, PG 81 mgs%, Urea 15 mgs%.

20-7-59

URINALYSIS: Amber, acid, 1.025, alb. neg., glu.neg., wbc rare, few epi cells.

22-7-59

ADMISSION NOTE

This man was today admitted to D3/4. On admission he appeared nervous, depressed and anxious. He did not talk freely and was not inclined to discuss the reasons for his being sent to hospital. However, under pressure, he did give some account of himself.

On May 28th, our patient was charged by the Ontario Provincial Police, St. Thomas, detachment, with illegal possession of liquor and also with an offence under the juvenile act; that of contributing to delinquency of a child under 16 years. The child in this case was a ten year year old girl. He told a resulting story about being friendly with an elderly couple, man and woman, who have a bird sanctuary in the St. Thomas district. He stated that himself and the old man had become quite friendly and had decided to give some children in the neighbourhood a party and have some games, etc.

In order that they should have prizes to give to the children, he purchased five pairs of girls panties and several boxes of candy. However, the plans for the party fell through and on the day in question he had several shots of liquor in the Sergeants' Mess at Aylmer, R.C.A.F. Station and several beers later in the afternoon. He stated he was driving aimlessly around the back roads of St. Thomas and became lost. He met a ten year old girl and stopped the car to ask her for directions back to the main road. When he had been talking to the girl for several minutes, her father came along and directed him back to St. Thomas. He had several more beers in St. Thomas, entered his car, and again commenced driving in an aimless fashion in the St. Thomas district. Purely by chance he stated, he found himself on the same road where he had met the ten year old girl earlier in the afternoon. A police car stopped him and interrogated him and searched his car. In the car was found a partly consumed bottle of spirits and the panties and candy already referred to.

O.P.P. officers took him to the farm house where the ten year old girl lived with her parents and upon her identification of him, charges already referred to were laid against him.

The following week he appeared in Magistrate's Court in St. Thomas and was found not guilty of the charge concerning the girl. He pleaded guilty to the liquor charge and was fined.

When questioned about the incident regarding the girl he was extremely vague and evasive. Indeed he professed very little recollection of the court proceedings and when asked if the child had testified that he had invited her

CASE HISTORY SHEET CONTINUATION

RECORD No. 9657

NAME KALIGUN ALEXANDER E.

SERVICE NUMBER 15113

ADMISSION NUMBER

INSTITUTION

WINDSOR HOSPITAL

PLACE WINDSOR ONTARIO

DATE	CLINICAL NOTES WITH SIGNATURES
	<p>into the car, he stated he could not remember. He, however, stated that the Magistrate, at the conclusion of the case, told him he was giving him the benefit of the doubt, but that if he ever saw him again the verdict might be entirely different.</p> <p>He stated his home is in Scarfath and he is home every weekend. His wife is a Polish refugee and was a widow when he married her. She has two children by her first marriage and one child of which he is the father. He states his home life is very happy and denies all problems - financial, sexual or otherwise. He said he could not remember if he had ever masturbated. Our patient was in the army from 1941-1946 and had a good record. He joined the Air Force in 1950 and in that year was convicted in Trenton of indecent behaviour. When questioned about this he developed nearly complete amnesia and under pressure gave a rather incoherent explanation. He admitted drinking to excess and said the only problem that he now has is that it would be very awkward for him if he is discharged from the service after fifteen years. He talked about W/C Beach and P/L Cotton, the latter being Medical Officer at Agnes H.C.A.F. Station, and he was quite paranoid in thinking. He denied ever being depressed or ever having thought life was not worth living and he referred continually to the fact that he has a good service record. He, further, went on to say that his commanding Officer had a letter from G.H. regarding the advisability of his being retained in the H.C.A.F. He stated he had been sleeping well and his appetite was good.</p>
	<p><u>SUMMARY</u></p> <p>Despite this man's protestations, there is little doubt that he is nervous, very depressed and anxious, and I would say that he has guilt feelings.</p>
	<p><u>RECOMMENDATION:</u></p> <p>Consultation with Dr. G.H. Hobbs, and Dr. F.V. Metcalfe, regarding this man.</p> <p>/sk Frank McCrystal, M.D.</p>
22-7-59	<p><u>X-RAY REPORT: P.A. CHEST</u></p> <p>No active lung disease. Pleural spaces are clear. Heart chest ratio is 12.2 to 21.8 cms.</p> <p>/sk in Wm.L. Veskey, M.D.</p>
24-7-59	<p><u>FAMILY HISTORY</u></p> <p>Father died at age 68 from carcinoma of the stomach. Was of Polish racial origin. Mother is now 65 and in good health. She is also of Polish racial origin. Parents are said to have been happy and were a well adjusted couple. Patient has two brothers alive and well and is third in a sibline of three. Mental illness in the family is denied.</p> <p><u>PERSONAL HISTORY</u></p> <p>Patient was born 3rd November, 1923, in Dauphin, Manitoba. Birth was stated to be normal and he stated economic conditions apparently were good. He was reared in favourable surroundings. He commenced school at age six and left school at age 16 when he had completed grade ten.</p> <p><u>OCUPATIONAL HISTORY</u></p> <p>He worked on a farm for six months and joined the army in 1941. He was discharged from the army in 1946 and farmed in Manitoba until 1950 when he joined the Air Force as Leading Aircraftman. His service history is good and he has never had a charge against him.</p> <p><u>LEGAL HISTORY</u></p> <p>This man had a conviction of indecent behaviour in Trenton, 1950. He was convicted of having liquor in a prohibited place in St. Thomas, 1959.</p>

CASE HISTORY SHEET CONTINUATION

DATE	CLINICAL NOTES WITH SIGNATURES
	<p>He was also found not guilty of contributing to the delinquency of a juvenile under the age of 16 years in St. Thomas, 1959.</p> <p><u>MEDICAL HISTORY</u> Usual childhood diseases, appendectomy in 1937, gonorrhoea in 1941. Patient's health has always been quite good.</p> <p><u>ALCOHOL</u> This man admits to drinking a fair amount and occasionally drinks to excess under tension.</p> <p><u>SEX HISTORY</u> Had some formal sex instruction from his parents. He married a widow in 1957 and she has two children by her first marriage. She was 34 when she married him and is Polish born. Sexual adjustment is claimed to be good. There is no history of previous mental illness.</p> <p><u>DEPRESSIVE ILLNESS</u> This man was depressed and anxious following his being charged on May 25th with contributing to the delinquency of a juvenile. However, the case against him was dismissed in Magistrate's court and he subsequently went on leave to Western Canada. He states he felt quite alright at that time. He, upon his return from leave, was informed by Flying Officer Malotte at Aymer air station, that a letter had been received from Headquarters questioning the advisability of his being retained in the R.C.A.F. as his contract comes up for renewal this year. This letter disturbed him very much and when subsequently ordered to report to this hospital, he became quite upset. When seen following admission he was nervous, depressed and anxious. He was quite defensive as he obviously feared that any admission would damage his chances of staying in the Air Force. There also appeared to be a fair bit of problem drinking in the background.</p> <p>/sk Frank McCrystal, M.D.</p>
27-7-59	<p><u>PROGRESS NOTE:</u> This man has settled down reasonably well. I interviewed him last Friday and told him that it was my intention to give him medication for his nerves as I felt he was depressed. He was started on Mefranil one tablet q.i.d.</p> <p>/sk Frank McCrystal, M.D.</p>
27-7-59	<p><u>PHYSICAL EXAMINATION</u> <u>General Appearance:</u> well, nourished and well developed. Going bald. <u>Scars, marks, stig:</u> Appendectomy scar. <u>Hair:</u> Fair, balding. <u>HEAD AND NECK</u> <u>Eyes:</u> Fundi normal, ocular movements normal, pupils: round, equal, react to light and accommodation. <u>Ears:</u> tympanic membranes not visualized, <u>Nose:</u> clear, <u>Teeth and Gums:</u> good repair, <u>Tongue:</u> clean, <u>Throat:</u> not injected, <u>Tonsils:</u> Tonsillectomy 1946, <u>Thyroid Gland:</u> not palpable. <u>HEENT:</u> <u>Respirations:</u> good and equal. No adventitious sounds. <u>HEART:</u> No enlargement. No murmur. Heart regular. Pulse 126-regular, volume and tension good, Arteries: not palpable. Varicosities: none, B.P. 120/80. <u>C.N.S.:</u> <u>Cranial Nerves:</u> intact, <u>Speech:</u> normal, <u>Co-ordination:</u> normal, <u>Rombergism:</u> none, <u>Gait:</u> normal, <u>Gloss:</u> none, <u>Tremor:</u> none, <u>Rendon Reflex:</u> physiological, <u>Brisk Cutaneous Reflexes:</u> Physiological. <u>Sensation:</u> Normal. <u>ABDOMEN AND PERINEAL GENITALIA:</u> Appendectomy scar. Normal genitalia. No hernia <u>NEURO-PSYCHIC SKIN:</u> Normal. <u>HAIR & NAILS:</u> Normal.</p> <p>/sk Frank McCrystal, M.D.</p>

s.19(1)

COMMANDING OFFICER
R. C. A. F. STATION
CLINTON - ONTARIO

OFFICER OR AIRMAN - REPORT ON ACCIDENTAL OR
SELF-INFLICTED INJURIES OR IMMEDIATE DEATH THEREFROM

N.B. - To be rendered in accordance with the instructions on pages 3 and 4.

1. NAME..... KALICHUK Alexander
(surname) (christian names in full)
RANK... LAC NUMBER... 15113 UNIT... RCAF AGE... 26 TRADE... Sup. Tech
DATE OF ACCIDENT AND TIME OF DAY... 4 Feb 51 0700 Hrs PLACE OF ACCIDENT... RCAF Stn. Clinton, Ont.
(exact locality)

2. Short statement by injured person of the circumstances (or manner) of injury (see instruction 6). Signed statements of witnesses, or of persons to whom the injured person may have mentioned his injury, to be attached (see instructions 7 and 9). Fractured Nose
Walking down the road, and got beat up by Airmen on the Station results
Fractured Nose.

A Kalichuk

N.B. - See Instruction 4 before completing the following section.

- 3. (a) Type and R.C.A.F. No. of aircraft.....
- (b) Name of pilot of aircraft (at time of crash).....
- (c) Number in aircraft, including pilot.....
- (d) Circumstances of accident: taxiing.....taking off.....landing.....forced landing.....
(designate one)
collision in air.....collision on ground.....other (specify).....
- (e) weather.....
- (f) In case of non-fatal crash does individual recall all events immediately preceding and following crash? If answer is "no", comment.....
- (g) Number of flying hours of person reported on: dual.....solo.....
- (h) Duty: instructor/pilot/pupil pilot/aircrew (specify).....passenger/other (specify).....
(strike out those not applicable)

- 4. (a) Description of injuries (in detail): Fracture of Nasal Bones.....
- (b) Are the injuries of such a nature that they might be the exciting cause of disability later? No.....
- (c) How long before initial treatment was given? Within 20 Minutes.....
- (d) Whether admitted to hospital or sick in quarters. Admitted DVA London, Ont......
(give name of hospital)

DATE..... 8 Feb 51 Signature of Medical officer..... (N Wade) S/L

5. Commanding officer's statement:-

(a) was the injury sustained

(i) In the performance of air force duty?..... No
(See instruction 9)

(ii) In a game or other form of physical recreation approved by proper Air Force authority?.....

..... No

(iii) on leave or pass? (State whether with or without pay)..... Pass with pay

NOTE:- If the answers to (a) (i), (ii) and (iii) are all in the negative, the commanding officer is to attach a concise statement of the circumstances surrounding the accident or injury.

N.B. - See instruction 8 before completing the following section.

(b) If the answer to (a)(ii) is in the affirmative; state

(i) By whom was the game, etc., supervised and under whose authority?.....

(ii) The nature of the game, etc. (e.g., hockey, baseball, etc.).....

(iii) was the officer or airman detailed to take part in it (a) as a member of an air force team,

or (b) to compete as an individual?.....

NOTE:- Questions (iv) to (vi) to be answered in addition only if the injury was sustained at practice.

(iv) For what service event was the practice held?.....

(v) Was the officer or airman a selected representative of an air force unit practising under

authority?.....

(vi) If so, under what authority and supervision?.....

(c) If sustained in a game, etc., but not in an organized game, state if there are any special circumstances which should be taken into account if and when the question of attributability comes to be

decided by the Canadian Pension Commission.....

N.B. - See instruction 12 before completing the following section.

(d) Was the injury due to his own fault, i.e., did it arise from negligence, wilful disobedience of

orders, misconduct, or any blameworthy cause within his own control?..... No

If so, state in what way.....

(e) Was anyone else to blame? If so, give name and particulars..... YES - 16255 LAC Willeneuve JLH

(f) Is the accident being investigated by
(i) Court of inquiry? If so, state date and place..... No

(ii) An investigating officer?..... YES - Provost Investigation

SIGNATURE..... (RAB. Ellis) F/L

DATE..... 26 Feb 51 for COMMANDING OFFICER RCAF Stn. Clinton Ont..... 001073

I N S T R U C T I O N S

1. This form is to be rendered as soon as possible after the event in the following cases depending on the personnel involved.

- (a) For all RCAF personnel and personnel of other Services attached to the RCAF

In all cases of accident or self-inflicted injuries involving:

- (i) death;
- (ii) absence from duty of 48 hours or more;
- (iii) absence from duty of less than 48 hours, when the medical officer (who should invariably be consulted) advises that the injury may be the exciting cause of disability later; and
- (iv) in all flying accidents which result in the flying category of an individual being changed, or in which any injury is suffered by personnel who are occupants of an aircraft, or who have jumped or fallen from a moving aircraft or who are struck by a moving aircraft or propeller.

The requirements of para 1(a)(iv) do not apply to personnel of other Services attached to the RCAF.

2. A separate form is to be used in respect of each individual affected.

3. The form is to be rendered notwithstanding the holding of a court of inquiry or investigation (see instruction 9).

- (a) Two copies of this form are to be forwarded in all cases direct to Air Force Headquarters, one copy is to be retained by the unit rendering the form, and one copy placed in the medical envelope, RCAF M 10 of the person concerned.
- (b) One copy of the form is to be forwarded to Command Headquarters for their information (but see instruction 9).
- (c) The two copies received at Air Force Headquarters are to be passed to Records officer who will forward one copy to the Canadian Pension Commission and place one copy on the document file of the person concerned.

4. Section 3 is only to be answered in cases of flying accidents described in instruction 1(a)(iv) above.

5. The statement made by the injured person in section 2 of this form should not be used as evidence against him in any subsequent disciplinary proceedings. The rendering of this form should not be delayed in the event of his being unable to make a statement, but the latter should be forwarded at the earliest opportunity.

6. No statements of witnesses are required in support of form R.78A when an accident forms the subject of a court of inquiry or an investigation under K.R. (Air) 718 or 723. Where no such inquiry is held, form R.78A must be accompanied by full statements taken by an officer or warrant officer from witnesses of the accident and signed both by the witnesses and the officer or warrant officer. When there are no witnesses, statements from any persons to whom the injured person may have mentioned his injury immediately after the occurrence should, when obtainable, be attached to the form. In the case of injury in supervised games, or other form of physical recreation, etc., when the witnesses of the accident are in agreement, the evidence of one witness only need be attached to the form, his statement being endorsed by the other witnesses in corroboration. When separate forms are rendered in accordance with instruction 2 above, a copy of the statements of witnesses is to be attached to each form.

7. In the case of an injury sustained in a supervised game, or other form of physical recreation, etc., it is most important in the interests of the injured officer or airman that the questions contained in section 5 (b) of the form should be answered carefully and in full detail, since if and when the question of attributability of the injury to conditions of service comes to be decided under the provisions of the pension Act, that decision may be based on the information given in answer to these questions.

8. When an affirmative answer is given to section 5 (a) (i) the statement required by section 2 should specify the particular act of air force duty on which the officer or airman was engaged at the time the injury was received.

9. Courts of inquiry are to be held or investigations made when required under K.R. (Air) 718 and 723 regardless of the rendering of this form, but a copy of this form should be included in the proceedings of the court of inquiry or investigation for information. The proceedings will be disposed of as laid down in regulations in force at the time of reporting.

10. In addition to being reported on this form all casualties are to be reported in accordance with the procedure laid down in A.F.A.O. P4/1.

11. Section 5(d) and (e) should be answered in all cases where no further investigation is being ordered, but in cases where further investigation is to be carried out, either by court of inquiry or investigating officer, in order to establish blame, a notation to that effect should be recorded as the answer to this question.

MEDICAL EXAMINATION ON ENTRANCE

15113

Recruiting Centre Brandon Manitoba Date 23 Jan 50

Name KALICHUK Christian Names Alexander Edward

Permanent Address Sifton, Manitoba.

Birthplace Sifton, Man. Date of Birth 3 Nov 1923

Previous Service C.A.F. 4 yrs 8 mos. Previous Occupation Farming

Marital Status Single Athletics Poor

Classification Test Flying Hours: Solo 0 Dual 0 Passenger 1

Previous History

Are you suffering from, or under treatment for, any disease or disability now? no. Have you ever suffered from any of the following? (State "Yes" or "No".)

Table with 4 columns: Condition, Answer, Condition, Answer. Rows include: Nervous trouble, or breakdown; Head injury, or concussion; Convulsions or fits; Bed wetting (after age 12); Frequent headaches; Sinus trouble; Frequent colds or sore throat; Ear trouble or deafness; Eye trouble; Lung trouble or cough; Chronic bronchitis; Tuberculosis or pleurisy; Asthma or hay fever; Heart trouble, shortness of breath; Rheumatism or rheumatic fever; Dizzy or fainting spells; Chronic indigestion, pain after food; Bowel trouble or appendicitis; Gall bladder trouble or jaundice; Hernia or rupture; Kidney or bladder trouble; Kidney stone or blood in urine; Venereal disease or stricture; Skin conditions; Foot trouble; Motion sickness.

Have you had any operations? yes. Days sick per year? 0-

Have you suffered from any illnesses or injuries not mentioned above? no.

Have you been medically rejected or discharged from the Navy, Army, or Air Force? no.

Have you been rejected, deferred, or rated up for life insurance? no.

Are you receiving a pension or compensation for any medical disability? no.

Has any member of your family suffered from any of the following conditions?

Tuberculosis no. Diabetes no. Nervous or mental trouble no. Fits no.

Positive Findings in History

- 1 Appendectomy 1936 Dauphin, Dr. Harrington
2 1941-44 - Ft. Osborne Barracks - OK since

Table with columns: POTENTIAL AIRCREW, Other factors, etc. and rows for various medical categories.

I HEREBY DECLARE that I have carefully considered the statements made above, that to the best of my belief they are complete and correct, and that I have not withheld any relevant information or made any misleading statement.

Date 23 Jan 50 Signature Alex E. Kalichuk Witness A. Thuyus MD

PHYSICAL FINDINGS

Identification marks:

Small scar over R. clavicle
McBurney scar

Complexion *light* Hair colour *Brown* Eye colour *Blue gray*
 Age *26* Height *66* ins. Weight *141* lbs.
 Build *Muscular* Pulse *74* Blood pressure: S. *130* D. *82*
 Physique *Muscular* Chest *33-35.5* ins.
 Mouth *N* Kidneys *N* Varicosities *N*
 Teeth and gums *N* Hernia *N* Haemorrhoids *N*
 Thyroid gland *N* Genitalia *N* Tremors *N*
 Lungs *N* Glandular system *N* Pupils L. & A. *N*
 Heart *N* Joints *N* Reflexes *N*
 Abdomen *N* Extremities *N* Cranial nerves *N*
 Liver and spleen *N* Feet *N* Skin *N*

Deformities

nil

Urinalysis: Sugar *N* Albumin *N* Microscopic *N*

Eyes:
 V.A. \bar{s} R. *20/20* $\bar{c} + 2.50 = 20/$ *Blur* V.A. \bar{c} R. *20/* Colour { Plates *CUN.*
 Glasses L. *20/20* $\bar{c} + 2.50 = 20/$ *Blur* Glasses L. *20/* Vision { Lantern
 Fundi *N*

E.N.T.: *W-701*
 Hearing: R. *N* L. *N* Tympanum: R *N* L. *N* Nose (airways) *N* Tonsils *cut*

Positive Findings on Examination

Special Chest x-ray Report *MG* Date *23 Jan* M.O. *H.S. Chape*
Tests: Serological test *taken* Report *MG* Date *26 Jan* M.O. *P.F. Myers*

ASSESSMENT

Vision	Colour Vision	Hearing	Hands	Arms	Legs	Other factors present	POTENTIAL AIRCREW
/	/	/	/	/	/	0	CATEGORY
Selected for training as: AIRCREW							<i>A4B</i>
GROUNDCREW <i>/</i>							
Exempt from drill and P.T.: Yes <i>/</i> No <i>/</i>							

APPROVED
 CAT. *A4B*
 DATE *8 Feb 50*
J. Jackson

Cause(s) of rejection (if any):

nil

Date *23.1.50* President *R. Phyers MD*
 Place *Brandon Man* Member

MEDICAL RECHECK

M.O.

Certified that I have suffered no illness or disability since my last examination.

Date Signature of Applicant

X RAY INSPECTION OF CHEST

SECTION 1

A radiograph of the chest of

Film No.....

Rank..... Name **KALICHUK AE**

Reg. No..... Unit **RCAF RECRUITING UNIT BRANDON MAN**

Civilian Address as per Registration Card

SIFTON MANITOBA Age **26** Height..... Weight.....

Signature of Recruit *Alex E. Kalichuk*

is reported as follows:—

- (a) Radiological examination does not disclose evidence of tuberculous disease of the lungs of such a nature as to indicate rejection for service in the Canadian Armed Forces except as stated below.
- (b) The transverse diameter of the heart is 11.5 cms. as compared with a transverse diameter of the chest of 30 cms.
- (c) Pathological conditions or congenital abnormalities of importance seen in the film are as under-noted. (In each instance an opinion should be expressed as to whether such was present prior to enlistment.)

Negative

Place *Brandon*

J. S. Sharp
Radiologist

Date *Jan 23rd 1950*

If a pathological condition or congenital abnormality is not observed by this method of examination, record "negative" after (c).

SECTION 2

Remarks of the Internist, Surgeon or Specialist in Tuberculosis. (State whether in your opinion the lesion present antedated enlistment.)

SECTION 3

Opinion of Consultant Physician and Radiologist as may be indicated by Section 2.

Conclusion.

Place.....

Date.....

Sig..... Sig.....