Veteran Name: James Roy
SSN: 400-41-8035
Ph: (860)634-6313

Date: 1/8/2026

From: Veteran James Earl Roy (SSN: 400-41-8035)

To: Veteran Affairs Claims Intake Center

Subj: Supporting Documentation / Statement For VA Form 21-526EZ Claims

To VA Intake Center,

I James Earl Ray (R8035), am filing the following statement in connection with my claims for Military Service-Connected benefits per VA Title 38 U.S.C. 1151. I am also submitting additional evidence that supports my claim(s) to be valid, true and associated with of my Active Military Service (United States Navy), as Primary and/or Secondary injuries/illness as a direct result of my Military service and hazardous conditions/exposures. Based on the totality of the circumstances, and additional evidence supporting my Injuries and concurrent conditions.

These conditions should have already been accepted and "presumptively" approved by the VA Executive Administration once discharged from Active Duty. Thus, the VA failed to "service connect" my injuries upon discharge of my Military service which is no fault of mine (the Veteran). I am requesting your office review and approve the following Twelve (12) medical conditions:

VA "Erroneous Denial" of Presumptive Conditions:

The VA had a lawful duty to obtain documents from the Military Medical Command, which would have validated my current and ongoing medical conditions. My medical conditions/injuries commenced while on active-duty status and my subsequent discharge. However, the VA denied and/or failed to accept my claims, due to the VA not having proof and/or documentation that was beyond my (Veteran) control.

All of my current claims and/or conditions have a direct nexus to my active-duty service which were caused by the multiple exposures, increased Military duty and performing such duties under duress while not medically fit due to my ongoing hip, knee and back injuries. My injuries were exacerbated while in service and further exacerbated as my injuries and body ages. The VA failed to acknowledge my conditions and affirm that my conditions are and/or were valid at the time of my discharge from active duty.

VA Corrective policy action provision to "Erroneous Denied" VA Decision:

Per VA Title 38 U.S.C 1120 and the P.A.C.T ACT states the following:

Error in a previous decision

If we find a clear and unmistakable error in a prior decision, the effective date of the new decision will be the date from which benefits would've been paid if there hadn't been an error in the prior decision.

Difference of opinion

A decision that's based on a difference of opinion will have an effective date of the original decision, had it been favorable.

Based on the totality of circumstances, and additional evidence supporting my Presumptive Injuries, my conditions have been "presumptively" approved by the VA Executive Administration via the Appeals Modernization ACT (AMA). The VA has a duty to re-evaluate my claims from my Military records and correct any errors and/or mishaps due to negligent governmental processing.

Legal Argument and Defense for Previous Denied Claims (Rating Errors)

Based on the military medical records, the following claims should be identified as having been previously denied, rated too low, or improperly adjudicated due to legal or factual error by the VA.

A. Right Knee Disability (Including Meniscal Injury, Arthroscopic Debridement Residuals, and Secondary Arthritis)

The VA Error: The VA likely erred by failing to adequately consider all elements of disability evaluation required by 38 C.F.R., specifically by not applying the functional loss criteria correctly, including the presence of pain, and by not identifying the established chronic condition.
Legal Argument and Defense (Citing 38 C.F.R. and Case Law):

1. Failure to Apply the Full Functional Loss Criteria:

The VA is legally required to rate the knee based on its limitation of motion and the functional loss caused by pain. Under 38 C.F.R. § 4.40 and § 4.45, the VA must consider the effects of pain, stiffness, and instability on the entire range of motion, not just terminal degrees.
Your service records document a history of Right knee intrasubstance injury to the medial meniscus, requiring Right knee arthroscopic medial meniscal synovial debridement (March 2012). Post-procedure notes explicitly state continued difficulty with running, pain, and the

recommendation to use crutches to limit weight bearing. This documented in-service residual of pain and functional impairment immediately following surgery, is itself a basis for a compensable rating. A rating of 10% or higher is warranted if there is painful motion, even if the range of motion is normal (38 C.F.R. § 4.59).

2. Failure to Rate for Documented Arthritis/Degenerative Joint Disease (DJD):

During the second arthroscopy, the surgeon documented "Minor kneecap cartilage wear (arthritis)" (September 2012). This in-service finding of chondromalacia/early arthritis establishes a chronic condition under the provisions of 38 C.F.R. § 3.303(b). The condition should be rated under the appropriate diagnostic code (e.g., Diagnostic Code 5260 for tibia and fibula, or 5003 for DJD) based on limitation of motion. The presence of DJD/arthritis, which is often progressive, warrants a higher current rating than a simple strain. The VA must consider the totality of evidence, including the chronic nature of the condition documented in service.

B. Bilateral Pes Planus (Flat Feet/Pronated Foot)

The VA Error: If the condition was previously rated as non-compensable (0%) or a low compensable rating (10%), the VA likely erred by failing to rate the condition according to the severity of all documented symptoms, particularly the objective evidence of marked deformity and the need for non-standard orthotics (if applicable).

Legal Argument and Defense (Citing 38 C.F.R.):

1.Rating Should Reflect Objective Severity (38 C.F.R. § 4.71a, DC 5276):
The service medical records explicitly list "Pronated foot" and "Flat foot" as chronic problems (August 2012). The rating for Acquired Flatfoot (Diagnostic Code 5276) is based on severity. The legal defense requires proving a level of severity beyond the typically mild/moderate non-compensable or 10% rating: 30% (Severe Bilateral): Requires objective evidence of marked deformity (pronation, abduction, etc.), pain on manipulation and use accentuated, and indication of swelling on use. 50% (Pronounced Bilateral): Requires marked pronation, extreme tenderness, marked inward displacement, and severe spasm of the Achilles tendon, not improved by orthopedic shoes or appliances.

The past denial or low rating may have failed to acknowledge the objective findings of Pronated foot and the corresponding pain and functional impact, requiring a new claim/appeal that presents current evidence of the highest schedular criteria.

Veteran Name: James Roy
SSN: 400-41-8035
Ph: (860)634-6313

Requesting "NEW" claims to be reviewed and Accepted as Per the "PACT ACT:

Requesting the following **"NEW PRIMARY or SECONDARY"** claims to be reviewed and Accepted:

1. VA needs to **"Accept," my New claim of "Sleep Apnea Syndrome,"** due to my service connected injury of Reactive Airway Disease, Chronic Gastroesophageal, and due to toxic exposures to the burn pit and numerous other combat related hazards, with a rating of 30% or greater Disability Rating, pursuant to 38 CFR § 4.88a (1)(2)(3) Diagnostic Code (DC) 6354 (EXHIBIT, #1, pg. #1-2 and #17).

2. VA needs to **"Accept," my New claim of "Chronic Fatigue Disorder and/or Sleep Disturbance,"** due to Chronic Gastroesophageal, Obstructed Sleep Apnea, due to chronic pain to my Back, Ankle, and Knee Injuries, a rating of 20% or greater Disability Rating, pursuant to 38 CFR § 4.88a (1)(2)(3) Diagnostic Code (DC) 6354 (EXHIBIT, #1, pg. #1-2 and #17).

3. VA needs **"Accept" my claim of "Patellofemoral chondritis, Left Knee, and Loss of Range of Motion,"** as Secondary or Primary condition to my knee injuries, and flat feet, due to daily military duty and mandatory physical fitness routine, with a rating Greater than 10%, as pursuant to 38 CFR § 4.71a, Diagnostic Code 5003, (see Supplemental EXHIBIT, #1, pg. #15-23).

4. VA needs to **"Accept" my claim of "Patellofemoral chondritis, Right Knee, and Loss of Range of Motion,"** as Secondary or Primary condition to my knee injuries, and flat feet, due to daily military duty and mandatory physical fitness routine, with a rating Greater than 10%, as pursuant to 38 CFR § 4.71a, Diagnostic Code 5003, (see Supplemental EXHIBIT, #1, pg. #15-23).

5. VA needs to **"Accept" my claim of "Left Foot Plantar Fasciitis with Metatarsalgia,"** as Secondary or Primary condition to my knee injuries, due to daily military duty and mandatory physical fitness routine, with a rating Greater than 20%, as pursuant to 38 CFR § 4.71a, Diagnostic Code 5269 and 5279, (see Supplemental EXHIBIT, #1, pg. #15-23).

6. VA needs to **"Accept" my claim of "Right Foot Plantar Fasciitis with Metatarsalgia,"** as Secondary or Primary condition to my knee injuries, due to daily military duty and mandatory physical fitness routine, with a rating Greater than 20%, as pursuant to 38 CFR § 4.71a, Diagnostic 5269 (see Supplemental EXHIBIT, #1, pg. #15-23).

7. VA needs to **"Accept" my claim of "Radiculopathy, Lumbar Region,"** as Primary and/or or Secondary condition to my flat feet and knee injuries, due to loss of balance and falling onto the ground and striking my rife on the ground and into my body, causing pain and a strain to my lumbar due to daily military duty, with a rating Greater than 20%, per 38 C.F.R. §§ 4.71a, 4.124a, Diagnostic Codes 5201,5237 and 8510 (see Supplemental EXHIBIT, #1, pg. #15-23).

8. VA needs to **"Accept" my claim of Neck Pain (Cervical Area),** due to Lumbar pain with muscle spasms, L-Hip, R-Hip, L-Knee, and R-Knee injuries, with **a 20- 30% Disability Rating, as pursuant to 38 CFR § 4.17a, section 5237**, with an (see Supplemental EXHIBIT, #1, pg. #15-23).

9. VA needs to **"Accept," my New claim of "High Cholesterol,"** due to my service connected injury knee, feet injuries, chronic asthma and/or exercise-induced asthma, which severely prevents me from having the ability to have a proper physical life, with a rating of 30% or greater Disability Rating, pursuant to 38 CFR § 4.97, Diagnostic Code (DC) 6522 (see Exhibit, 1, pg.#12-17).

10. VA needs **"Accept" my claim of "Lung Defect and/or Asthma"** as Secondary or Primary condition to my ankle and knee injuries, due to daily military duty and mandatory physical fitness routine, with a rating Greater than 10%, as pursuant to 38 CFR § 4.97, Diagnostic Code , (see Supplemental EXHIBIT, #1, pg. #19-21).

11. VA needs to **"Accept," my New claim of "Alcohol Dependence with Alcohol-Induced Anxiety Disorder,"** due to my lifelong, ongoing physical and mental pain from my injuries, which has been documented in my medical record, which I was using as pain reliever. I was exposed and introduced to alcohol on Active Duty, which was used as a supplemental mental and physical pain killer, a 50% or greater rating,

pursuant to 38 CFR § 4.130, Diagnostic Code (DC) 5003, and F10.280 (see EXHIBIT, #1, pg. #12-23).

Medical Proof of Mental Health Claims

As documented throughout my Military Medical Records, it has been validated that I suffered numerous injuries while in military service, which left me with a limited range of motion, lifetime pain, hearing, and extremity pains. My mental health was also negatively impacted and caused me to use alcohol supplied on base as a coping mechanism given it was common for young soldiers to drink on base. My Mental Health injuries and alcohol use are a direct result of my Military injuries as primary and secondary injuries.

As documented in EXHIBITS #1, there is sufficient evidence documented in my Medical Treatment Records, that I suffer from the above "NEW," submitted claims, which are and were a direct and/or secondary condition to my Active Military Service.

12. VA needs to **"Accept," my New claim of High Blood Pressure (Hypertension),** due to my service connected Asthma, Depressive Disorder, Sleep Apnea, and High Cholesterol with a rating of 20% or greater Disability Rating, pursuant to er VA Title 38 U.S.C. 1120 and the P.A.C.T ACT (EXHIBIT, #, pg. #12-23).

Conclusion / Rationale

The evidence provided has proven that it is at least as likely as not (more likely than not), that my reported and documented medical conditions are directly related to events and/or exposure due to Active Military service. The medical evidence from my service records shows I have knee, feet, and breathing injuries and subsequent lifetime pain, and injuries which are direct causation of my active-duty service. All medical issues were present and existed within the first year after being discharged from active duty to present. Moreover, the VA made an "Error," during my original rating process which should be rectified and correctly dated from my discharge from Active Military Duty. Please accept my formal written statement and evidence as proof of accepted VA claims.

Please accept my formal written statement and evidence as proof for accepted VA claims. If there is anything you need or would like to talk to me about, please get in touch with me at (860) 634-6313 or via personal email at: 90jroy@Gmail.Com

Veteran Name: James Roy
SSN: 400-41-8035
Ph: (860)634-6313

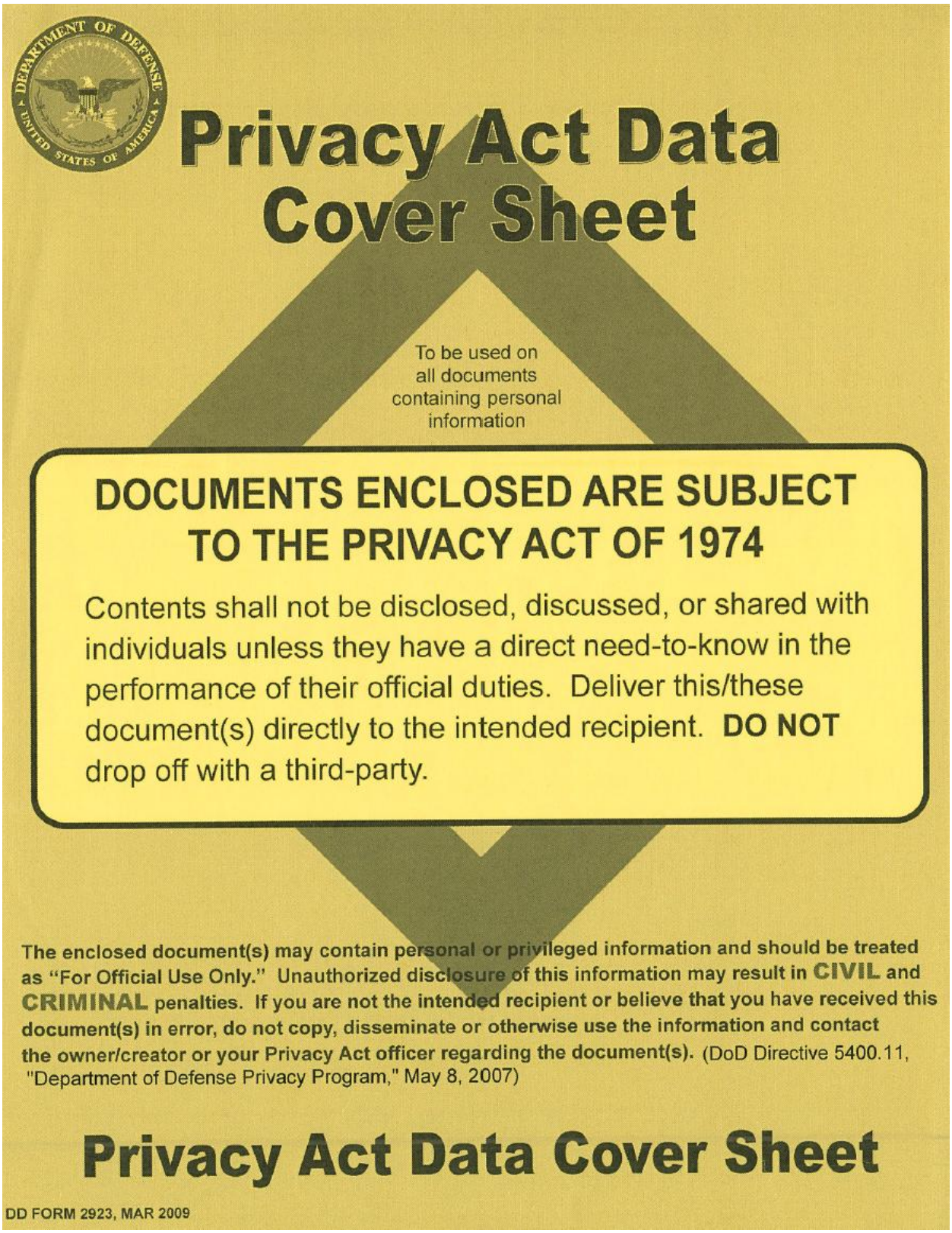
Respectfully submitted,

Veteran James Roy

Veteran Name: James Roy
SSN: 400-41-8035
Ph: (860)634-6313

Supportive Evidence/Exhibits For Claims

(Preponderance of the evidence is that degree of relevant evidence that a reasonable person, considering the record as a whole, would accept as sufficient to find that a contested fact is more likely to be true than untrue).


Privacy Act Data Cover Sheet
To be used on all documents containing personal information
DOCUMENTS ENCLOSED ARE SUBJECT TO THE PRIVACY ACT OF 1974
Contents shall not be disclosed, discussed, or shared with individuals unless they have a direct need-to-know in the performance of their official duties. Deliver this/these document(s) directly to the intended recipient. DO NOT drop off with a third-party.
The enclosed document(s) may contain personal or privileged information and should be treated as "For Official Use Only." Unauthorized disclosure of this information may result in CIVIL and CRIMINAL penalties. If you are not the intended recipient or believe that you have received this document(s) in error, do not copy, disseminate or otherwise use the information and contact the owner/creator or your Privacy Act officer regarding the document(s). (DoD Directive 5400.11, "Department of Defense Privacy Program," May 8, 2007)
Privacy Act Data Cover Sheet
DD FORM 2923, MAR 2009

Veteran Name: James Roy
SSN: 400-41-8035
Ph: (860)634-6313

Military Medical Records – Exhibits #1

Exhibit, 1,

LAWRENCE & MEMORIAL HOSPITAL

Pt Loc: SLEE

Job#: 000002333

2018035
Hunter
Sub Sch

Name: ROY, JAMES MR#: M0556039
DOB: 08/25/1990 Case #:
Date of Study: 11/23/2011 Sleep #:
Authorization #:
Account #: V011977745
EPN: HNE1103807253
Referred By:

POLYSOMNOGRAM SUMMARY REPORT

Referred By: Donna O'Brien, MSN

DIAGNOSTIC POLYSOMNOGRAM (PSG) REPORT

STUDY INDICATION: Unspecified Sleep Apnea.

CLINICAL HISTORY: 21 year-old African American male [Epworth Sleepiness Score = 18 (NL<10/24), BMI = 26.2] presented for a split-night PSG, however due to insufficient respiratory events during the initial 120 minutes of this study, a diagnostic PSG was performed. The patient had self-reports of: difficulties initiating and maintaining sleep, sleeping too little, restless sleep, snoring, witnessed nocturnal apneic episodes, awakening with headaches, sleep paralysis, nocturnal dysesthesias in the lower extremities, unrefreshing sleep, hypersomnia, and drowsy driving.

MEDICATIONS: Ibuprofen.

PAST MEDICAL HISTORY: Unremarkable.

FAMILY HISTORY: Uncontributory.

SOCIAL HISTORY: Does not use caffeine, nicotine, or alcohol.

TYPE OF STUDY: The PSG Study was performed with EEG derivations, EOG derivations, EMG (chin and anterior tibialis) derivations, ECG (single modified Lead II), snore microphone, nasal-oral airflow by thermistor, abdominal/thoracic impedance, pulse oximetry, body position sensor and closed circuit video monitor.

SLEEP SCORING DATA*: Lights out clock time: 10:07:53 PM. Lights on clock time: 5:39:53 AM. Total sleep time (TST): 406.5 minutes. Total recording time: 452.0 minutes. Sleep latency (SL): 26.0 minutes. Stage R latency: 83.0. Wake after sleep onset (WASO): 19.5 minutes. Percent sleep efficiency: 89.9%. Time in Stage (minutes) - W: 19.5, N1: 18.5, N2: 286.0, N3: 11.5, R: 90.5. Percent of TST in Stage -N1: 4.6, N2: 70.4, N3: 2.8, R: 22.3.

AROUSAL EVENTS: Number of arousals: 97. The arousal index: 17.3/hr.

RESPIRATORY EVENTS**: Number of - obstructive apneas: 0, mixed apneas: 0, central apneas: 3, hypopneas: 1, apneas + hypopneas: 4. Apnea index (AI): 0.4. Hypopnea index (HI): 0.1. Apnea + hypopnea index (AHI): 0.6. Oxygen

SCANNED

desaturation index (DI): 2.7. Mean continuous oxygen saturation: NREM 97% REM 97%. Minimum oxygen saturation: 92%. TST with an oxygen saturation <90%: 0.0 minutes. Snoring: mild. Cheyne Stokes breathing: no.

CARDIAC EVENTS: Normal sinus rhythm. Average heart rate (HR) during sleep (bpm): NREM: 60.2, REM: 58.0.

MOVEMENT EVENTS: Number of periodic limb movements of sleep (PLMS): 0. PLMS index (PLMSI): 0. Limb Movements with Arousals: 0. Limb Movement arousals index (LMSArI): 0.

SUMMARY STATEMENTS: The majority of sleep occurred in the supine and lateral position and adequate REM supine time was observed. No clinically significant EEG abnormalities were observed. Bruxism was observed.

PATIENT COMMENTS: Overall, the patient's sleep was believed to be the same as usual.

IMPRESSION:
Sleep architecture was abnormal. Sleep latency was slightly prolonged, and reduced slow wave sleep was observed. The findings on this polysomnography are not consistent with sleep disordered breathing. This study did however mild heavy snoring without evidence for discrete respiratory events, sleep fragmentation, arousals or gas exchange abnormalities. There is no increase in periodic limb movements (PLMs). The clinical history is somewhat suggestive of restless legs syndrome (RLS). Bruxism (teeth grinding) was observed during this PSG.

RECOMMENDATIONS:
Therapeutic strategies for snoring include upper airway surgery, oral appliances, nasal steroids, and nasal splinting strips, either alone or in combination. Also, recommend weight loss/fitness regimen, sleep hygiene education and avoidance of substances such as alcohol, tobacco, and caffeine.

There is a self-report that might represent restless legs syndrome (RLS), but few PLMs in the study. In up to 20% of patients with RLS a significant number of PLMs are not found on a one-night PSG. Thus, a more detailed clinical history must be obtained. Recommend checking renal function, complete blood count/iron studies and hemoglobin-a1c lab testing. If patient's ferritin level is less than 50 ng/ml, iron supplementation with Vitamin C should be instituted, and a search for potential blood loss entertained. Decreasing alcohol intake can be beneficial. Therapeutic options include dopaminergic agents (ropinirole, pramipexole, carbidopa/levodopa), opioids, and anticonvulsants (gabapentin, carbamazepine).

Clinical history and PSG findings support a diagnosis of bruxism. Studies indicate that 70-90% of individuals grind their teeth to some degree during their lifetime, although it is only problematic in 5% of the population. Stress can be a source of bruxism and should be explored as a contributing factor. If dentition is negatively affected or persistent complaints of jaw pain are present, use of a nighttime intraoral appliance should be considered, and dental referral would be warranted.

This level of self-reported sleepiness is associated with personal and societal risk from fall asleep crashes or accidents. Sleep extension can be recommended to reduce sleepiness, as well as other measures to reduce exposure to hazardous situations such as driving automobiles. Please feel free to contact me with any questions, concerns or assistance.

* WASO includes all wake activity, including wake out of bed.
**Hypopneas are scored based on a 4% or greater oxygen desaturation from the baseline.

+++

Amit Khanna, MD,D.ABSM
AK:lt
D: 11/30/2011 1:51 P
T: 11/30/2011 2:13 P
C: Amit Khanna, MD,D.ABSM

X: *Donna O?Brien, MSN Polysomnogram
Unauthenticated unless signed; changes may occur after physician review.
@@

Veteran Name: James Roy
SSN: 400-41-8035
Ph: (860)634-6313

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

Patient: **ROY, JAMES EARL**
Treatment Facility: **NBHC GROTON**
Patient Status: **Outpatient**

Date: **21 Nov 2011 1320 EST**
Clinic: **GR UNDERSEA MED**

Appt Type: **EST**
Provider: **LAI,REMI HINYEUNG**

AutoCites Refreshed by LAI,REMI H @ 21 Nov 2011 1325 EST

Problems
Chronic:
- Sleep disturbances
- Pronated foot
- Knee joint pain
- Flat foot
- Patellofemoral syndrome

Family History
- Family medical history (General FHx)

Allergies
- No Known Allergies

Other PMHs
No Other PMHs Found.

Social History
No Social History Found.

Procedures
- FOOT INSERT, MOLDED TO MODEL, LONGITUD ARCH SUPPORT, EA (19 Oct 2011)

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
IBUPROFEN, 800 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH THREE TIMES A DAY AS NEEDED FOR PAIN	4 of 10	01 Jun 2011

Reason for Appointment:
F/U KNEE PAIN-PHYS THER IN PROGRESS/SUBSCH-TM
Appointment Comments:
jmeh/BKAA

Vitals
Vitals Written by SWEITHELM,CLIFFORD R @ 21 Nov 2011 1309 EST
BP: 120/78, HR: 80, RR: 13, T: 98.1 °F, HT: 71 in, WT: 180 lbs, SpO_2: 100%, BMI: 25.11, BSA: 2.017 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 3/10 Mild, Pain Scale Comments: Both knees and shins

Questionnaire AutoCites Refreshed by LAI,REMI H @ 21 Nov 2011 1325 EST
Questionnaires

SO Note Written by LAI,REMI HINYEUNG @ 21 Nov 2011 1611 EST
Chief complaint
The Chief Complaint is: PFS.
History of present illness
The Patient is a 21 year old male.
21 y/o male with PFS seen by me on 7NOV11 still reports B/L lat knee sx with prolonged run/sit. Has tried more cross-training (run, walk, bike) and stretching and still reports same achy pain to lat knees. Denies numb/tingle. Hasn't changed condition much.
Musculoskeletal symptoms.
Review of systems
Systemic: No systemic symptoms, no fever, and no chills.
Cardiovascular: No cardiovascular symptoms.
Pulmonary: No pulmonary symptoms.
Gastrointestinal: No gastrointestinal symptoms.
Neurological: No neurological symptoms.
Physical findings
Vital Signs:

Vital Signs/Measurements	Value
Blood pressure: Reviewed	

- Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed.

Name/SSN: ROY, JAMES EARL/400418035

		Sex:	M	Sponsor/SSN:	ROY, JAMES EARL/400418035
FMP/SSN:	20/400418035	Tel H:	703-398-7988	Rank:	SEAMAN APPRENTICE
DOB:	25 Aug 1990	Tel W:	860-694-1237	Unit:	N3056576
PCat:	N11 USN ACTIVE DUTY	CS:		Outpt Rec. Rm:	G SUBSCH MED RECORDS
MC Status:		Status:	Sub	PCM:	
Insurance:	No			Tel. PCM:	

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE		
21 Nov 2011 1309	Facility: Naval Branch Health Clinic Groton	Clinic: Groton Undersea Medicine	Provider: LAI, REMI H

General Appearance:
• In acute distress. ° Normal. ° Oriented to time, place, and person. ° Well developed. ° Well nourished.
Musculoskeletal System:
General/bilateral: • Musculoskeletal system: 5/5 ms to B/L LE/feet F/E, muscle spasms to left glut max/med/min/piriformis/gemelli/OI/pectineus, right innom ant, right longer leg by 2-3mm.
Neurological:
Balance: ° Normal.
Gait And Stance: ° Normal.

A/P Written by LAI,REMI H @ 21 Nov 2011 1617 EST
1. PATELLOFEMORAL SYNDROME: See below.
2. NONALLOPATHIC LESIONS PELVIC: PFS is biomechanically linked to SD found. Tx without complication with OMT, and pt tolerated tx to include Still tech/ME/indirect. SD resolved tx. Pt felt more relaxed after tx. Educ given, exercises demonstrated, pt to do exercises shown and to RTO in 3 wks. NPQ underway/transfer pending resolution of pain enough to remain functional for sub environment.
Procedure(s): -Osteopathic Manip Treatment (OMT) 1-2 Body Regions Involved x 1
3. NONALLOPATHIC LESIONS LOWER EXTREMITIES: See above.

Disposition Written by LAI,REMI H @ 21 Nov 2011 1618 EST
Released w/o Limitations

Signed By LAI, REMI H (UMO, NHCNE Groton) @ 21 Nov 2011 1618

Name/SSN: ROY, JAMES EARL/400418035			
	Sex: M	Sponsor/SSN:	ROY, JAMES EARL/400418035
FMP/SSN: 20/400418035	Tel H: 703-398-7988	Rank:	SEAMAN APPRENTICE
DOB: 25 Aug 1990	Tel W: 860-694-1237	Unit:	N3056576
PCat: N11 USN ACTIVE DUTY	CS:	Outpt Rec. Rm:	G SUBSCH MED RECORDS
MC Status:	Status: Sub	PCM:	
Insurance: No		Tel. PCM:	

Veteran Name: James Roy
SSN: 400-41-8035
Ph: (860)634-6313

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

Patient: **ROY, JAMES EARL**
Treatment Facility: **NBHC GROTON**
Patient Status: **Outpatient**

Date: **22 Jul 2011 0840 EDT**
Clinic: **GR UNDERSEA MED**

Appt Type: **ROUT**
Provider: **OBRIEN,DONNA M**

Reason for Appointment: difficulty sleepin x2wks
Appointment Comments:
jabw

AutoCites Refreshed by OBRIEN,DONNA MARIE @ 22 Jul 2011 0932 EDT

Problems	Family History	Allergies
No Problems Found.	No Family History Found.	• No Known Allergies

Active Medications

Active Medications	Status	Sig	Refills Left	Last Filled
IBUPROFEN, 800 MG, TABLET, ORAL	Active	TAKE ONE TABLET BY MOUTH THREE TIMES A DAY AS NEEDED FOR PAIN	4 of 10	01 Jun 2011

Vitals
Vitals Written by BINDNER,MICHAEL A @ 22 Jul 2011 0845 EDT
BP: 115/70, HR: 89, RR: 18, T: 98.4 °F, HT: 5' 11", WT: 188 lbs, SpO_2: 98%, BMI: 26.22,
BSA: 2.054 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 0 Pain Free

Questionnaire AutoCites Refreshed by OBRIEN,DONNA MARIE @ 22 Jul 2011 0932 EDT
Questionnaires

SO Note Written by OBRIEN,DONNA M @ 22 Jul 2011 0950 EDT
History of present illness
The Patient is a 20 year old male.
He reported: Encounter Background Information: 20 y/o male w/3w hx of waking up every nigh due to difficulty breathing. Roommates have witnessed his loud snoring at night. They have also noticed episodes of apnea and him awakening, gasping for breath. (-) pain, (-) breathing issues while awake. Not facing any stressful situations. Coping well in school and does not have relationship problems. Normal sleeping pattern is 6h of sleep/night. Not taking any meds, no allergies noted. No other complaints at this time.
Dyspnea and paroxysmal nocturnal dyspnea.
Sleep disturbances.
Review of systems
Systemic symptoms: No generalized pain, no fever, no chills, no night sweats, and no recent weight loss.
Head symptoms: No headache. No facial pain and no sinus pain.
Neck symptoms: No neck pain, no neck muscle tightness, and no neck stiffness. No swollen glands in the neck.
Eye symptoms: No vision problems. No eye pain. No photophobia and no red eyes.
Otolaryngeal symptoms: No ear symptoms. No hearing loss, no earache, and no tinnitus. No nasal symptoms. No nasal discharge. No sore throat, no itchy throat, no lump in the throat, no feeling of foreign body in the throat, no feeling of tightness in the throat, and no choking.
Cardiovascular symptoms: No chest pain or discomfort. No palpitations.
Pulmonary symptoms: No difficulty taking a breath. Not sleeping upright or with extra pillows and no cough. Not coughing up sputum. No wheezing.
Gastrointestinal symptoms: No nausea and no vomiting.
Neurological symptoms: No vertigo, no lightheadedness, no fainting, and no motor disturbances.
Psychological symptoms: Mood was euthymic. No anxiety, no depression, and no decreased functioning ability.
Skin symptoms: No skin lesions and no rash.
Physical findings
Vital signs:
• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • SBP: Reviewed.
General appearance:
° Oriented to time, place, and person. ° Well developed. ° Well nourished. ° In no acute distress.
Neck:

- Neck: 16.5 inch neck.
  Palpation: * No tenderness of the neck.

Eyes:
General/bilateral:
* Eyes: normal.
Pupils: * PERRL.
Sclera: * Normal.

Ears:
General/bilateral:
Tympanic Membrane: * Normal.
Middle Ear: * Normal.
Hearing: * No hearing abnormalities.

Nose:
General/bilateral:
* Nose: normal.
Nasal Discharge: * No nasal discharge seen.
Sinus Tenderness: * No sinus tenderness.

Oral cavity:
* Normal.

Pharynx:
Oropharynx: * Posterior pharyngeal wall was normal 2+ tonsils (L), 3+ on the (R).

Lymph Nodes:
* No adenopathy. * Cervical lymph nodes were not enlarged. * Submandibular lymph nodes were not enlarged.

Chest:
* Visual inspection revealed no abnormalities.

Lungs:
* Clear to auscultation. * No wheezing was heard. * No rhonchi were heard. * No rales/crackles were heard.

Cardiovascular system:
Inspection: * Normal.
Auscultation: * Normal.
Heart Rate And Rhythm: * Normal.
Heart Sounds: * S1 normal. * S2 normal. * No S3 heard. * No S4 heard. * No gallop was heard. * No pericardial friction rub heard.
Murmurs: * No murmurs were heard.

Neurological:
Balance: * Normal.
Gait And Stance: * Normal.

Psychiatric Exam:
Appearance: * Normal. * Not tired. * Grooming was normal. * Not unkempt.
Mood: * Euthymic.
Affect: * Normal.

Skin:
* Showed no ecchymosis. * No skin lesions.

A/P Written by OBRIEN,DONNA MARIE @ 22 Jul 2011 1005 EDT
1. periods of not breathing while asleep (sleep apnea): Sleep study. Will RTC after sleep study done to review results and plan. Stated understanding.
Consult(s): -Referred To: P-SLEEP STUDY (Routine) Specialty: Clinic: GR FAM PRACTICE Primary Diagnosis: Sleep apnea

Disposition Written by OBRIEN,DONNA MARIE @ 22 Jul 2011 1006 EDT
Released w/o Limitations
Follow up: as needed with PCM.
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.
Administrative Options: Consultation requested

Signed By OBRIEN, DONNA MARIE (Nurse Practitioner, NHCNE Groton) @ 22 Jul 2011 1007

CHANGE HISTORY
The following Disposition Note Was Overwritten by OBRIEN,DONNA MARIE @ 22 Jul 2011 0932 EDT:
The Disposition section was last updated by OBRIEN,DONNA MARIE @ 22 Jul 2011 0932 EDT - see above.Previous Version of Disposition section was

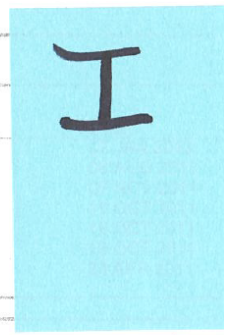
Veteran Name: James Roy
SSN: 400-41-8035
Ph: (860)634-6313

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

(This form is subject to the Privacy Act of 1974 - Use DD Form 2005)

1. ALLERGIES

Allergen	Reaction	Information Source	Onset Date
No Known Allergies			



2. CHRONIC ILLNESSES

Chronic Illness
Knee Sprain
Exercise-induced Asthma
Sleep Disturbances
Pronated Foot
Knee Joint Pain
Flat Foot
Patellofemoral Syndrome

3. MEDICATIONS

Medication	Sig	Expiration Date
Albuterol Sulfate 90mcg, (Ventolin Hfa), Aerosol Powder, Inhalation, Hfa	Inhale 2 Puffs By Mouth Every 4 Hours As Needed For Wheeze, And 20 Minutes Prior To Exercise	08 Aug 2013
Sodium Fluoride, Cream, Dental	Brush Teeth For 2 Minutes Preferably At Bedtime , Spit Out And Do Not Rinse	26 Apr 2013

4. HOSPITALIZATIONS / SURGERIES

5. Counseling

6. FAMILY HISTORY (M = Mother, F = Father, S = Son, D = Daughter, B = Brother, S = Sister, MGM/PGM = Maternal/Paternal Grandmother, MGF/PGF = Maternal/Paternal Grandfather, Children = Biological Children of Veteran, Spouse = Maternal/Paternal Aunt, Other = Other)

Family Medical History
Supplemental Hpi [use For Free Text]
No Family History Of Heart Disease
No Family History Of Mental Illness (not Retardation)
No Family History Of Cancer
No Family History Of Diabetes Mellitus

ADVANCED DIRECTIVES:
PATIENT'S IDENTIFICATION
Name:ROY, JAMES EARL
Sex:M DOB:25 Aug 1990
SSN: 400-41-8035
FMP/SponsorSSN:20/400-41-8035

RECORDS MAINTAINED AT:
G MILMED RECORDS

RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
Sponsor	Active Duty	SEAMAN

SPONSOR'S NAME *(Last, First, Middle Initial)*: ROY, JAMES EARL
DEPT/SERVICE: Navy
ORGANIZATION: N68231660

Veteran Name: James Roy
SSN: 400-41-8035
Ph: (860)634-6313

NAVAL HEALTH CARE NEW ENGLAND

MEDICAL TREATMENT FACILITY: NBHC Groton

DATE: 1/4/13

From: MEGHAN HUNTER, D.O.
LTJG MC USN

To: _____

Subj: LIGHT DUTY STATUS ICO Roy, James E (Patient Name) SN (Rate/Rank/Service)

8035 (SSN) _____ (Command)

1. The above-named individual has been examined by a Medical Officer and should be pl
on light duty with the following limitations:

- ✓ No climbing stairs or ladders
- ✓ No marching
- ✓ No running/jumping
- ___ No heavy lifting
- ___ No swimming
- ___ Wearing of sneakers is approved
- ✓ No PRT – no running
- ✓ No duties requiring high impact exercises

2. This is valid until 0700 (Time) on 3/4/13 (Date), at which time the above-named individual is to:

- ___ Return to full duty.
- ✓ Return to PCC / DR. Hunter (Clinic/Provider) at _____ (Date/Time) for further evaluation.

3. If you have any questions regarding these limitations, please contact MEGHAN HUNTER, D.O. LTJG MC USN at x31666.

Signature of Provider

NHCNE 6330/2 (Rev 03/05)

Veteran Name: James Roy
SSN: 400-41-8035
Ph: (860)634-6313

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

Patient: ROY, JAMES EARL
Treatment Facility: NBHC GROTON
Patient Status: Outpatient

Date: 04 Jan 2013 1340 EST
Clinic: GR FAM MED PCMH 1

Appt Type: EST
Provider: HUNTER,MEGHAN E (MD)

AutoCites Refreshed by HUNTER,MEGHAN E @ 04 Jan 2013 1410 EST

Problems
Chronic:
- Knee sprain
- Exercise-induced asthma
- Sleep disturbances
- Pronated foot
- Knee joint pain
- Flat foot
- Patellofemoral syndrome

Family History
- Family medical history (General FHx)
- Supplemental HPI [use for free text] (General FHx)
- No family history of heart disease (General FHx)
- No family history of mental illness (not retardation) (General FHx)
- No family history of cancer (General FHx)
- No family history of diabetes mellitus (General FHx)

Allergies
- No Known Allergies

Social History

No Social History Found.

Reason for Appointment:
f/u LIMDU
Appointment Comments:
npq

Screening Written by MINTAH,MANASEH M @ 04 Jan 2013 1359 EST
Reason For Appointment: f/u LIMDU

Allergen information verified by MINTAH, MANASEH M @ 04 Jan 2013 1359 EST

Vitals
Vitals Written by MINTAH,MANASEH M @ 04 Jan 2013 1400 EST
BP: 118/64, HR: 60, RR: 16, T: 97.9 °F, HT: 70 in, WT: 190 lbs, SpO_2: 100%, BMI: 27.26, BSA: 2.042 square meters, Tobacco Use: No, Alcohol Use: No, Pain Scale: 4/10 Moderate, Pain Scale Comments: right knee pain

Questionnaire AutoCites Refreshed by HUNTER,MEGHAN E @ 04 Jan 2013 1410 EST
Questionnaires

SO Note Written by HUNTER,MEGHAN E (MD) @ 04 Jan 2013 1738 EST
Chief complaint
The Chief Complaint is: Follow up on Right Knee Pain.
History of present illness
The Patient is a 22 year old male.
<<Note accomplished in TSWF CORE>>

Pt presents to f/u R knee pain & limdu status. He says he was DQ subs by the UMO. He says things have been relatively stable with his knee this month. He is trying to stay off it. He says the knee still pops quite a bit and this is painful. The knee brace given to him is helping, as are the Lidoderm patches. Pt takes motrin 800 MG for pain. He has a f/u with Ortho & his limdu re-eval next month.
Patient accompanied / Chaperoned by: HN MINTAH.
Currently on active duty. Visit is not deployment-related.
Good general overall feeling.
Pain localized to one or more joints R knee and joint swelling localized to one or more joints right knee - minimal.

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE		
04 Jan 2013 1340	Facility: N61726	Clinic: GR FAM MED PCMH 1	Provider: HUNTER,MEGHAN E (MD)

Pain assessment: Pt c/o Rt knee pain.
Pain Severity 4 / 10.
Attending Physician: <DR. HUNTER>. Discussed with attending who concurs with the plan.
PHQ-2 Depression Screen Negative.
Patient feels safe at home.
Care Plan Given to patient.

Allergies
Current Allergies Reviewed.

Current medication

Ibuprofen (motrin EQ) po 800mg tid
Albuterol (ventolin HFA) INH 90mcg inhale two puffs every 4 hours prn for wheeze, and 20 minutes prior to exercise

Past medical/surgical history
Reported:
Medical: Reported medical history
Exercise-induced asthma
Sleep disturbances
Pronated foot
Knee joint pain
Flat foot
Patellofemoral syndrome.
Surgical / Procedural: Surgical / procedural history
2010 - Right knee arthroscopy.
Medications: No medication noncompliance.

Personal history
Social history reviewed
Active Duty, LIMDU, works in Weapons Compound at a desk job.
Behavioral: No tobacco use in the last 10 years.
Alcohol: Not using alcohol Screening Date: 05 JAN 13.
Sexual: Not sexually active.
History ANNUAL SCREENING DATE: 05 JAN 13

What is your preferred method of learning? [x] Verbal [ ] Written [x] Visual [ ] Other (Specify):
Do you have a learning disability, language barrier, hearing/vision deficit? [ ] Yes [x] No Specify:
Advanced directives completed? [ ] Yes [x] No
Do you have any cultural or religious beliefs that may affect your care? [ ] Yes [x] No
Are you enrolled in EFMP? [ ] Yes [x] No
Do you use a Personal Health Record (PHR)? [ ] Yes [x] No Specify:
Contact info: 571-991-4267.

Family history
Family medical history
Pt reports none.

Review of systems
Systemic: No fever and no chills.
Gastrointestinal: No nausea and no vomiting.
Musculoskeletal: No muscle aches and no limb pain.
Neurological: No motor disturbances and no gait abnormality. No sensory disturbances.

Physical findings
Vital Signs:
• Temperature: Reviewed. • RR: Reviewed. • PR: Reviewed. • Blood pressure: Reviewed.
General Appearance:
° Oriented to time, place, and person. ° Well developed. ° Well nourished. ° In no acute distress.
Lungs:
° Respiration rhythm and depth was normal.
Cardiovascular:
Heart Rate And Rhythm: ° Normal.
Musculoskeletal System:
Knee:
Right Knee: • Effusion minimal. • Tenderness on palpation anterior, medial and lateral sides of patella. • Pain was elicited by motion full flxn and extn. • Tenderness was observed on ambulation. ° No erythema. ° No misalignment. ° Motion was normal. ° No crepitus on motion was noted but knee does occasionally click with ROM. ° No anterior drawer sign was present. ° No posterior drawer sign was present. ° A McMurray test was negative.
Neurological:

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE		
04 Jan 2013 1340	Facility: N61726	Clinic: GR FAM MED PCMH 1	Provider: HUNTER,MEGHAN E (MD)

Motor (Motor Strength): * No weakness of the right knee was observed.
Balance: * Normal.
Gait And Stance: * Normal.

Psychiatric:
Mood: * Euthymic.
Affect: * Normal.

Practice Management
Patient's BMI < 30. Screening Date: 05 Jan 13.

A/P Written by HUNTER,MEGHAN E @ 04 Jan 2013 1743 EST
1. joint pain, localized in the knee: RF on Lidoderm patches.
Continue Motrin 800mg TID prn.
Wear brace with any prolonged walking/standing.
LLD chit was renewed for command.
Pt will f/u with Ortho mid FEB.
Medication(s): -LIDOCAINE(LIDODERM)--TOP 5% TDSY - AAA UD (INTACT SKIN) **LEAVE ON 12 HOURS/THEN OFF 12 HOURS** #30 RF2 Qt: 30 Rf: 2

Disposition Written by HUNTER,MEGHAN E @ 04 Jan 2013 1743 EST
Released w/ Work/Duty Limitations: Profile: joint pain, localized in the knee 719.46 from 02 Jan 2013 to 04 Jan 2013; Comment: SUB DQ.
Follow up: 6 week(s) with PCM or sooner if there are problems.
Discussed: Diagnosis, Medication(s)/Treatment(s), Alternatives, Potential Side Effects with Patient who indicated understanding.

Signed By HUNTER, MEGHAN E (D.O./Physician/Pier 1, NHCNE - Groton) @ 04 Jan 2013 1743

CHANGE HISTORY
The following SO Note Was Overwritten by HUNTER,MEGHAN E @ 04 Jan 2013 1742 EST:
SO Note Written by MINTAH,MANASEH M @ 04 Jan 2013 1407 EST
Chief complaint
The Chief Complaint is: Follow up on Right Knee Pain.
History of present illness
The Patient is a 22 year old male.
<<Note accomplished in TSWF CORE>>

Pt presents to f/u R knee pain. He said he had his second surgery 25SEP2012 and said the scar tissue around his ACL was removed. He also said the doctor found a cracked femur behind his patella, which he said would heal itself. He complains of tingling sensation and pain currently.States his movement has considerably improved but pain can not be sustained. Knee is a little bit swollen but without discoloration and or fluid build up. Pt takes motrin 800 MG for pain.
Patient accompanied / Chaperoned by: HN MINTAH.
Currently on active duty. Visit is not deployment-related.
Good general overall feeling.
Pain localized to one or more joints R knee. Swelling localized to one or more joints right knee.

Pain assessment: Pt c/o Rt knee pain.
Pain Severity 4 / 10.
Attending Physician: <DR. HUNTER>. Discussed with attending who concurs with the plan.
PHQ-2 Depression Screen Negative.
Patient feels safe at home.
Care Plan Given to patient.
Allergies
Current Allergies Reviewed.
Current medication

Ibuprofen (motrin EQ) po 800mg tid
Albuterol (ventolin HFA) INH 90mcg inhale two puffs every 4 hours prn for wheeze, and 20 minutes prior to exercise

Past medical/surgical history
Reported:
Medical: Reported medical history
Exercise-induced asthma
Sleep disturbances
Pronated foot
Knee joint pain
Flat foot
Patellofemoral syndrome.
Surgical / Procedural: Surgical / procedural history
2010 - Right knee arthroscopy.
Medications: No medication noncompliance.
Personal history
Social history reviewed
Active Duty, LIMDU, works in Weapons Compound at a desk job.
Behavioral: No tobacco use in the last 10 years.
Alcohol: Not using alcohol Screening Date: 05 JAN 13.