IN THE CIRCUIT COURT OF FLORIDA, EIGHTH JUDICIAL CIRCUIT,
IN AND FOR BRADFORD COUNTY, FLORIDA.

SUBPOENA DUCES TECUM

STATE OF FLORIDA,
Plaintiff,

CASE NO.: S. A. INVESTIGATION

vs.

S. A. INVESTIGATION
Defendant.

IN THE NAME OF THIS STATE OF FLORIDA, TO ALL AND SINGULAR THE SHERIFFS OF SAID STATE:

You are hereby commanded to subpoena CUSTODIAN OF RECORDS, NORTHEAST FLORIDA STATE HOSPITAL, MACCLENNY, FLORIDA, if found in your County, to be and appear before **JOEY B. DOBSON, STATE ATTORNEY'S OFFICE INVESTIGATOR,** at STATE ATTORNEY'S OFFICE, ROOM 237, BRADFORD COUNTY COURTHOUSE, STARKE, FLORIDA, INSTANTER to testify and the truth to speak in behalf of the State of Florida in a certain matter before said Court pending and undetermined, wherein State of Florida is Plaintiff.

And the said CUSTODIAN OF RECORDS is hereby commanded to bring into the Court with HIM/HER the following described records, to-wit:

ANY AND ALL MEDICAL RECORDS INCLUDING ADMISSION AND DISCHARGE DATES FOR LARRY LEON WALDO, W/M, DOB: 7/27/55, SSN/265-25-6963.

NOTE: IN LIEU OF APPEARANCE, RECORDS MAY BE MAILED TO STATE ATTORNEY'S OFFICE, P. O. BOX 779, STARKE, FLORIDA, 32091, PRIOR TO DATE OF APPEARANCE.

And this you shall in no wise omit.

Dated this 16 day of May, 1996.

Elzie S. Sanders, Circuit Judge

Original Praecipe Witness Copy File Copy

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

STATE OF FLORIDA

COUNTY OF BAKER

Before me this day personally appeared Patricia Crews, ART, who, being first duly sworn, deposes and says that the attached are true and correct copies of the medical records of Larry Waldo on file at Northeast Florida State Hospital, Macclenny, Florida

Patricia Becan
Patricia Becan, ART
Medical Records Director

Sworn to and subscribed before me this 22nd day of May, 1996.

Sharon Long
Notary

OFFICIAL NOTARY SEAL
SHARON LONG
NOTARY PUBLIC STATE OF FLORIDA
COMMISSION NO. CC496652
MY COMMISSION EXP. SEPT 21,1999

NORTHEAST FLORIDA STATE HOSPITAL

Macclenny, Florida

S.S.# 265-25-6963 ADMISSION SHEET VOLUNTARY (Competent)

Name WALDO, Larry Leon

Date November 16, 1981 Hosp. No. A-88081

Date Committed VOLUNTARY (Competent)

County Columbia (RES. BROWARD)
Patient on Unit IV

Date of Admission November 16, 1981

Home Address 2130 Adams Street
Hollywood, FL 33020

Birthplace Florida

Date of Birth: Day 27 Mo July Yr 1955 Age 26

Nearest Relative Trudy Vanzant (mother)

Address 2130 Adams Street, Hollywood, FL 33020

Guardian

Address

Sex Male White

Nationality American

Ht. 5'7½" Wt 128

Occupation Religion Baptist

Marital State(S) M. W. D.

Resident of Florida (life)

War Service

Prev. Hospitalization SFSH

Father's Name Al Calvin J. Waldo (dec'd)
SFSH Carvil Waldo

Birthplace

Mother's Maiden Name Trudy
SFSH Gertrude

Birthplace

Former or subsequent admissions, furloughs, escapes and discharges:

SEE TRANSFER INFORMATION FROM SFSH FOR ADMISSIONS AND SEPARATION FROM 2-1-77 thru 3-3-77 (FILED IN SECTION #III):

Adm. NEFSH 11-16-81: DISCHARGED 6-10-82 Vol/comp w/o AWOL

Tentative diagnosis on admission: 295.92 Schizophrenic Disorder, Undifferentiated, Chronic

WALDO, LARRY LEON
A-88081
VOLUNTARY COMPETENT

DISCHARGE SUMMARY

DATE OF ADMISSION: November 16, 1981

DATE OF DISCHARGE: June 10, 1982

ADMITTING DIAGNOSIS: 295.92 SCHIZOPHRENIC DISORDER, UNDIFFERENTIATED TYPE, CHRONIC, (in relapse)

GENERAL DATA: This is the first admission of this 26-year-old, white male, single, from Broward County, who was brought in by the staff of Lake Shore Hospital in Lake City as a voluntary competent patient, on account of what he stated, "They have sent me here, because I have been bad with animals."

MENTAL STATUS ON ADMISSION: Mental status on admission revealed that the patient is in normal ambulation, physically unkept, dressed in a very inappropriate way, but in no acute distress. Affective display was noted flat, speech was noted incessant, and expressive of extreme circumstantiality, incoherent and irrational. Though process and though content are markedly disorganized. Sensorial functioning, orientation and memories are intact. Insight and judgment are impaired.

PHYSICAL EXAMINATION: Physical examination revealed presence of scar over the left infrascapular area, cause was unknow to the patient. Heart, lungs and neurological examinations are within normal limits.

LABORATORY EXAMINATION: Routine blood workup done on November 20, 1981, revealed hematocrit of 54.1, hemoglobin of 16.6, VDRL non-reactive. Urinary assessment done on November 18, 1981, revealed a specific gravity of 1.012, ph 6, negative for occult blood. Chest X-ray done on May 5, 1982, revealed within normal limits. X-ray of the left hand done on March 5, 1982, revealed negative findings. X-ray of the face done on March 5, 1982, revealed fractured nose without deviation of the septum. Chest X-ray done on November 20, 1981, revealed presence of left thoracotomy with multiple surgical clips, fusion of posterior upper ribs and perhaps resection of the left fifth rib. There is no definite acute disease noted.

PATIENT'S PROBLEMS: Auditory and visual type hallucinations, physically unkept appearance, combative attitude, are all resolved.

COURSE IN THE HOSPITAL: During the first week of confinement the patient was restricted in the ward to monitor his behavior.

WALDO. LARRY LEON
A-88081
VOLUNTARY COMPETENT
PAGE -2-

He was placed on Haldol 10 mg., 3 times a day to prevent further psychosis. On one occasion he became combative and was placed on four point restraints for protection of others. On December 4, 1981, he was granted supervised acitivites and dining room privileges without any problems. This was followed by full ground privileges with very compatible results.

During this paticular confinement, the patient showed much improvement, as manifested by cheerful attitude, sociable with other patients, and helping in some ward work. He denied suicidal or homicidal ideations.

MENTAL STATUS ON DISCHARGE: The patient was noted in normal ambulation, neat, clean, tidy, cheerful, cooperative without any physical complaints. His speech was noted within normal limits, and expressive of rational and coherent ideas. Thought process and thought content are within normal limits. Sensorial functioning, orientation and memories are intact. Insight and judgment are maintained.

On May 11, 1982, at approximately 12:30 p.m., the patient failed to return to the ward on a specified time from full ground privileges. Proper notification of the family and Baker County Sheriff was done. Search of the hospital grounds revealed negative findings. On June 10, 1982, the patient was formally dropped from the census as discharge.

FINAL DIAGNOSIS: 295.95 SCHIZOPHRENIC, UNDIFFERENTIATED TYPE, (in remission)

PROGNOSIS: Is poor on account of numerous hospital confinement.

DISPOSITION: On June 10, 1982, the patient was dropped from the census as discharge while on AWOL.

R.N. SOTOMAYOR M.D.

RNS/kah

9/23-9/23-9/27/82

Northeast Florida State Hospital
Macclenny, Florida

WALDO, Larry Leon
A-88081
Voluntary (Competent)

ADMISSION HISTORY

Date of Admission:	November 16, 1981
GENERAL INFORMATION:	This is the first Northeast Florida State Hospital admission of this 26-year-old, white male, single, of Baptist faith, residing by himself, from Broward County, who was brought in by staff of Lake Shore Hospital in Lake City as a voluntary, competent patient.
PREVIOUS HOSPITALIZATIONS:	Lake City Mental Center on November 8, 1981, and Northeast Florida State Hospital for the first time.
CHIEF COMPLAINT:	"They have sent me here, because I have been bad with animals."
COMPLAINTS OF OTHERS:	Confused, hostile, combative attitude, withdrawn, and mumbling to himself.
HISTORY OF THE PRESENT ILLNESS:	Revealed that the patient was confined at Lake City Medical Center on November 8, 1981. According with information papers, messing with animals (the patient denied). He was relocated to this facility for long-range psychiatric management.
MENTAL STATUS ON ADMISSION:	General Appearance and Behavior: Noted is a white male, in normal ambulation, asthenic in body build, drowsy looking, disheveled, dirty, ungroomed, cooperative, but in no acute distress. Affective display was noted flat.
	Speech: Revealed spontaneity, expressive of irrelevant and incoherent ideas. He was noted extremely circumstantial, and unable to reach a point in providing feedback.
	Thought Process: During admission the patient was noted self-mumbling, and stated, "They said I'm bad with animals."
	Thought Content: Self-mumbling of inaudible type phrases.
	Sensorial functioning, orientation and memories are not tested on account of drowsy state of the patient.
	Insight and Judgment: Were not responded to by the patient.

WALDO, Larry Leon
A-88081
Voluntary(Competent)
Page -2-

According with information papers, the patient had a history of seizures (?), he denied suicidal or homicidal ideation.

PHYSICAL ILLNESSES: None noted during the time of admission.

PHYSICAL EXAMINATION RESULT: Presence of scar over the left infrascapular area, cause was unknown to the patient. Heart, lungs and neurological examinations are within normal limits.

JUSTIFICATION FOR ADMISSION: Confused, withdrawn, drowsy and self-mumbling.

FORMULATION: This is the first admission of this 26-year-old, white male, single, from Broward County, who was brought in by staff of Lake City Medical Center on account of what the patient stated, "I am messing with animals."

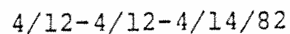
TENTATIVE DIAGNOSIS: 295.92 SCHIZOPHRENIC DISORDER, UNDIFFERENTIATED TYPE, CHRONIC, (in relapse)

INITIAL TREATMENT PLAN: Inpatient treatment, a regular diet, routine laboratory examinations and chest X-ray, Haldol, 10 mg., t.i.d., Haldol, 5 mg., I.M., q4h, p.r.n., and Tylenol, 2 tablets, q4h, p.r.n., for pain.

R. N. SOTOMAYOR, M. D.

RNS/vn

4/12-4/12-4/14/82



Northeast Florida State Hospital
Macclenny, Florida

PHYSICAL EXAMINATION OUTLINE
(Refer to Physical Examination Guides)
NORTHEAST FLORIDA STATE HOSPITAL

PATIENT'S NAME Waldo, Larry PATIENT'S HOSPITAL NUMBER ?

DATE 11-16-81 WARD 5

1. IDENTIFYING DATA:

Sex Male

Height ______ Weight ______

Color of Eyes ______

Color of Hair Black

2. CONDITION:

Temperature 98.4

Pulse 104

Respiration 24

Blood Pressure 98/52

3. HISTORY, INCLUDING CURRENT COMPLAINTS AND THERAPY RECEIVED:

Illnesses ______

Operations ______

Injuries ______

Alcohol ______

Drugs ______

Venereal Disease ______

Allergies ______

4. DEVELOPMENT AND APPEARANCE:

Body Build ______ Hair ______

Nutrition ______ Nails ______

Skin (Including Scars, Eruptions and Trophic Disorders) ______

PATIENT ______________ # ______________

5. HEAD AND NECK:

Eyes ____

____

Mouth (Including Teeth) ______________________________

Pharynx ____

Neck(Including Nodes and Thyroid) ______________________

____

6. CHEST

HEART

P.M.I. ____

____

Rhythm ____

Murmurs ____

LUNGS ____

____

Breasts ____

7. ABDOMEN:

Tenderness ____

____

Rigidity ____

Masses ____

Liver ____

Spleen ____

Hernia ____

8. GENITO-URINARY:

Genitalia ____

____

Rectal(Including Prostate and Hemorrhoids) ______________________

____

PATIENT ______________ # ______________

9. EXTREMITIES:

Osseous Abnormalities ______________

____

Muscle Abnormalities ______________

Joint Abnormalities ______________

Edema ______________

Peripheral Vascular System ______________

10. NEUROLOGICAL:

A. CRANIAL NERVES:

I. Olfactory ______________

II. Optic ______________

Fields ______________

Fundi ______________

Acuity ______________

III., IV, VI. Extraocular Movements ______________

Pupils ______________

Nystagmus ______________

V. Trigeminal ______________

Mastication ______________

Facial Sensation ______________

VII. Facial ______________

VIII. Acoustic ______________

Hearing ______________

Equilibrium ______________

IX., X. Swallowing ______________

Phonation ______________

Gag Reflexes ______________

XI. Spinal Accessory ______________

Trapezius ______________

Sternocleidomastoid ______________

XII. Hypoglossal ______________

B. SENSATION:

Pain and Temperature ______________

Vibration and Position ______________

C. MOTOR:

Muscle Strength ______________

Muscle Tone ______________

Faciculation ______________

Atrophy ______________

Gait and Station ______________

Coordination ______________

Involuntary Movements ______________

PATIENT ______________ # ______________

D. REFLEXES: Indicate 0 to 4 (0-absent; 1-sluggish; 2-active; 3-very active; 4-exaggerated to clonus)

	R	L
Biceps		
Triceps		
Brachioradialic		
Patellar		
Achilles		
Plantar		

11. SUMMARY OF POSITIVE FINDINGS, WITH RECOMMENDATIONS:

PHYSICIAN SIGNATURE: ______________________________

NORTHEAST FLORIDA STATE HOSPITAL

Psychosocial Assessment

PATIENT'S NAME: Larry Waldo DATE: 11-17-81

UNIT: III WARD: 5 HOSPITAL NO:

DATE OF ADMISSION: 11-16-81 COUNTY: Broward

TYPE OF ADMISSION: Voluntary RE-ADMISSION:

DATE OF BIRTH: 7-27-55 age 26 PLACE: Florida

ADDRESS: 2130 Adams Street TELEPHONE NO.:

Hollywood Fla

S.S.NO: 265-5 6963 MARITAL STATUS: single

GUARDIAN, NEXT OF KIN, FIRST REPRESENTATIVE:

Trudy Vanzant (mother) (mother is in Alabama)

2130 Adams St

Hollywood Fla. 33020

TELEPHONE:

I. Informant: (Name, address, telephone number, relationship to patient).

Medical Records

Evaluation of Informant:

This information is considered reliable

Patient's Name Hospital Number

HRS4 NEF 04.24 (12/80) Temp.

II. Presenting Problem:

The presenting problem is confusion hostility + incoherent.

III. Significant Family Members: (Parents, Spouse, Siblings, Children)

Trudy Vanzant (mother)
2130 Adams St.
Hollywood Fla 33020

7 Brothers + 2 sister
singe never married
father deceased

IV. Personal History: (chronological age, developmental, religion, education, military status, work history, marriage).

The patient is a 26 year old White male from Broward county. His religious preference is Baptist. He has a ninth grade education. No military background. He is singe + never has married.
His work history consist of restaurant worker, security guard, Winn Dixie as a stock person. He has not held a job in years now.

Patient's Name Hospital Number

V. Significant Illnesses: (mental and physical)
Time and Place of Hospitalizations; Onset of Present Illness

This is patients first admission to NEFSH. He has been hospitalized in Hollywood Fla for about 2 months.

VI. Family Background: (Ethnic and religious background; family stability and family history of physical and mental problems; Substance abuse problems related to patient or family members -note frequency, preference, overdose, and treatment -Relate information to environment and home)

The patient states his childhood was normal. He states that his mother was strict on him. He states he drinks but not excessively. Stated he has smoked marijuana but not in a long time. Denied any other substance abuse. The patient states that his mother & other family is in Alabama.

Patient's Name

Hospital Number

VII. Financial: (Employment,salary,health insurance -insurance Medicaide. Social Security benefits, SSI,Public Assistance Pension;give identifying information such as amounts,I.D.#'s, and agency address).

The patient states he receives an SSA check in the amount of $283.33.
It is going Direct Deposit to Hallandale Bank in Hollywood.

VIII. Tentative Discharge Plans:

Possible placement in a Boarding Home.

D. Cooper S.W.
(Signature of Social Worker)

DOCTOR | TREATMENT RECORD | DATE

DATE 11/16/81 NAME Waldo, Larry Leon A- [illegible] 5 RACE-SEX WM AGE 26 EXAM. BY JL

MENTAL DIAG. Schiz disorder, undiff, chronic

PHYSICAL DIAG.

CONDITIONS FOUND		TREATMENT INDICATED	
TEETH MISSING	none	EXTRACTIONS	UR8 UL68 LR6
RESTORATIONS PRESENT	none	FILLINGS	none
SOFT TISSUES	wnl	CR. & BR. WK.	none
DEPOSITS	hvy	REMOVABLE APPLIANCES	none
MASTICATING EFFICIENCY	Class I	PROPHYLAXIS	yes
ABNORMALITIES		RADIOGRAPHS	yes
REMARKS		REMARKS	

DATE	TREATMENT RECORD	DOCTOR
11/16/81	Admitted to wd 5; volt (Comp)	JL
12/9/81	Routine exam	JL
6/10/82	discharged	RDM

NAME

Waldo, Larry Leon A- WM

WALDO, Larry A. [illegible]-[illegible]081

ADMISSION - 76
CH. FM - NO. 1

SOUTH FLORIDA STATE HOSPITAL
ADMISSION SHEET

AME	RACE	SEX	ADMISSION DATE	HOSPITAL NO.
WALDO, Larry A.	W	M	2-1-77	A-88081

IRTHDATE	AGE	BIRTHPLACE	NATIONALITY	MARITAL STATUS	COMPUTER NO.
'-27-55	21	Fla.	U.S.A.	Sgle.	

CIAL SECURITY NO.	VETERANS STATUS	RELIGION - CHURCH	OCCUPATION - INDUSTRY	EDUCATION
65-25-6963	None	Baptist	Security Officer	9th Grade

TATUS ON ADMISSION	COUNTY	COMMITMENT DATE	JUDGE
NVOLUNTARY	Brwward	1-20-77	Thomas Reddick, Jr.
	STATUTE	CASE NO.	LEGAL STATUS
		#77-0043	

HANGE OF STATUS	DATE	CHANGE OF STATUS (cont'd.)	DATE

PECIAL NOTATIONS:

ATIENT'S ADDRESS			ZIP	COUNTY OF RES.
5731 Forrest St., Hollywood, Fla.				Broward
NCOMPETENT	DATE	COUNTY OF INC.	DATE RESTORED	TIME IN FLORIDA
				1 Yr.

UARDIAN	PERSON	PROP.	ADDRESS	PHONE

st REPRESENTATIVE	RELATIONSHIP	ADDRESS	PHONE
Pearl Waldo	Grandmother	6316 Johnson Street, Hollywood, Florida	None

nd REPRESENTATIVE	RELATIONSHIP	ADDRESS	PHONE
George Dennis	Friend	5713 Forrest Street, Hollywood, Florida	966-5571

FATHER'S NAME	BIRTHPLACE	MOTHER'S MAIDEN NAME	BIRTHPLACE
Carvil Waldo (D)	Ga.	Gertrude (Unknown)	Unknown

ADMISSION AND DISPOSITION (This Hospital)

ADMITTED 2-1-77 - DISCHARGED [illegible]

PREVIOUS HOSPITALIZATIONS:

Memorial Hosp., Hollywood (3 times) Last time 1-13-77 Trans. to SFSH

No Other Hosps. or Clinics

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FOLLOW-UP TREATMENT:

PROVISIONAL DIAG.	DISCHARGE DIAG.
311	3/6

RECEIVED FROM	DOCTOR	SOCIAL WORKER	WARD
Mem. Hosp.	Carrillo	Kilmer	Orange

FINAL SUMMARY

IDENTIFICATION DATA: The patient is a 21-year-old, white, single male, who was admitted for the first time to South Florida State Hospital on February 1, 1977 as an Involuntary admission. He has a 9th grade education, is a security officer by occupation and his religion is Baptist.

PAST PSYCHIATRIC HISTORY AND REASON FOR ADMISSION: Past psychiatric history is that of having numerous admissions to Hollywood Memorial Hospital, the last time on January 13, 1977 and transferred to South Florida State Hospital.

According to the report from the police, the patient was threatening suicide by jumping off an over-pass into traffic after having a fight with his roommate. At that time a diagnosis of depressive reaction was given. He also had a history of drinking to excess when out of the hospital. He stated that his father has no interest in caring for him.

The background in this patient is that he had an unhappy childhood, that no-one cared for him and everything went wrong was blamed on him. The feeling of rejection was strong in this patient since he could not do anything right and was beaten up by his mother and father. His work history is that of doing odd jobs and sporadic baby sitting for his family.

From the physical point of view he had a scar on his chest apparently due to heart surgery when he was one year old, but he could not give a reason. First, he said they had to pump blood into his heart and then said they put a tube in it.

Apparently, the patient had been taking Hygroton 50 mg. 1 tablet daily; however, on admission his blood pressure was within normal limits.

MENTAL STATUS: From the physical point of view the patient was not in distress and he exhibited a scar on his chest from surgery. His head shows a mild degree of dolichocephalia and there are a few pimples on his facial tissues. His psychomotor activities are somewhat increased and his trend of thought is that of being partially relevant due to the fact that he is a very poor historian. He was concrete in the interpretation of proverbs. He denies hallucinations and delusions were not elicited. Apparently, this patient reaches the end of his rope when people on the outside tease him and he does not have the proper ammunition to fight back. This may be the cause of his suicidal attempt and his despondent behavior. Sensorium was well oriented in the three spheres, attention span was rather short, intelligence appeared to be below average and insight and judgment into his condition were nil.

COURSE IN THE HOSPITAL: Chest x-ray was essentially normal. A slight increase in hemoglobin and hematocrit were probably due to his congenital cardiopathy. He was placed on Sinequan 25 mg. b.i.d. and sent to the clinic for cardiac evaluation. Most of the time his blood pressure was within normal limits but from time to time this cleared up to 100 millimeters diastolic and another time racing up to 90. His behavior was that of being well mannered, cooperative most of the time, even helping

Patient's Last Name--First Name--Middle Name		Register No.	Ward No.
WALDO,	Larry	A-88081	Orange

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on the ward - feeding other patients who were unable to feed themselves and another time he was demanding and showed a very low frustration tolerance level at which time he became hostile and aggressive. His I.Q. was Borderline Mental Retardation, even with a Full Scale of 70.

At time of discharge the patient was not psychotic; however, his intelligence remains the same, as suspected.

FINAL DIAGNOSIS: Borderline Mental Retardation (310).

DEGREE OF IMPAIRMENT: Borderline.

PROGNOSIS: Poor.

RECOMMENDATIONS: Patient will be discharged on Sinequan 50 mg. b.i.d. and he will have followup at Henderson Clinic and by his medical doctor regarding his cardiac and blood pressure problems.

Alejandro A. Carrillo, M. D.

AAC/tcb

3/9/77

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Patient's Last Name--First Name--Middle Name	Register No.	Ward No.
WALDO, Larry	A-88081	Orange

PSYCHIATRIC EXAMINATION
February 2, 1977

IDENTIFICATION DATA: The patient is a 21-year-old, white single male, who was admitted for the first time to South Florida State Hospital on February 1, 1977 as an Involuntary admission. He has a ninth grade education, security officer by occupation and Baptist religion.

PAST PSYCHIATRIC HISTORY & REASON FOR ADMISSION: Past psychiatric history is that of having numerous admissions to Hollywood Memorial Hospital, the last time on January 13, 1977 and transferred to South Florida State Hospital.

According to the report from the police, the patient was threatening suicide by jumping off an over-pass into traffic after having a fight with his roommate. At that time a diagnosis of depressive reaction was given.

He also has a history of drinking to excess when out of the hospital. He also stated that his father has no interest in caring for him.

The background in this patient is that he had an unhappy childhood, that no-one cared for him and everything that went wrong was blamed on him. Feeling of rejection was strong in this patient since he could not do anything right and was beat up by his mother and father. His work history is that of doing odd jobs and sporadic baby sitting for his family.

From the physical point of view a scar on his chest apparently due to heart surgery when he was one year old, but he could not give the reason. First he said they had to pump blood into his heart and then said to put a tube into it. Social service will contact the mother to obtain more information about this past history, since he could be brain damage from that time or even before.

There is also a history of the patient concur with certain regularity to Memorial Hospital out patient clinic for treatment of hypertension and apparently he is receiving Hygroton 50 mg. 1 tablet daily. However on admission his blood pressure was within normal limits as well as on the second day of hospitalization.

MENTAL STATUS ON ADMISSION: From the physical point of view the patient is not in distress and he exhibits a scar on his chest from surgery. His head shows a mild degree of dolichocephalia and has a few pimples on his facial tissues. His psychomotor activities are somewhat increased and his trend of thought is that of being partially relevant due to the fact that he is a very poor historian. He was concrete in the interpretation of proverbs. He denies hallucinations and delusions were not elicited. Apparently this patient reaches the end of his rope when people on the outside tease him and he does not have the proper ammunition to fight back. This may be the cause of his despondent behavior and his suicidal attempt. Sensorium well oriented in the three spheres, attention span is rather short, intelligence appears to be below average and insight and judgment into his condition is nil.

Patient's Last Name--First Name--Middle Name	Register No.	Ward No.
WALDO, Larry A.	A-88081	Orange

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DIAGNOSTIC IMPRESSION: Mental retardation, mild (311).

RECOMMENDATION: The patient will have a consultation for his clinical problems. He will be placed on neuroleptic medication and participate in ancillary services.

Alejandro A. Carrillo, M. D.

AAC/kb
2/3/77

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Patient's Last Name--First Name--Middle Name	Register No.	Ward No.
WALDO, Lary A.	A-88081	Orange

PHYSICAL EXAMINATION

ADMISSION DATE: 2-1-77 AGE: 21

PRESENT PHYSICAL COMPLAINT: None

PAST MEDICAL HISTORY: [illegible]

GENERAL APPEARANCE: [illegible]

HEIGHT 6'7" WEIGHT 135 TEMP. 98.6 PULSE 88 RESP. 20 B/P 170/90

SKIN: No [illegible]

HEAD AND NECK: Normocephalic

EYES: PERLA

EARS: Normal Tympanic membranes

NOSE: Septum in midline

BREASTS: No nodules palpable

MOUTH: Normal

THROAT: Not injected.

CARDIOVASCULAR: [illegible] No murmurs

CHEST AND LUNGS: Bilateral [illegible] normal

ABDOMEN: Soft No [illegible]

RECTUM: No [illegible]

GENITALIA: Normal

LYMPHATICS: No lymphadenopathy

BONES, MUSCLES, JOINTS: No [illegible]

SPINE AND EXTREMITIES: No [illegible]

NEUROLOGICAL: [illegible]

DIAGNOSTIC IMPRESSION: [illegible]

SPECIAL NOTATIONS: [illegible]

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2-8-77
Date

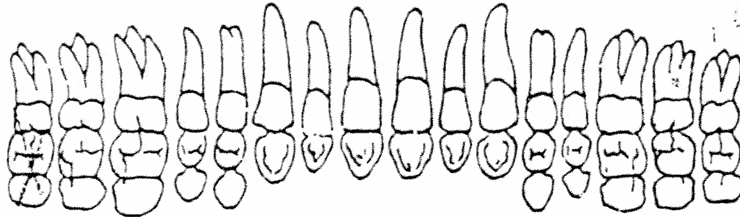
[illegible] M.D.
Doctor's Signature

Patient's Last Name	First	Middle	Register No.	Ward
[illegible]DO,	LARRY	A.	A-88081	ORANGE

South Florida State Hospital
Physical Examination - 1976

CLINICAL RECORD | **DENTAL**

1. CHART



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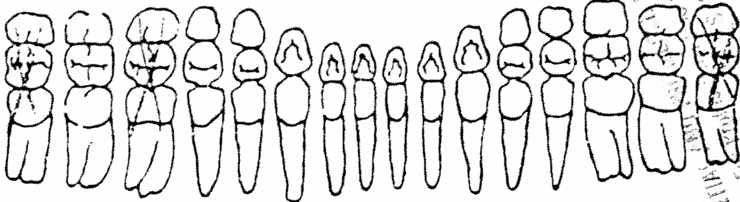
8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8



2. ROENTGENOGRAMS
☐ Periapical ☐ Bite Wings
☐ Other

3. PERIODONTOCLASIA
☑ Incipient ☐ Moderate
☐ Severe ☐ Local ☐ General

4. CALCULUS ☐ Slight
☑ Moderate ☐ Heavy

5. GINGIVAL PATHOLOGY
☑ Gingivitis
☐ Vincent's Infection
☐ Stomatitis (Specify)

6. DENTURE INDICATED (include dentures needed after indicated extractions)
☐ Full Upper ☐ Full Lower
☐ Partial Upper
☐ Partial Lower
☐ Repair

7. ABNOMALTIES OF OCCLUSION
ANGLES CLASSIFICATION
☑ I ☐ II ☐ III ☐ Normal

8. ADDITIONAL FINDINGS

9. RECOMMENDATIONS

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INVOL. ADM.

DATE	SEX	RACE	AGE	SIGNATURE OF DENTIST
7-1-77	☒ M ☐ F	W	21	

PATIENT'S LAST NAME - FIRST NAME - MIDDLE NAME	REG. NO.	WARD
WALDO, LARRY A.	A-88081	ORANGE

Dental
Std. Form D-100-65
S.F.S.H.
CH FM NO. 20

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DOCTOR | TREATMENT RECORD | DATE

DATE 2-1-77 NAME WALDO, LARRY A. (A-68081) RACE SEX W/M AGE 21 EXAM. BY

MENTAL DIAG.

PHYSICAL DIAG.

BLOOD

CONDITIONS FOUND		TREATMENT INDICATED	
TEETH MISSING	UR-8 UL-6(PE) LR-6&8 LL-8	EXTRACTIONS	NONE
RESTORATIONS PRESENT	NONE	FILLINGS	UR-NONE UL-6&7(O) LR-NONE LL-6(O)
SOFT TISSUES	INCIPIENT GING. MOD.	CR. & BR. WK.	NONE
DEPOSITS	MODERATE	REMOVABLE APPLIANCES	NONE
MASTICATING EFFICIENCY	CLASS I	PROPHYLAXIS	NONE
ABNORMALITIES		RADIOGRAPHS	NONE
REMARKS	OH-FAIR	REMARKS	NONE

TREATMENT RECORD

DATE		DOCTOR
-1-77	INVOL. ADM. (BROWAR[illegible] CO.)	JC
-10-77	ADMS. L XAMS	MS
-3-&&	DISCHARGED - INVOL.	JC

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