7-16-1954

Defendant's Exhibit 072: Sam Sheppard Bay View Hospital Records

Gervase C. Flick

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BAY VIEW HOSPITAL

CASE SUMMARY RECORD

NAME: Sheppard-Dol, Sam
SERVICE: Trauma
(Referring): C. Ellin, Foot

ADMITTING DIAGNOSIS: Concussion Cerebri

ASSOCIATED DIAGNOSES: Cerebral spinal fluid contusion

RECORD OF TREATMENT OR OPERATION:

- 7/4-4/52 6:30 A.M. Admittance
- 7/8-5/52 24:30 P.M. Discharge

- D. N. P. H. I. A. F. H. V. A. I. Flow of skull
- Cervical side injury + lumbar + sedation, and again heavy
- Cervical ice pack + spinal tap

- Code No. 9172-023

COMPLICATIONS

- Code No. 930-428

SUMMARY:

50 yrs. W. D. admitted to KH on service P. B. 7/4/52 at 6:30 P.M.

FINAL DIAGNOSIS:

- Concussion Cerebri
- General spinal cord concussion

SECONDARY DIAGNOSES

- Code No. 97022-402

SULTS:

- Recovered
- Improved
- Unimproved
- Not Treated
- In for Diagnosis Only
- Expired
- Autopsy

- I have reviewed this record and find it accurate and complete.

Signature of Intern:

Signature of Resident:

Signature of Attending Physician:
ADMITTING OFFICE RECORD

NAME OF PATIENT: Shepard-St. Lew

ADDRESS: 2892 Whitetake Rd

SOCIAL SECURITY NUMBER: Bay Village, Ohio

PREVIOUS AdMITTANCE TO THIS HOSPITAL: No

PHYSICIAN IN CHARGE: R. A. S.

AGE: --- COLOR: --- SEX: --- CITIZENSHIP: ---

MARITAL STATUS: --- DATE OF BIRTH: ---

PATIENT'S OCCUPATION: Surgeon

PERSON TO NOTIFY IN EMERGENCY: --- RELATIONSHIP: ---

ADDRESS: --- TELEPHONE: ---

NAME OF FATHER: --- MOTHER: ---

INSURANCE COMPANY: CHSA

BLUE CROSS OF: --- CONTRACT NO: 5-14-266

BILL PAID BY: Physician Surgeon

EMPLOYER: Physician Surgeon

POSITION WITH FIRM: --- ADDRESS: ---

SIGNED: --- ADMITTED BY: ---

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Bay View Hospital to release any necessary information to the above-named insurance company.

Date: 195 --- Signed: (Patient or Legal Guardian)

Shepard-St. Lew
**BAY VIEW HOSPITAL ADMISSION - PHYSICAL**

Previous Admittance to the Hospital ______ Hospitalization Company __________

In A. R. ___ Ref. Physician _____________ Physician in Charge ____________


Tr. Surg. ___ Orth. ___ C U ___ GYN. ___ CH ___ PED. ___

CC _______________________________________________________________________

ENT _______ H. & L. _______ ABD _______ SM __ E.S.P. __________

NEURO __________________________________________________________________

CD CONTACTS (Specify) __________________________________________________________________

Are ______ Immun? No ___ Yes ___ Year __ Vac? No ___ Yes ___ Year __

Special Procedure in A. R. __________________________________________________________________

A. R. Diagnosis ___________________________________________________________________

Anticipated Surgery and Treatment ___________________________________________________________________

<table>
<thead>
<tr>
<th>Ref. Phys. notified?</th>
<th>Yea</th>
<th>No</th>
<th>Ident.</th>
<th>Time</th>
<th>By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police notified?</td>
<td>Yea</td>
<td>No</td>
<td>Ident.</td>
<td>Time</td>
<td>By</td>
</tr>
<tr>
<td>Relatives?</td>
<td>Yea</td>
<td>No</td>
<td>Ident.</td>
<td>Time</td>
<td>By</td>
</tr>
<tr>
<td>Coroner?</td>
<td>Yea</td>
<td>No</td>
<td>Ident.</td>
<td>Time</td>
<td>By</td>
</tr>
<tr>
<td>Others?</td>
<td>Yea</td>
<td>No</td>
<td>Ident.</td>
<td>Time</td>
<td>By</td>
</tr>
</tbody>
</table>

**CONSENT FOR TREATMENT:** I hereby give consent for treatment including surgery and/or anesthesia as necessary by staff physicians, house doctors and nurses of Bay View Hospital. Treatment received by: 1. Myself __ 2. Son ___ 3. Daughter ___ 4. Ward __

Signature of Patient ___________________________________________________________________

Signing for Patient 1. __________________________ Relationship to pt. __________________________

2. __________________________ Relationship to pt. __________________________

Witness: 1. __________________________ Emergency 1 2 3

2. __________________________ Prog A B C D

Disposition ___________________________________________________________________

Intern __________________________ Patient's P.F. No. __________________________

Patient's Surname __________________________ First. __________________________ Middle __________________________
HOSPITAL FORM 19-W

NAME: Shipman, W. L.  
ADDRESS: 28924 Lake Rd.

NEAREST RELATIVE OR FRIEND  
ADDRESS

RELIGION: Prot.  
TELEPHONE

S.M.W.D.  
AGE: 30  
NATIONALITY:  
OCCUPATION

ATTENDING PHYSICIAN: R. A. L. S.  
ATTENDING SURGEON

DATE ADMITTED: 7-4-54  
DATE DISCHARGED: 7-8-54.

ADMITTING DIAGNOSIS: Concussion, Contusio

FINAL DIAGNOSIS: Concussion, Contusio

CONDITION ON DISCHARGE

A. Chief Complaint

Retention of Saliva  
Fairly good appetite

B. Onset and Course

6'  
1/8th

C. Past History

1. Previous Illness

2. Previous Operations

3. Previous Accidents

D. Family History

1. Father  
2. Mother  
3. Sisters  
4. Brothers

S. M. W. D.

ADDRESS

CASE No.

EXAMINATION

A. Chief Complaint

Retention of Saliva  
Fairly good appetite

B. Onset and Course

6'  
1/8th

C. Past History

1. Previous Illness

2. Previous Operations

3. Previous Accidents

D. Family History

1. Father  
2. Mother  
3. Sisters

4. Brothers
E. Gynecological
   1. Menstrual
      Distinctly normal as essentially negative by Dr. S. M.
   2. Obstetrical

F. Inventory of Systems
   1. Gastro-Intestinal
   Essentially negative
   2. Genito-Urinary
   Essentially negative
   3. Cardio-Vascular
   Essentially negative
   4. Neuro-Muscular
   Essentially negative
   5. Respiratory
   Essentially negative

A. General Appearance
   Sustained well nourished male 30 years old
   in some distress because of pain in the neck. Some
   puffiness about right eye.
   Normal symmetry
   No lacerations or bruises noted.
   Pupils = react to light. Pupils negative (Examination
   in dim light).
   No bloody discharge noted. Hearing normal.
   No alteration in shape, no bloody discharge

B. Head
   1. Skull
   2. Scalp
   3. Hair
   4. Skin
   5. Eyes
   6. Ears
   7. Nose

C. Mouth
   1. Teeth
   Some upper front teeth lost
   2. Gums
   Normal
   3. Tongue
   Not tense or deviation
   4. Tonsils
   Not infected
**D. Neck**
- Thyroid: **Impalpable**
- Lymph Glands: **Noted**

**E. Thorax**
1. Symmetry, etc.:
   - Normal symmetry

2. Breasts
   - Normal feel

3. Heart
   - Rate accelerated on admission but has since leveled off. Rhythm normal, sinus, C regularity
   - Clean in all fields

4. Lungs
   - **Flat**
   - **None noted**
   - **None complained**
   - **None noted**

**F. Abdomen**
1. Contour
   - Flat

2. Scars and Masses
   - **None noted**

3. Pain
   - **None**

4. Tenderness
   - **None**

5. Rigidity
   - **None**

6. Signs
   - **None**

**G. Genitalia**
- Normal male

**H. Extremities**
1. Reflexes
   - Babinski: **Neg**
   - Patellar: **1 on less R & L**
   - **md.**

**I. Rectal Examination**
- **nd.**

**J. Vaginal Examination**
DATE 7/1/84

Remarks:

Tentative Diagnosis
1) Multiple contusions
2) Possible cervical

Final Diagnosis

R. Carver DD
### PHYSICIANS FINDINGS AND PROGRESS RECORD

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Observation</th>
<th>Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4-54</td>
<td>6:30A</td>
<td>Pt admitted by ambulance as emergency patient due to traumatic injuries.</td>
<td></td>
</tr>
<tr>
<td>7:00A</td>
<td></td>
<td>B.P. 140/90, heart sounds full, strong, slightly irregular</td>
<td>R. Cammell</td>
</tr>
<tr>
<td>7:10A</td>
<td></td>
<td>Externals checked by Dr. Begin - negative. Pt checked for fractures, cuts,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>bruises, sprains, lacerations - none noted. Some contusions on right side,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 jaw &amp; under right eye. No other contusions noted. Pt complains of severe</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>neck pain felt in area 1 2 and 3 cervical. X-rays taken as ordered. Orders:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discontinue sternal.</td>
<td></td>
</tr>
<tr>
<td>7:50</td>
<td>140/90</td>
<td>Skull X-rays negative</td>
<td></td>
</tr>
<tr>
<td>8:00</td>
<td>100/70</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>9:00</td>
<td>136/70</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>10:00</td>
<td>120/70</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>11:00</td>
<td>120/70</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>12:00</td>
<td>124/74</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>8:10A</td>
<td></td>
<td>Shunting collar applied - Pt fairly comfortable. Baseline</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>temperature: 98.5, pressure: 120/70, level.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bilateral Rad. No abcess noted on hands, face, or body.</td>
<td></td>
</tr>
</tbody>
</table>

**Patient's Surname**  
Shepperd

**Address**  
Doctor in Charge

**Referring Doctor**  

**Age**  

**Occupation**  

---

Form 641-B
Feb 11

The lower half of the skull has new incision at base of jaw.

Two feet of muscle tissue are removed. There may be some question ofIDE.

May need muscle specialist to check in near future.

Consult Dr. Foster for next step.

Rec consult Dr. Foster.

2/15
BP 148/60

Pt's incision base of skull closed.

Dr. Foster - Call lateral views for definite conclusion of extensive edema seen at base of skull. Posteriorly, much discoloration in front cup of skull.

Call Dr. Foster next.

Cullen was replaced.

9:30

Still feeling very bad.

Examined by Dr. SA - RM.

V3 by Dr. RA.

Request O.D.

Sedative needed for H.S.

5:30PM: Outside strength & rhythm. Face still swollen.

Dr. Foster.
### PHYSICIANS FINDINGS AND PROGRESS RECORD

<table>
<thead>
<tr>
<th>Date</th>
<th>Diagnosis and Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/15/54</td>
<td>cc. Pains in both upper limbs, multiple contusions, abrasions, lacerations, high tension headache, loss of consciousness, exposure past 6-8 H.</td>
</tr>
<tr>
<td></td>
<td>Viol. Contusions, lacerations, bruises</td>
</tr>
<tr>
<td></td>
<td>Rx. Basal Skull Fracture</td>
</tr>
<tr>
<td></td>
<td>Rx. Frank Jaw Fracture</td>
</tr>
<tr>
<td></td>
<td>Rem. Demoral (H) 4-6 H for restlessness</td>
</tr>
<tr>
<td></td>
<td>Still serious but stable &amp; firm soon</td>
</tr>
<tr>
<td></td>
<td>H. S. Act and Sph. pr. is</td>
</tr>
<tr>
<td></td>
<td>Last 8 H fine mandate</td>
</tr>
<tr>
<td></td>
<td>House Order as fol.</td>
</tr>
<tr>
<td></td>
<td>Watch for fluid and intestinal dysesthesia</td>
</tr>
<tr>
<td></td>
<td>mL of change takes place</td>
</tr>
<tr>
<td></td>
<td>B.P. 74/42 for 6 Hr. to return B &amp; R</td>
</tr>
<tr>
<td></td>
<td>Pulse rate on Bp. notes</td>
</tr>
<tr>
<td></td>
<td>No visitors, other than family</td>
</tr>
</tbody>
</table>

**Physician's Signature:**

**Patient's Surname:**

**First:**

**Middle:**

**P. F. Number:**
<table>
<thead>
<tr>
<th>Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/56</td>
<td>wtht 31st not agree w/ carbol ydlt.</td>
</tr>
<tr>
<td>1/56</td>
<td>Neck Injg. A tnsion contusion was clearly</td>
</tr>
<tr>
<td></td>
<td>visible at base of neck anteriorly.</td>
</tr>
<tr>
<td>1/56</td>
<td>L&gt;R vert &amp; SUB in vital area lots trouble</td>
</tr>
<tr>
<td>3/66</td>
<td>Progress Fair</td>
</tr>
<tr>
<td></td>
<td>Dr. seems less alert &amp; somewhat confused</td>
</tr>
<tr>
<td></td>
<td>as compared to his Att.</td>
</tr>
<tr>
<td></td>
<td>Rec &amp; Extends 3 times per min.</td>
</tr>
<tr>
<td>3/66</td>
<td>Bed rest to feel better physically &amp;</td>
</tr>
<tr>
<td></td>
<td>not mentally.</td>
</tr>
<tr>
<td>4/66</td>
<td>Dr. Fitch reports that a review of x-ray</td>
</tr>
<tr>
<td></td>
<td>cervical films reveals cervical fracture</td>
</tr>
<tr>
<td></td>
<td>Dig. Fractured Cervical Vertebra.</td>
</tr>
<tr>
<td></td>
<td>Rec &amp; Cline Ortho. Coll. H. S. 0 in</td>
</tr>
<tr>
<td></td>
<td>App. &amp; order Shnte Coll. to be applied as</td>
</tr>
<tr>
<td></td>
<td>Soon as possible</td>
</tr>
<tr>
<td>1/66</td>
<td>Progress Fair</td>
</tr>
<tr>
<td>1/66</td>
<td>HTT 70</td>
</tr>
</tbody>
</table>

Form 641-B
1/4/54
Progress Fair.

    o. Films of Fractured Bones: 1. special
    attention to Zappings (+) + x-ray ort.

Postural

Rin. Fair

1/7/54
3:00 p.m.
Progress Fair. Pt. seems a little improved
Pulse regular & strong.

1/7/54
3:30 a.m. Of sleeping quietly.

1:30 p.m. De all recurring

Discharge 3:40 p.m. to home in proper state
     Final diagnosis: Cerebral concussion + confusion -
     a) Cerebral Edema -
     b) Maxillary Fracture of cheek.
     c) Dislocation all teeth in right upper jaw - Two 6’s teeth chipped in this area -
     d) Confusion of Spinal cord -
     e) Multiple Cerebral absorption

Upper lip in Superior alveolar

Face & head of 6th eye -

Postural

10:10 a.m. No motoric change in 2nd C. in frontal Dr. - mild to slight
<table>
<thead>
<tr>
<th>Date</th>
<th>PHYSICIANS FINDINGS AND PROGRESS RECORD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/15/54</td>
<td>Pt brisk + in us groin</td>
</tr>
<tr>
<td></td>
<td>Refer Dir as above</td>
</tr>
</tbody>
</table>

---

**Patient's Surname**  |  **First**  |  **Middle**  |  **P. F. Number**
14/1/64 6:30 a.m. Called to home of Pt. a W/H, W/H, W/H
that appears to be about 31 yrs. of age, around
of home at about 6:15 a.m. Pt. was seen lying
on his side in front room on floor being
examined by the SA: Sheppard. Pt. talked in
slightly confused manner. SA's. mentions
possibility of brain concussion. Pt. taken
to Bay View Hospital by Dr. A. Sheppard
in his station wagon accompanied by H. Carter & Betty Sheppard.
Bay Village Police & Police Ambulance come to the home. Pt. complains
Pain in neck type upper cervical region. No abrasions noted on body.
However, slight swelling of left side noted. Pt. reports he had a fight in the
dark to unknown accident & only remembers coming to consciousness in
the water. Eye grounds clear, pupils equal & react to light & motion.
Pt. reflexes normal limits Pt. 1930 R: 24 P: 82
chest clear (At received demand 100 mg. Hycl SAS). Should receive ice
slices AP of chest & Pelvis ordered & an x-ray
exam as fracture noted. Shuntly Collar kept
on neck of Pt. & Pt. put back to bed
in room 25. All orders on order sheet.

7 A.M.

Prompt recall of felt to go under neck of Pt. at
his request. Pt. said it was not known.

---
1:50 AM: Complains - full anodyne completely worn - today in place.

[Signature]
REPORT OF CONSULTATION

Name: [Redacted]

Findings:
1. Marked swelling + Erythema of Right Eye - + orbital tissue extending over entire right side of face. A contusion is noted on left side of neck, anterior.
2. Marked edema, sub-acutely.

Diagnosis:
1. Contusion of Eye + orbital edema
2. Probable fracture of maxillary - (Molar + Zygoma
3. Contusion of left side of neck
4. If sub-acutely.

Recommendations:
1. Intermittent Hot & Cold Packs or Ice bag to face
2. X-Ray of Facial Bones - Zygoma

Date of consultation: 2:50 P.M.

Signature of Consultant: [Redacted]

M.D.
REPORT OF CONSULTATION

Date: ___________________________  M.D.

Findings:

Mr. Sam is alert and answers questions quickly. There is swelling of right periodontal tissue. Radii are equal and read. Moves all extremities well. No Babinski's. He has a worded complaint of occipital headache.

Cervical collar in place, neck not examined.

Imp. Cerebral concussion

Advice: Augo fluid Sedation

C.W. Ehrin

Date of consultation: ___________________________
REPORT OF CONSULTATION

Findings:

July 6 1954

Of complaint of urgency or
incontinence this morning when
attempting to pass gas caused
his chest and fecal material.

He has also complained of
numbness over visual distribution of
right (one) eye.

Exam today:

Eyes:
- EOM normal
- No facial weakness
- Improved visual equal to reach.

Sensory:
- Sensory distribution left
- Moderate weakness of interossei left
- Left triceps reflex not obtained
- Both triceps reflexes present as is
right triceps reflex
- Right abdominal reflexes active
- Left abdominal reflexes absent

Recommendations:

Date of consultation: ____________________________ M. D.

Signature of Consultant
Neither cremasteric reflex obtained.
Knee jerks active x equal.
Babinski normal.
Cervical x-rays show
chip fracture spinous process C2
L.P done this morning demonstrates
clear fluid with normal pressure
(150 mm of spinal fluid) and
normal dynamics.

Local examination of neck
discloses tenderness over spinous
process of C2 & spasmodic
contractions of cervical muscles to
pressure.

Imp. cervical spinal cord
Spinal fluid
+ for cells
Low total protein

C.W.E.

C.W. Edlin, M.D.
LABORATORY REPORTS

LABORATORY REQUISITION
LUTHERAN HOSPITAL, Cleveland, Ohio

- staff
- private
- outside
- not admitted

Name: Samuel Shepard
Age: [Missing]
Sex: [Missing]
Hgt: [Missing]
Wgt: [Missing]

Clinical Data; Diagnosis

Spinal Fluid (10cc)

EXAMINATION REQUESTED: (Please be specific)

Cell Count: 1 crenated red blood cell
Total Protein: 25 mg per 100 cc
Spinal fluid clear, colorless.

Date: July 6, 1959
Requested by: [Signature]

WPC 66M 6-46 NOPA

Name: SHEPPARD DR. SAM
Doctor: R.A. SHEPPARD

Color: Lt. YELLOW
Character: CLEAR
Reaction: 6.5

S. G.: 1.023
R.B.C.: [Missing]
W.B.C.: [Missing]

Albumen: YEG
Sugar: U.C.
Acetone: [Missing]
Bile: [Missing]

Other Tests: [Missing]

Date: 7/6/59
Technician: E.L.

URINALYSIS

STD. FORM 751-A SANGE. S.F.
Diagnostic
X-RAY REPORT

PATIENT Sheppard, Dr. Sam
P. F. No. Age 30, Weight 180

REFERRING DOCTOR Dr. R. A. Sheppard/Dr. S. A. Sheppard/
                     Dr. R. N. Sheppard
PARTS EXAMINED Skull, cervical spine, ribs, pelvis

X-RAY NO. 54-5560
DATE 7/4/54

CONSULTANT
HOSPITALIZED Yes
INDUSTRIAL Yes

FINDINGS:

Paranasal sinuses: there is no evidence of extravasation of blood into the maxillary
sinuses. The orbital shadows give negative findings. The right 3/4 of the
frontal sinuses show either thickened membrane or extravasation of fluid; this
should be checked later. The nasal septum shows a large spur on the right;
also, some deflection to the right. The mandible shows no evidence of
fracture in this film.

Left lateral skull: the inner and outer tables are normal. The convolutional
markings, vessel markings, and suture markings give normal appearance.
Sella turcica and sphenoids are normal. The nasal bone shows no evidence
of fracture.

Right lateral skull gives negative findings.

Anterior vault gives no evidence of fracture. The mandible gives a negative appear-
ance. This shows very plainly the deflection of the septum to the right.

Posterior vault gives negative findings.

Film of the ethmoids and maxillaries, shows negative findings. The nasal septum
shows a very deep deflection and a large spur, to the right.

Lateral neck: there is a chip fracture in the infero-posterior margin of the
2nd cervical vertebral spinous process. There is rather marked hypertrophic
change at C5-6; as a matter of fact, there is bridging between these
vertebral bodies. Soft structures in the anterior neck are negative.

Open mouth film of the atlas-axis shows normal relationships. No evidence of
fracture.

The anterior view of the cervical spine and cervico-dorsal junction: no evidence
of fracture. The neck tilts to the right.

Film of the ribs: this film shows AP projection of the lower cervical and dorsal
bodies; also, the rib cage. I see no evidence of fracture. Both clavicles
give a normal appearance.

(continued on page 2)
AP pelvis: no evidence of fracture in the upper femurs or pelvis.
CLEVELAND OSTEOPATHIC HOSPITAL
BAY VIEW HOSPITAL

Diagnostic
X-RAY REPORT

PATIENT
Sheppard, Dr. Sam
Age 30, Weight 180

P. F. No.

REFERRING DOCTOR
Dr. R. N. Sheppard/Dr. S. A. Sheppard/
Dr. R. A. Sheppard

PARTS EXAMINED
Lateral cervical, Water's sinuses,
standing lumbar.

X-RAY NO. 54-5560
DATE 7/7/54

CONSULTANT

HOSPITALIZED Yes

INDUSTRIAL Yes No

FINDINGS:

Paranasal sinuses: maxillaries essentially normal. I see no fracture in the malar bone or zygoma. The right 3/4 of the frontal sinuses slightly dull as compared with the left. No evidence of fracture of the right or left orbit.

Lateral neck, patient erect, cone-down at 72" distance: there is evident white streaking through the film, which detracts from its value. This film does not show finding interpreted on a previous film as a chip fracture of the spinous process of C2. There is a white streak running through the film in this area.

Collar removed. Patient's neck cleaned with alcohol. Second 72" film of the lateral neck, patient erect, was taken. This film does not show the finding previously interpreted as a chip fracture.

Standing lumbar spine and pelvis, AP position: there is no evidence of intrinsic bone disease, fracture or dislocation. The pelvic base levels, the lumbar spine is straight.

Lateral lumbar spine: no evidence of intrinsic bone disease, fracture, or dislocation.

7/8/54
GCF'er (5)

G. C. FLICK, D.O.
<table>
<thead>
<tr>
<th>Date Begun</th>
<th>Date Discont.</th>
<th>Medication</th>
<th>Date Begun</th>
<th>Date Discont.</th>
<th>Diet and Other Treatment</th>
</tr>
</thead>
</table>
| 1-4-54    |               | 1. Bed patient |               |               | R. CARRASCO ...
<p>|           |               | 2. M.B.M. till ordered |               |               | Acquiesce      |
| 6:30 A    |               | 3. Lab work |               |               |                          |
|           |               | 4. Skull series, carotid series, chest X-ray, pelvis |               |               |                          |
|           |               | 5. Warm water bottles about pt. |               |               |                          |
| 7:00 A    |               | 1. Dexam 100 mg q 4 h. pm constres |               |               |                          |
|           |               | 2. ASA q x 2 pm constres and part q 8 h. tabs q 4 h. pm constres |               |               |                          |
|           |               | 3. House diet as tolerated |               |               |                          |
|           |               | 4. Watch for lucid intervals. Notify Dr. SAS if change taken place |               |               |                          |
|           |               | 5. BP q h x 6, record B.P. and pulse on progress notes |               |               |                          |
|           |               | 6. No VISITORS other than family |               |               |                          |
| 10:00 A   |               | 1. Ice cold pack to right side of face. |               |               |                          |
| 10:30 P.M. |               | M. S. 7/21(4) 10:30 P.M |               |               |                          |
| 7/5/54    |               | 1. NO ONE other than immediate family to be admitted to see pt. |       |               |                          |
|           |               | 2. Estab. gauze packs + dextrose         |               |               |                          |
| 7/5/54    |               | 3. Encour. patient in amn. (Order from C clinging) |               |               |                          |
|           |               | 4. Prescribed pastes (a) at l.r.       |               |               |                          |</p>
<table>
<thead>
<tr>
<th>Date Begun</th>
<th>Date Discont.</th>
<th>Medication</th>
<th>Date Begun</th>
<th>Date Discont.</th>
<th>Diet and Other Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/6/54</td>
<td></td>
<td>Methylprednisolone</td>
<td>0/05</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7/7/54</td>
<td></td>
<td></td>
<td>0/06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7/8/54</td>
<td></td>
<td></td>
<td>0/07</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: The entries are handwritten and partially legible.
**NURSE'S RECORD**

<table>
<thead>
<tr>
<th>Date</th>
<th>Temp</th>
<th>Pulse</th>
<th>Respiration</th>
<th>Medicine</th>
<th>Nourishment</th>
<th>Notes on Medication, Condition of Patient, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday 5/8/59</td>
<td>37°</td>
<td>97</td>
<td>14</td>
<td></td>
<td></td>
<td>Sleeping, Restless @ times</td>
</tr>
<tr>
<td>3/8/59</td>
<td>97</td>
<td>74</td>
<td>18</td>
<td></td>
<td></td>
<td>Good night, S. T. K. S. S. S. S. S.</td>
</tr>
<tr>
<td>Med</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Routine on case.</td>
</tr>
<tr>
<td>2/1/59</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Discharged in wheelchair, Improv.</td>
</tr>
<tr>
<td>Name of Patient</td>
<td>Sheppard, Dr. Sam.</td>
<td>Case No.</td>
<td>70965</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------</td>
<td>---------</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NURSE'S RECORD</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DATE AND HOUR</strong></td>
<td><strong>TEMP.</strong></td>
<td><strong>PULSE</strong></td>
<td><strong>RESP.</strong></td>
<td><strong>MEDICINE</strong></td>
<td><strong>NOURISHMENT</strong></td>
<td><strong>NOTES ON MEDICATION, CONDITION OF PATIENT, ETC.</strong></td>
</tr>
<tr>
<td>Sunday 7/4/54</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Adm. to room vic. East</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Warm Water Gas Fire applied</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>To X-ray</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>From X-ray 10.00</td>
</tr>
<tr>
<td>7:00</td>
<td>72 18</td>
<td>81 128/70</td>
<td></td>
<td>Doe poor to 1st exp.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00</td>
<td>84 18</td>
<td>81 138/80</td>
<td></td>
<td></td>
<td></td>
<td>PRONTZ COLLAR applied</td>
</tr>
<tr>
<td>11:00</td>
<td>85</td>
<td>127/6</td>
<td></td>
<td>O Jt 2.00 er Tumor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:00</td>
<td>127/6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Condition Satisfactory</td>
</tr>
<tr>
<td>2:00</td>
<td>B/P 148/80</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Resting for well</td>
</tr>
<tr>
<td>5.00</td>
<td>77.5</td>
<td>95/65</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Monday 7/5/54**
- Sleeping
- Regist. x 3
- Sleeping A.M. very well
- Became up by Dr. R.A.S. 8:00
- Taking fluids for well
- Exhusted from winters
- Resting for well
- BRUNO

- Orange juice

- Urine Spec. Saved

- Quiet
- Ambulatory Satisfactory

**Tuesday 7/6/54**
- Urine
- E. WETTS
### Nurse's Record

**Name of Patient:** Sheppard and Stans

**Case No.:** B10965

<table>
<thead>
<tr>
<th>Time</th>
<th>Temp.</th>
<th>Pulse</th>
<th>Resp.</th>
<th>Medicine</th>
<th>Nourishment</th>
<th>Notes on Medication, Condition of Patient, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:45</td>
<td>98.5</td>
<td>88</td>
<td>13</td>
<td>Reg. diet</td>
<td></td>
<td>Routine am care</td>
</tr>
<tr>
<td>8:00</td>
<td>98.5</td>
<td>88</td>
<td>13</td>
<td>Reg. diet</td>
<td></td>
<td>Reg. diet</td>
</tr>
<tr>
<td>8:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>H. S. Case</td>
</tr>
<tr>
<td>8:45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Fruit juice</td>
</tr>
<tr>
<td>9:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Back rub refused</td>
</tr>
<tr>
<td>11:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mt. seems very</td>
</tr>
<tr>
<td>11:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Nebulized 9:15</td>
</tr>
<tr>
<td>12:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Wm. 7/7/54</td>
</tr>
<tr>
<td>12:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Appears Exhausted Sleep.</td>
</tr>
<tr>
<td>1:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Seems restless</td>
</tr>
<tr>
<td>8:00</td>
<td>98</td>
<td>80</td>
<td>13</td>
<td>Reg. diet</td>
<td></td>
<td>Refused bathjet</td>
</tr>
<tr>
<td>10:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Routine am care</td>
</tr>
<tr>
<td>12:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Leave of absence from hospital.</td>
</tr>
<tr>
<td>4:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Returned to hospital.</td>
</tr>
<tr>
<td>4:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>40 mg. of ice</td>
</tr>
<tr>
<td>8:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Washed by Dr. RAS, Dr. RMS</td>
</tr>
<tr>
<td>8:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dr. RMS</td>
</tr>
<tr>
<td>10:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Orange Juice</td>
</tr>
<tr>
<td>11:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Alcohol back rub</td>
</tr>
</tbody>
</table>

**Physician:** M. Herridge
<table>
<thead>
<tr>
<th>BAY VIEW HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>X-RAY REQUISITION</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>X-RAY NO.</th>
<th>In Patient</th>
<th>DATE</th>
<th>7-4-54</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out Patient</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Has the patient ever been x-rayed in this hospital (or C.O.H.) before?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Industrial</td>
</tr>
<tr>
<td>C. H. S. A.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLEASE PRINT</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT'S NAME:</td>
</tr>
<tr>
<td>(Last)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADDRESS:</th>
<th>18724 Lake Rd. Bay Village</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>TELEPHONE NO:</th>
<th>TR-1-4434</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MODE OF TRANSPORTATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMBULATORY</td>
</tr>
<tr>
<td>(Circle one of the above)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>X-RAY EXAMINATION OF (specific areas):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest X-Ray, Shoulder series</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PERTINENT HISTORY, PHYSICAL FINDINGS, AND PROVISIONAL, OR CLINICAL DIAGNOSIS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traumatic injuries</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SIGNATURES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR IN CHARGE:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONSULTANT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>R. Cameron</td>
</tr>
</tbody>
</table>
BAY VIEW HOSPITAL

X-RAY REQUISITION

X-RAY NO. _______ In Patient _______ DATE 2/1/54

Out Patient _______ P. F. NO. _______

Has the patient ever been x-rayed in this hospital (or C.O.H.) before? [ ]

Industrial _______ ROOM NO. 1189

C. H. S. A. _______ WEIGHT: _______

PLEASE PRINT

PATIENT'S NAME: [ ]

(First) (Middle)

(Last)

ADDRESS: ____________________________________________ TELEPHONE NO.: _______

MODE OF TRANSPORTATION: [ ] Ambulatory [ ] Wheel Chair [ ] Cart [ ] Bed (Portable Unit)

(Circle one of the above) [ ] Stretcher

X-RAY EXAMINATION OF (specific area): [ ] Upright [ ] Lateral [ ] Supine [ ] Oblique

LATERAL Views: [ ] thoraco [ ] lumbo [ ] scoliosis [ ] pubic

SENTIMENT HISTORY, PHYSICAL FINDINGS, AND PROVISIONAL, OR CLINICAL DIAGNOSIS:

R. O. Freeth

SIGNATURE: [ ]

INTER: [ ]

CONSULTANT:

DOCTOR IN CHARGE: _______
Sheppard, Dr. Sam
Age 30, Weight 180
Dr. R. A. Sheppard/Dr. S. A. Sheppard/
Dr. R. N. Sheppard
Skull, cervical spine, ribs, pelvis

Paranasal sinuses: there is no evidence of extravasation of blood into the maxillary sinuses. The orbital shadows give negative findings. The right 3/4 of the frontal sinuses show either thickened membrane or extravasation of fluid; this should be checked later. The nasal septum shows a large spur on the right; also, some deflection to the right. The mandible shows no evidence of fracture in this film.

Left lateral skull: The inner and outer tables are normal. The convolutional markings, vessel markings, and suture markings give normal appearance. Sella turcica and sphenoids are normal. The nasal bone shows no evidence of fracture.

Right lateral skull gives negative findings.

Anterior vault gives no evidence of fracture. The mandible gives a negative appearance. This shows very plainly the deflection of the septum to the right.

Posterior vault gives negative findings.

Film of the ethmoids and maxillaries shows negative findings. The nasal septum shows a very deep deflection and a large spur, to the right.

Lateral neck: there is a chip fracture in the infero-posterior margin of the 2nd cervical vertebral spinous process. There is rather marked hypertrophic change at C5-6; as a matter of fact, there is bridging between these vertebral bodies. Soft structures in the anterior neck are negative.

Open mouth film of the atlas-axis shows normal relationships. No evidence of fracture.

The anterior view of the cervical spine and cervico-dorsal junction: no evidence of fracture. The neck tilts to the right.

Film of the ribs: this film shows AP projection of the lower cervical and dorsal bodies; also, the rib cage. I see no evidence of fracture. Both clavicles give a normal appearance.

(continued on page 2)
AP pelvis: no evidence of fracture in the upper femurs or pelvis.
Paranasal sinuses: maxillaries essentially normal. I see no fracture in the malar bone or zygoma. The right 3/4 of the frontal sinuses slightly dull as compared with the left. No evidence of fracture of the right or left orbit.

Lateral neck: patient erect, come-down at 72" distance: there is evident white streaking through the film, which detracts from its value. This film does not show finding interpreted on a previous film as a chip fracture of the spinous process of C2. There is a white streak running through the film in this area.

Collar removed. Patient's neck cleaned with alcohol. Second 72" film of the lateral neck, patient erect, was taken. This film does not show the finding previously interpreted as a chip fracture.

Standing Lumbar spine and pelvis, AP position: there is no evidence of intrinsic bone disease, fracture of dislocation. The pelvic base levels, the lumbar spine is straight.

Lateral lumbar spine: No evidence of intrinsic bone disease, fracture, or dislocation.

G. C. FLICK, D.O.

7/8/54
GCF/er (5) The date 7/7/54 should read 7/6/54.

G. C. FLICK, D.O.