FBC Note: The following is the receipt and diagnoses from Byron Case's doctor visit on 6/6/01, the day following his late-night recorded telephone conversation with the state's witness, which was admitted into evidence as a "tacit admission" of guilt. Horton Lance, Byron's public defender, submitted this document into evidence without an explanation as to its relevance.

THE UNIVERSITY OF KANSAS MEDICAL CENTER
3901 RAINBOW BOULEVARD • KANSAS CITY, KANSAS

HISTORY, PHYSICAL EXAMINATION AND PROGRESS NOTES

PATIENT NAME: Byron Case
DATE OF VISIT: 6/6/01
MR#: 9414066
DOB: 11/23/78

ACUTE CARE VISIT

CHIEF COMPLAINT: Sore throat and fever.

SUBJECTIVE: Patient is a 22-year-old white male with a five to six day history of sore throat, fever, nasal congestion, nausea, dizziness, some ear pain, shaking, chills, and occasional emesis.

ALLERGIES: NKDA.

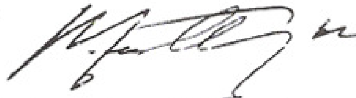
CURRENT MEDICATIONS: None.

PHYSICAL EXAM:
VITAL SIGNS: Temp of 38.4°; BP of 115/69; pulse, 80.
GENERAL: Well-developed, well-nourished in no acute distress.
HEENT: TM's appear within normal limits. Oral pharynx is extremely erythematous with petechia covering his soft palate and exudate on tonsils bilaterally. Evidence of some posterior pharyngeal cobblestoning.
NECK: Mild adenopathy in his anterior cervical chain.
LUNGS: Clear to auscultation bilaterally.
HEART: RRR.

ASSESSMENT:
1. Strep pharyngitis.

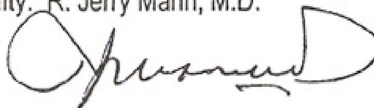
PLAN: Supportive care of fluids and Tylenol along with Pen-Vee K 500 mg PO t.i.d. for approximately 10 days. Patient is to follow up on a prn basis.

Examiner: Merrill Stanley, M.D.



I have reviewed this case with Dr. Stanley and agree with the above evaluation and plan.

Faculty: R. Jerry Mann, M.D.



DEPARTMENT OF FAMILY PRACTICE