Please list **PROBLEMS** you would like evaluated today in order of significance:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever been diagnosed with**? (select all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| * Asthma | * Seasonal/ Food Allergies | * High Blood Pressure | * Heart Murmur |
| * Cataracts | * Glaucoma | * Seizure/ Epilepsy | * Lung Disease/COPD |
| * Stroke | * Heart Disease | * Heart Attack | * Liver Disease |
| * Ulcers/ GERD | * Digestive Disorder | * Kidney Disease | * Kidney Stone |
| * Diabetes/Pre-Diabetes | * Hypo/ Hyperthyroidism | * Depression | * Anxiety |
| * Anemia | * Bleeding Disorder | * Bone/ Joint disease | * Osteoporosis |
| * High Cholesterol | * Frequent Infections | * Cancer (type)\_\_\_\_\_\_\_\_\_ | * Prostate Enlargement |
| * HIV/ Hepatitis C | * STD (type)\_\_\_\_\_\_\_\_\_\_\_ | * Mental Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

**PAST MEDICAL HISTORY**

Please describe and give dates of chronic illnesses and surgeries:

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE LIST ANY SPECIALIST THAT YOU CURRENTLY SEE**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMMUNIZATIONS**

Hepatitis B □ Yes □ No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hepatitis A □ Yes □ No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tetanus shot □ Yes □ No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Influenza (flu) □ Yes □ No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumonia Shot □ Yes □ No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Shingles Shot? □ Yes □ No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shingles Outbreak? □ Yes □ No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a test for Tuberculosis? if yes (select): □ Positive □ Negative Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

How was your Positive Tuberculosis diagnosed: Skin Prick/Blood Test/Chest X-ray?

Have you ever had a blood transfusion? if yes: Date(s): \_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY CONTINUED:**

|  |  |  |
| --- | --- | --- |
| **Is there any family history of?** | **Type or Age of onset** | **Relation to you** |
| **Cancer** |  |  |
| **Heart Attack** |  |  |
| **Stroke** |  |  |
| **Mental Illness** |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **FAMILY HISTORY** | **Living/Deceased** | **Cause & Age of Death** | **Medical Conditions** |
| MOTHER |  |  |  |
| FATHER |  |  |  |
| SISTER (S) |  |  |  |
| BROTHER (S) |  |  |  |
| DAUGHTER (S) |  |  |  |
| SON (S) |  |  |  |
| MATERNAL GRANDMOTHER |  |  |  |
| MATERNAL GRANDFATHER |  |  |  |
| PATERNAL GRANDMOTHER |  |  |  |
| PATERNAL GRANDFATHER |  |  |  |

**SOCIAL HISTORY**

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Your Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # Boys\_\_\_\_\_\_\_\_\_ # Girls\_\_\_\_\_\_\_\_\_# of People in Household: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Currently Live With: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gender Identity** □Male □Female □Female to Male □Male to Female

**Sexual Orientation:** □Lesbian/Gay □Straight □Bi-sexual □Don’t know

**Sexual Activity: □** Monogamous Relationship □ Not sexually active □ Multiple partners □ Does not practice “safe” sex

Are you an **ORGAN DONOR?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recent **Significant Changes** in Your Life? □Yes □No If yes, Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Financial Hardships? □Yes □No Have Special Stresses in Your Life? □Yes □No

I am **NOT** happy with (select those that apply) □Myself □My Health □My Work □My Partner □My Life

**SOCIAL HISTORY CONTINUED**

Do you feel safe in your current relationships? (family, friends, significant other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a Living Will or Advanced Directive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise regularly? □Yes □No Type of exercise and frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you happy with your weight? □Yes □No How many meals/snacks do you eat per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many meals do you eat out/carry out per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any nutrition or diet concerns you would like help with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are on a special diet? If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have regular Dental check-ups? □Yes □No How often do you brush/floss per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last Eye exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear your seatbelt? □ Always □ Sometimes □ Never

Do you ride a motorcycle? □ Y □ N Bicycle? □ Y □ N Ski/Snowboard? □ Y □ N Skateboard? □ Y □ N

If yes, do you wear a helmet? □ Y □ N

Have you fallen in the last 6 months? If so, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been exposed to any Toxic Substances, such as asbestos, DES, radiation, chemicals? □ Yes □ No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a smoke detector in the home: □ Y □ N When was it last checked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List the amount **PER DAY** of beverages you regularly consume:

Coffee/Tea: \_\_\_\_\_\_\_ Beer: \_\_\_\_\_\_\_\_ Wine: \_\_\_\_\_\_\_\_\_ Hard liquor: \_\_\_\_\_\_\_\_ Soda: \_\_\_\_\_\_\_\_\_\_ Water: \_\_\_\_\_\_\_\_\_\_\_\_

I drink alcohol: □ Currently □ Occasionally □ Never □ Socially

Have you ever used illicit drugs: □Yes □No If so, last date and which drug(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| **History Form** | | | | | | | | | | | | | | **Provider Comments** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REVIEW OF SYSTEMS**:  Select those items you **currently** have significant problems with. | | | | | | | | | | | | | |  |
| **GENERAL** | | | | | | | | | | | | | |  |
| □Recent Weight Change | | | □Increased Thirst or Urination | | | | | | | □Night Sweats/Hot Flashes | | | |  |
| □Always Hot/Always Cold | | | □Rashes or Skin Problems | | | | | | | □Significant Fatigue | | | |  |
| Do you have chronic pain problems? □Yes □No | | | | | | | | | | | | | |  |
| **BREASTS: Men & Women** | | | | | | | | | | | | | |  |
| □Lumps/Tenderness | | | | | | Do You Do Monthly Self Breast Exams? □Y □N | | | | | | | |  |
| □Drainage from nipples | | | | | | Month and Year of Last Mammogram: \_\_\_\_\_\_\_\_\_\_ | | | | | | | |  |
| **EYE, EAR, NOSE, AND THROAT** | | | | | | | | | | | | | |  |
| □Glaucoma | □Blurred or Double Vision- Ever | | | | | | | □Use Glasses or Contact Lenses | | | | | |  |
| □Hearing Loss | □Brief Loss of Vision- Ever | | | | | | | □Use Dentures (Partial or Total) | | | | | |  |
| □History of Radiation Therapy to Head or Neck | | | | | | | | □Teeth or Gum Problems | | | | | |  |
| **CARDIOPULMONARY** | | | | | | | | | | | | | |  |
| □Shortness of Breath with Activity | | | | | | | □Dizziness | | | | | | □Chest Pain |  |
| □Daily Sputum (Phlegm) Production | | | | | | | □Coughing Up Blood | | | | | | □Heart Palpitations |  |
| □Difficulty Breathing While Lying Flat | | | | | | | □Leg Cramps While Walking | | | | | | □Wheezing |  |
| □Waking Up Short of Breath | | | | | | | □Daily Cough | | | | | | □Ankle Swelling |  |
| **GASTROINTESTINAL** | | | | | | | | | | | | | |  |
| □Change of Appetite | | □Abdominal Pain | | | | | | | □Blood in Stool/Black Stool | | | | |  |
| □Difficulty Swallowing | | □Diarrhea/Constipation | | | | | | | □Frequent Nausea/Vomiting | | | | |  |
| □Heartburn | | □Indigestion from Fatty Foods | | | | | | |  | | | | |  |
| **NEUROPSYCHIATRIC** | | | | | | | | | | | | | |  |
| □Frequent Disabling Headaches | | | | | □Difficulty Sleeping | | | | | | | □Tremors | |  |
| □Frequent Anxiety or Anxiety Attacks | | | | | □Memory Loss | | | | | | | □Passing Out/Fainting | |  |
| Treated in Past for Emotional or Psychological Problems: please describe \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | □Often Feel Sad or Depressed | |  |
| **MUSCULOSKELETAL & SKIN** | | | | | | | | | | | | | |  |
| □Frequent Neck or Back Pain | | | | □Muscle Pain | | | | | | | □Disabling Night Leg Cramps | | |  |
| □Joint Problems | | | | □Use a Brace or a Splint | | | | | | |  | | |  |
| Mole that has changed color, size, shape, or won’t heal? □Yes □No | | | | | | | | | | | | | |  |
| **GENITOURINARY: MEN & WOMEN** | | | | | | | | | | | | | |  |
| □Urinary Tract Infections | | | | | | □Sores in the Genital Area | | | | | | | |  |
| □Difficult or Painful Urination | | | | | | □Blood in Urine | | | | | | | |  |
| □History of Kidney or Bladder Stones | | | | | | □Urination More Than Once a Night | | | | | | | |  |
| □History of Four or More Sex Partners | | | | | | □Sexual Intercourse Before 18 years old | | | | | | | |  |
| Method of Birth Control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  | | | | | | | |  |
| Have you ever had any Sexually Transmitted Disease: □Yes □ No  if yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |  |
| **GENITOURINARY: MEN ONLY** | | | | | | | | | | | | | |  |
| Pain or Lump in Testicles/Scrotum  □Yes □No | | | | | | Do you do Self Testicular Exam: □Yes □No  Have you had a PSA: □Yes □No | | | | | | | |  |
| **GENITOURINARY: WOMEN ONLY** | | | | | | | | | | | | | |  |
| Age of first Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Frequency/Length of Menstrual Periods: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  |
| Date of Last Menstrual Period: \_\_\_\_\_\_\_\_ | | | | | | Change in Menstrual Pattern □Y □N | | | | | | | |  |
| Number of Pregnancies: \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Number of Children: \_\_\_\_\_\_\_\_ | | | | | | | |  |
| Disabling Menstrual Cramps □Y □N | | | | | | Unusual Vaginal Discharge/Itching □Y □N | | | | | | | |  |
| Date of Last Pap Smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Date of last Mammogram\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  |
| History of Abnormal Pap Smear: □Y □N | | | | | | Any Treatments for Abnormal Pap: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |  |

**Medication List**

Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OTHER ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(such as penicillin) (such as bees/wasps, foods, latex etc.)

**What happens when you take that medication:** **What happens when you are exposed:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| Name of Medication | Dosage | How often you take the Medication |
| 1.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 5.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 6.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 7.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 8.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 9.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 10.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 11.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 12.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 13.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 14.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 15.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 16.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 17.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 18.) |  |  |