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 □ Noif yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **GENITOURINARY: MEN ONLY** |  |
| Pain or Lump in Testicles/Scrotum□Yes □No | Do you do Self Testicular Exam: □Yes □NoHave 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.) |  |  |