**Medical/Vision History Questionnaire Hudson Valley Eye Doctor**

Last First Today’s Date

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Eye Exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Eye Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What Brings you in today??\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear glasses [ ] NO [ ] YES If yes, how old is your present pair of glasses?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contact lenses [ ] NO [ ] YES How old is the pair of lenses you are wearing today?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of contact lenses: [ ]Ridgid [ ] Soft [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are they comfortable [ ] NO [ ] YES

What type/brand of contact lens disinfection system do you use?

**VISION EXAM** Without Glasses or Contact lenses With Glasses With Contact Lenses

How is your vision? Clear / Not Clear Clear / Not Clear Clear / Not Clear

Distance Vision Clear / Not Clear Clear / Not Clear Clear / Not Clear\_\_\_\_\_

Near Vision Clear / Not Clear Clear / Not Clear Clear / Not Clear

Computer,phone,tablet Clear / Not Clear Clear / Not Clear Clear / Not Clear\_\_\_\_\_

**Refraction is the determination of your eyeglass prescription. This may be covered under your vision benefit for a Routine Eye Care. If you are here for an eye health issue and you will be using your medical insurance, and want glasses or a fitting for contact lenses, there will be a charge.**

***If you have any of symptoms below, they require a medical visit and will be billed to your medical coverage. Evaluation and treatment are not routine and are not covered under your routine vision benefit. Treatment and care,* *follow-up visits may be necessary. You will be responsible for any co-pays or deductibles.\_***

**Do you have problems with the following areas? If yes, please provide information.**

Loss of Vision NO YES Excessive Tearing NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blurred Vision NO YES Glare/light sensitivity NO YES \_\_\_

Distorted vision NO YES Eye pain or soreness NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Double Vision NO YES Infection of eye or lid NO YES \_\_\_\_\_\_\_\_\_\_\_\_\_

Mucous discharge NO YES Tired Eyes NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Redness NO YES Crossed eyes, lazy eye NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sandy or gritty NO YES Drooping Eyelid NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_

Itching NO YES Flashes/Floaters NO YES \_\_\_\_\_\_\_\_\_\_\_\_\_

Burning NO YES Other NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Foreign body

Sensation NO YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*OVER\*\*\*

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medial History:**

**Last Medical Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Care Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have any Allergies or Allergies to Medication [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Diabetes [ ] NO [ ] YES TYPE 1 (Insulin dependent) TYPE 2 (Non-Insulin dependent) Years Diabetic\_\_\_\_\_\_\_\_\_\_\_**

**Last Blood Sugar:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_A1C\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Diabetes is a medical diagnosis and requires a medical visit including testing and imaging. Diabetic evaluation is not part of a routine vision care visit. It will require a scheduled appointment separate from your vision benefit exam.\_\_\_***

**Females: Are you pregnant and or nursing [ ] NO [ ] YES**

***LIST ALL MEDICATIONS* Surgeries**

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

**Preferred Pharmacy and location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY: This information is kept strictly confidential.**

**Tobacco products [ ] NO [ ] YES Alcohol [ ] NO [ ] YES**

**Non-prescribed drugs [ ] NO [ ] YES STD’S [ ] NO [ ] YES**

**Hepatitis [ ] NO [ ] YES HIV [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Review of Systems FAMILY HISTORY Parent(P) Grandparent (GP)**

**EAR, NOSE, MOUTH, THROAT [ ] NO [ ] YES Sibling (S) (living or deceased) \_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Allergies/ Hayfever [ ] NO [ ] YES Blindness [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_**

 **Sinus [ ] NO [ ] YES Cataract [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_**

 **Chronic Cough [ ] NO [ ] YES Crossed Eye [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_**

 **Dry Throat/Mouth [ ] NO [ ] YES Macular Degeneration [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_**

**RESPIRATORY Retinal Detachment [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_\_**

 **Asthma [ ] NO [ ] YES Glaucoma [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_\_**

 **Chronic Bronchitis [ ] NO [ ] YES Arthritis [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_\_**

 **Emphysema [ ] NO [ ] YES Cancer [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_\_**

**VASCULAR/CARDIOVASCULAR Diabetes [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_**

 **Diabetes [ ] NO [ ] YES Heart Disease [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_**

 **Heart Pain [ ] NO [ ] YES High Blood Pressure [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_**

**GASTROINTESTINAL Kidney Disease [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_**

 **Diarrhea [ ] NO [ ] YES Auto-immune Disease [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_**

 **Constipation [ ] NO [ ] YES** **Thyroid Disease [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_**

**GENITO-URNIARY Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Genitals/ Kidney [ ] NO [ ] YES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Bladder [ ] NO [ ] YES**

Current Occupation/ or School Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 [ ] Single [ ]Married [ ]Widowed [ ] Divorced Living Arrangements (asked only to determine if assistance is needed for the visually disabled).

**BONES/JOINT/MUSCLES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Rheumatoid Arthritis [ ] NO [ ] YES**

 **Muscle/Joint Pain [ ] NO [ ] YES**

**LYMPHATIC/HEMATOLOGIC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Anemia [ ] NO [ ] YES**

 **Bleeding [ ] NO [ ] YES**

**PSYCHIATRIC [ ] NO [ ] YES**

**PATIENT INFORMATION HUDSON VALLEY EYE DOCTOR DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Mr. Miss. Ms. Mrs. Dr Marital Status: Single Divorced Married Widow

Last Name First Name MI Nickname

Address: City State Zip

Phone: Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ e-mail [ ] NO [ ] YES TEXT [ ] NO [ ] YES

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Student: full/part-time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **GUARANTOR, RELATIONSHIP** [ ] SELF If you are filling this form out for your child, please list **YOUR i**nformation here

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor’s Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_e-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

**Health / Major Medical Insurance**: Name of Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appointment cancellation or no show without 24 hour notice incurs a charge of $50.00. All Co-Pays and unpaid deductibles are due at the visit. Payments accepted: Cash Debit Card Credit Card CareCredit\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I authorize release of information to all my insurance companies.

2. I authorize my insurance company to send payment directly to my doctor.

3. I understand that I am responsible for my bill, and there may be charges that my insurance company does not cover, and I will pay for those non-covered services.

4. I give my consent to electronic filing of my insurance claims and prescriptions.

5. I understand that it is my responsibility to obtain a referral for service if it is required by my insurance company.

If I do NOT have the necessary referrals required by my Insurance company, I will be responsible for payment of the services rendered.

**Print Patient’s Name Patient’s Signature (Guarantor/Guardian) Date**

**Lifestyle Questionnaire** : Answers assist us in assessing your visual needs.

**1. What do you like about your current pair of glasses and or contact lenses?**

**2. What don’t you like about your current pair of glasses and or contact lenses?**

**3. Your activities (circle all that applies:** Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cooking sewing needlepoint/knitting board games soldering/welding painting golf

Woodworking art skiing/skating/snowboard motocycle/motorcross autorepair cards

Crafts fishing boating nature/birding snorkeling/scuba/swim electrical sports

Musical instruments gaming hunting target shooting/archery gardening/landscaping

**4. Does your work entail unusual visual demands?**

Driving Distance viewing Outdoor work Natural or artificial lighting caustic environment

Near work Indoor work clean room abrupt changes in light level clean room

Position microscope/telescope Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Are you bothered by glare from any of the following? (circle all that apply)**

Night driving/headlights haze fluorescent lights LED lights smart phone

Sunshine/UV exposure tablets computer screen other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. What electronic devices do you use and how much time do you spend on each device?**

Smart Phone\_\_\_\_\_\_\_\_ Tablet\_\_\_\_\_\_\_\_\_ Video Games\_\_\_\_\_\_\_\_\_\_\_\_\_ IPod\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other electronic devices:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you wear Blue-blocking eyewear? [ ] NO [ ] YES

Do your eyes tire or do you have fluctuating vision while using these devices? [ ] NO [ ] YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Do you use a computer/ laptop?** [ ] NO [ ] YES How many screens/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Distance from your eyes to the computer screen?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Laptop screen?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Screen Position?** Right Left Center **Screen Top** [ ] straight ahead [ ] below line of sight

How many hours a day are you using the computer/laptop work and home?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Do you currently use more than one pair of glasses?** [ ] NO [ ] YES

Bifocals Distance Golf Scuba specs Tennis Shooting Ski goggles Swim goggles

Trifocals Reading Sunglasses Driving Hobby Sports/safety Hobby

Progressive computer Intermediate Music Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Contact Lenses** [ ] NO [ ] YES Type and Brand:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disinfection system:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How many hours of wear?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all family members living at home:

Name Last Eye Exam Date of Birth

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