 NATUROPATHIC PATIENT CASE HISTORY

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REFERRED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SURNAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GIVEN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER: \_\_\_\_\_\_\_\_\_\_\_

CONTACT #: (home)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mobile) \_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ POSTCODE: \_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ AGE: \_\_\_\_\_\_\_\_\_ WEIGHT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEIGHT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please note that the questions asked are to prompt you into remembering information to help gain a whole picture of physical, emotional and mental health that all contribute to signs and symptoms that develop in our bodies. The more information you can think of the better.**

**\* Not all questions may be relevant to you. They are a guide.**

\*All Personal Health History Information is protected under the ‘Privacy Act (1988) and will be stored and protected appropriately.

REASON FOR VISIT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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When did it start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does it occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long does it last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes it better/ worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER CONCERNS: (give details) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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MARITIAL STATUS: \_\_\_\_\_\_\_\_\_\_\_\_ # CHILDREN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION (past/present): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOBBIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXERCISE (type/how often): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELAXATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STRESS CAUSES AND LEVELS (1 - 10): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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GENERAL FEELING OF WELLBEING: (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICAL DOCTOR**: (name/contact details) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **MEDICATIONS** | **REASON** | **DOSAGE** | **FREQUENCY** |
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| **SUPPLEMENT/HERB** | **REASON** | **DOSAGE** | **FREQUENCY** |
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CURRENT MEDICAL / HEALTH PROBLEMS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PAST MEDICAL / HEALTH PROBLEMS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PAST OPERATIONS: (include date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PAST TRAUMA/ACCIDENTS/INJURIES/BROKEN BONES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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BLOOD RESULTS: (please bring any copies with you) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VACCINATIONS: (fully vaccinated/up to date/ never) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OVERSEA TRAVELS? (when/where?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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ALLERGIES (foods/drugs/chemicals/seasonal etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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SLEEP HABITS: (quality:sound/broken/restless) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time asleep? \_\_\_\_\_\_\_ Time awake? \_\_\_\_\_\_\_Hours? \_\_\_\_\_ What wakes you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DREAM RECALL? (many/none/often/never/pleasant/unpleasant?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMOTIONAL STATE: (stressed/anxious/depressed/panic attacks/irritable/restless/angry/calm/relaxed/happy/sad) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How often do I feel this way? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ENERGY LEVELS: (low/medium/high) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BEST TIME OF DAY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORST TIME OF DAY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TYPICAL EVERYDAY DIET:**

BREAKFAST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MORNING TEA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LUNCH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AFTERNOON TEA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DINNER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DESSERTS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SNACKS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COFFEE: \_\_\_\_\_\_\_\_\_cups (milk/sugar) TEA: \_\_\_\_\_\_\_\_\_cups (milk,sugar) HERBALS: \_\_\_\_\_\_\_\_\_\_cups

WATER: \_\_\_\_\_\_\_ (glasses) ALCOHOL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (type/amount) CIGARETTES: \_\_\_\_\_\_\_\_\_\_

RECREATIONAL DRUGS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DIET RESTRICITONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FOOD INTOLERANCES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **HISTORY OF DISEASE** |  |  |
| Cancer: | Heart Disease: | Epilepsy: |
| HIV/AIDS: | Haemophilia: | Arthritis/ Rheumatism: |
| Tuberculosis: | Thyroid problems: | Metal pins/plates |
| Diabetes: | Osteoporosis: | Pacemaker: |
| Kidney disease: | Anything Else? |  |
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| **CHILDHOOD DISEASES** |  |  |
| Measles | Chicken pox | Asthma |
| Mumps | Tonsillitis | Eczema |
| Glandular Fever | Ear infections | Croup |
| Bronchitis | Worms: | Anything Else? |
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| **FAMILY MEDICAL HISTORY** |  |
| MOTHER: | FATHER: |
| GRANDFATHER: | GRANDFATHER: |
| GRANDMOTHER: | GRANDMOTHER: |
| SIBLINGS: | SIBLINGS: |
| CHILDREN: | CHILDREN: |
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| **LIVER/GALL BLADDER** |  |  |
| Pale/clay coloured stools: | Unexplained itching: | Nausea: |
| History of Jaundice: | Intolerance to fatty foods: |  |
| History of Hepatits A,B,C: | Yellow in eyes: |  |
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| **IMMUNE SYSTEM** |  |  |
| Colds/Flus: | Allergies/ Hayfever: | Cold Sores: |
| Frequent infections: | Thrush/ Candida: | Lumps of concern: |
| Phlegm/sputum: |  |  |
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| **EARS, NOSE, THROAT** |  |  |
| Sore throat: | Sinusitis: | Ear Infections: |
| Tonsillitis: | Tinnitus: | Allergies/ Hay fever: |
| Tonsil stones: | Nose bleeds: | Poor hearing: |
| Excessive ear wax: | Poor sense of smell: |  |
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| **MOUTH** |  |  |
| Mouth Ulcers: | Sore tongue: | Bleeding gums: |
| Sores in corner of mouth: | Coating on tongue: | Sensitive gums: |
| Poor sense of Taste: | Root canal treatments: | Crowns/dentures: |
| Metallic Taste in mouth: | Bad breath: | Tooth erosion: |
| Lumps in mouth: |  |  |
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| **RESPIRATORY:** |  |  |
| Emphysema: | Asthma: | Wheezing: |
| Cough: | Difficulty breathing: | Shortness of breath: |
| Pneumonia: | Bronchitis: |  |
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| **MUSCULOSKELETAL** |  |  |
| Aches/pains: | Muscle cramps/twitching: | Sciatica: |
| Joint pain: | Headaches: | Migraines: |
| Joint swelling: | Disc herniation: | Bone Pain: |
| Morning stiffness: | Back pain: | Tendonitis: |
| Bone deformities: |  |  |
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| **CARDIOVASCULAR** |  |  |
| High blood pressure: | Stroke: | Leg pain on exertion: |
| Low blood pressure: | Dizziness: | Palpitations: |
| High cholesterol: | Chest Pain: | Racing Heart: |
| Arrhythmia: | Breathless on exertion: | Easy bruising: |
| Varicose veins: | Nose bleeds: | Cold hands/feet: |
| Poor eyesight: | Declining memory: |  |
| Numbness/tingling hands/feet: |  |  |
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| **URINARY** |  |  |
| Frequent urination: | Pain/burning urination: |  |
| Dribbling after urination: | Waking at night to urinate: | Strong smell to urine: |
| Strong/sudden urge: | Poor urine stream: |  |
| Frequent bladder infections: | Incontinence: |  |
| Blood in urine: | Mucous in urine: |  |
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| **SKIN** |  |  |
| Acne: | Blackheads: | Psoriasis: |
| Eczema: | Dry skin: | Spots on back of arms: |
| Dermatitis: | Dandruff: | Skin tags: |
| Moles of concern: | Poor wound healing: | Cysts: |
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| **UPPER DIGESTION** |  |  |
| Heartburn/acid reflux: | Burping: | Nausea/vomiting: |
| Indigestion: | Stomach pain: | Feeling fullness after meals: |
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| **LOWER DIGESTION/ BOWEL** |  |  |
| Irritable Bowel Syndrome: | Leaky Gut: | Hard/dry stools: |
| Crohns Disease: | Stomach noises: | Loose/watery stools: |
| Ulcerative colitis | Excess gas/bloating: | Stools change daily: |
| Appendicitis: | Undigested food in stools: | Stools sink: |
| Haemorrhoids: | Burping: | Stools float: |
| Polyps: | Flatulence: | Blood/mucus in stools: |
| SIBO: | Anal itching: | Yellow stools: |
| Celiac Disease: | Regular laxative use: | Black/green stools: |
| Lower abdominal pain/cramping: |  |  |
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| **EMOTIONAL STATE** |  |  |
| Anxiety: | Pessimistic/negative thoughts: | Difficulty concentrating: |
| Panic attacks: | Feelings of guilt: | Nervousness: |
| Frequent sad thoughts: | Change in appetite: | Shaking hands: |
| Nail biting: | Racing thoughts: |  |
| Social withdrawal: | Over stressed: |  |
| No down time: |  |  |

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| **METABOLIC** |  |  |
| Sugar cravings: | Fatigue: | Brittle hair: |
| Salt cravings: | Weakness: | Dry skin: |
| Weight loss: | Sensitive to heat: | Sensitive to cold: |
| Weight gain: | Anaemia/iron deficiency: | Change in appetite: |
| Increased thirst: | Nausea: | Itchy skin: |
| Small bumps on skin (back of arms or legs): |  |  |

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| **FEMALES** |  |  |
| PMS/PMT: | Bloating: | Excess facial hair/acne: |
| Endometriosis: | Fluid retention: | Cystitis: |
| POCS: | Heavy bleeding: | Thrush/vaginal itching: |
| Amenorrhoea: | Vaginal discharge: | Menopausal symptoms: |
| Ovarian cysts: | Blood clots: | Hysterectomy: |
| Fibroids: | Painful periods: | Hot flushes: |
| Abnormal pap smear: | Breast tenderness: | Low libido: |
| History of STIs: | Irregular cycles-long/short | Vaginal dryness: |
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| **PREGNANCIES** |  |  |
| Currently pregnant: |  |  |
| Currently breastfeeding: |  |  |
| Number of Pregnancies: | Number Of Children: | Delivery type: |
| History of miscarriage: |  |  |

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| **MENSTURAL CYCLE** |  |  |
| Cycle length/days: | Age started: |  |
| Duration of bleed: | Products used: |  |
| Planning to Conceive: | When: |  |
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| Peri/Menopause: | Age started: |  |
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| **MEN** |  |  |
| Prostate issues: | History of STIs: |  |
| Low libido: | Difficulty sustaining erection: | Poor beard/hair growth: |
| Pain/swelling in groin/testes: | Difficulty urinating: |  |
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| **LIFESTYLE** |  |  |
| Smoking: | How much: |  |
| Cannabis: | How much: |  |
| Other drugs: |  |  |
| Alcohol: | How much: | Type: |
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**Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**