| Tina Joyce D.O., LLC<br>Pediatric Health History Form<br>Your relationship to child:<br>Child's previous doctor/primary<br>care provider:<br>Present health concerns:                                                                         |                                                                                                                                                                                                                                                                                                                                                         |
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| Medicines/Vitamins:<br>Herbs/Home Remedies:<br>Allergies/Reactions to<br>medicines or vaccinations:<br>PREGNANCY & BIRTH                                                                                                                      | DEVELOPMENT         At what age did your child: Sit alone         Walk alone       Say words         Toilet train (daytime)         Girls only: Age at first menstrual period                                                                                                                                                                           |
| Where was your child born?         Is the child yours by:       Birth       Adoption         Stepchild       Other:         Please indicate any medical problems during pregnancy                                                             | DENTAL HISTORY         Has child been seen by a dentist?       No         Yes         If so, how often?         Date of last visit                                                                                                                                                                                                                      |
| None       Specify:         Delivery by       Vaginal birth       Caesarean         If Caesarean, why?                                                                                                                                        | IMMUNIZATIONS/INFECTIOUS DISEASES         Please bring your child's immunization records to your         appointment.         Has your child had any of the following diseases:         Chickenpox       Measles         Rubella       Meningitis         Tuberculosis (TB)                                                                             |
| Other problems:<br><b>NUTRITION &amp; FEEDING</b><br>Was your child breastfed? No Yes<br>If so, how long?<br>Has your child had any unusual feeding/dietary<br>problems? No Yes If yes, specify:<br>Milk intake now: Type Cow's milk ( Nonfat | <ul> <li>Any concerns about lead exposure?</li> <li>(old home/plumbing/peeling paint) No Yes</li> <li>Do any household members smoke? No Yes</li> <li>TV – hours per day</li> <li>Computers – hours per day</li> <li>Video games – hours per day</li> <li>PAST MEDICAL HISTORY</li> <li>Please describe any major medical problems and their</li> </ul> |
| 1% fat2% fatWhole)Soy milkRice milkAverage ounces per day (Note: 8 ounces = 1 cup)                                                                                                                                                            | dates?                                                                                                                                                                                                                                                                                                                                                  |

| Please indicate any deaths of your immediate tamly members:       Current grade         Please indicate famly members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:       Any concerns about telationship with:         Alcoholism       Any concerns about relationship with:         High cholesterol       Teachers         Cancer, specify type       If more than 4 years old: does your child have a best triend?         Heart disease       Stroke         Depression/suicide       How often?         Beeding or clotting disorder       Review Of SYMPTOMS: Please check any current probler your child has on the list below:         Genetic disorders       Genetic disorders         Asthma/COPD       Genetic disorder         GoltA HISTORY       Who lives at home?         Name       Age Relatorship Highest Education Level         Mour child's parents       Married Unmarried         Genetic Socupation       Divorced         If divorced or separated       Divorced         If divorced or separated       Divorced         Father's Occupation       Separated         Mother's Employer       Separated         Child care situation       Parents         Any concerns about relationship with:       Separated         Divorced       Conelenging         C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Hospitalization/operations (with dates):              | Is violence at home a concern?                        | No           | Yes                |  |
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| SCHOOL HISTORY         Piease indicate any deaths of your immediate<br>family members:       Dickdoes your child attend school or preschool?         No       Yes         Piease indicate family members (parent, sibling,<br>grandparent, aunt or uncle) with any of the following<br>conditions:       Alcoholism         Alcoholism                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                       | Are there guns in the home?                           | No           | Yes                |  |
| AMILY HISTORY       No       Yes         Please indicate any deaths of your immediate family members:       Current grade       Name of school       Aname of school         Alcoholism                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Broken bones or severe sprains:                       | SCHOOL HISTORY                                        |              |                    |  |
| Please indicate any deaths of your immediate<br>family members:       Current grade         Please indicate family members (parent, sibling,<br>grandparent, aunt or uncle) with any of the following<br>conditions:       Any concerns about school performance?         Alcoholism                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                       | Did/does your child attend school or preschool?       |              |                    |  |
| family members:       Current gades         Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:       Name of school         Alcoholism                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                       | No Yes                                                |              |                    |  |
| Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:       Any concerns about school performance?         Alcoholism                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                       | Current grade                                         |              |                    |  |
| Tease inductor function of the following conditions:       Any concerns about school performance?         Alcoholism       Any concerns about relationship with:         High cholesterol       Teachers       No         Cancer, specify type       Peers       No       Yes         High blood pressure       If more than 4 years old: does your child have a best friend?       No       Yes         Stroke       Sports/exercise: Type       How often?       How often?         Depression/suicide       How often?       How often?       How often?         Bleeding or clotting disorder       Genetic disorders       REVIEW OF SYMPTOMS: Please check any current probler your child has on the list below:         Genetic disorders       Genetic disorders       Bedraetting       Bedraetting         Jiabetes       Genetic disorder       Bedraetting       Bedraetting         OCIAL HISTORY       Who lives at home?       Muscules/eteral       Muscules/eteral         Name       Age Relationship Highest Education Level       Sint Basing       Muscules/eteral         Zers/Nose/Throat       Unusual moles       Unusual moles       Unusual moles         Mother's Cocupation       Frashes       Currentingsmoring       Headeches         Are your child's parents       Married       Unusual moles       Currentingsm                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | -                                                     | Name of school                                        |              |                    |  |
| High cholesterol       Teachers       No       Yes         Cancer, specify type       If more than 4 years old: does your child have a best friend?       No       Yes         High cholesterol       If more than 4 years old: does your child have a best friend?       No       Yes         Heart disease       Sports/exercise: Type       How often?       How often?         Depression/suicide       How often?       How often?       How long (minutes)?         Bleeding or clotting disorder       General       General       General       General       General       General       General       Bedvetting         Jiabetes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | grandparent, aunt or uncle) with any of the following |                                                       |              |                    |  |
| High cholesterol       Teachers       No       Yes         Cancer, specify type       If more than 4 years old: does your child have a best       If more than 4 years old: does your child have a best         High blood pressure       If more than 4 years old: does your child have a best       friend?       No       Yes         Heart disease       Sports/exercise: Type                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Alcoholism                                            | Any concerns about relationship                       | with:        |                    |  |
| Cancer, specify type       Peers       No       Yes         High blood pressure       If more than 4 years old: does your child have a best       friend?       No       Yes         Heart disease       Stroke       Sports/exercise: Type                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | High chalasteral                                      | Teachers No Yes                                       |              |                    |  |
| High blood pressure       If more than 4 years old: does your child have a best         Heart disease       Stroke         Stroke       Stroke         Depression/suicide       How often?         Bleeding or clotting disorder       How often?         Genetic disorders       REVIEW OF SYMPTOMS: Please check any current probler         your child has on the list below:       Genitourinary         Diabetes       Genetal         Other:       Unexplained weight         Uhes at home?       Sequinting*crossed* eyes/         Name       Age         Age       Relationship         Highest Education Level       Muscleful         Unusual void voice/hard       Unusual moles         Unusual void voice/hard       Unusual moles         Mother's Decupation       Muscleful         Problems       Muscleful         Mother's Occupation       Married         Mother's Occupation       Fequent runny nose         Feduent runny nose       Fequent runny nose         Tries easily with earling through voices       Shortheeze         Genitouring       Clumsheese         Cordiovascular       Clumsheese         Tries easily with earling through voices       Paelever/lichy eyes         Bad b                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                       | Peers No Yes                                          |              |                    |  |
| Heart disease       Interit?       No       Tes         Stroke                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                       | If more than 4 years old: does your child have a best |              |                    |  |
| Stroke       Sports/exercise: Type         Depression/suicide       How often?         Bleeding or clotting disorder       How long (minutes)?         Genetic disorders       REVIEW OF SYMPTOMS: Please check any current problem your child has on the list below:         Genetic disorders       Genetic disorders         Asthma/COPD       Genetic disorders         Diabetes       Genetic disorder         Other:       Genetic disorder         Other:       Discharge: penis or vagions of vagions                                                                                                                                                                                                                                                                                          | Hoart discass                                         | mena? No res                                          |              |                    |  |
| Depression/suicide       How often?         Bleeding or clotting disorder       How long (minutes)?         Genetic disorders       REVIEW OF SYMPTOMS: Please check any current probler your child has on the list below:         Sathma/COPD       General       Gentiourinary         Diabetes       General       Gentiourinary         Other:       Severs(chills/excessive       Bedwetting         Name       Age       Relationship       Highest Education Level         Separated       Divorced       Greateath       Rashes         Mouth breathing/soroning       Allergy       Mouselefant         Mother's Occupation       Divorced       Cardiovascular       Clumsually loud voice/hard         Givorced or separated, when?       Divorced       Cardiovascular       Clumsines         Mother's Cocupation       Fainting       Anxiety/stress       Seperhyrobiens         Mother's Separated       Divorced       Cardiovascular       Clumsiness         Father's Occupation       Fainting       Anxiety/stress       Seep presion         Antiety/stress       Cocuph/wheeze       Depression       Rashes         Child care situation       Parents       Others (Specify who       Stortness ot breath       Spech problems         Gourd child's parents                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                       | Sports/exercise: Type                                 |              |                    |  |
| Bleeding or clotting disorder       How long (minutes)?         Genetic disorders                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                       |                                                       |              |                    |  |
| Genetic disorders                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ·                                                     | How long (minutes)?                                   |              | _                  |  |
| Asthma/COPD       your child has on the list below:         Diabetes       General       Genitourinary         Diabetes       Severs/chills/excessive       Bedwetting         Other:       Unexplained weight       Discharge: penis or vac         OCIAL HISTORY       Unexplained weight       Discharge: penis or vac         Vocial HISTORY       Kin       Musculoskeletal         Who lives at home?       Eyes       Muscle/joint pain         Name       Age       Relationship       Highest Education Level       Skin         Unusually loud voice/hard       of hearing       Allergy       Mouth breathing/snoring       Hay fever/itchy eyes         Are your child's parents       Married       Unmarried       Problems with teeth/gums       Weakness         If divorced or separated, when?       Stores of treath       Speech problems       Ankiely/stress         Mother's Cocupation       Fainting       Speech problems       Ankiely/stress         Mother's Employer       Cough/wheeze       Depression       Depression         Father's Cocupation       Chiers (specify who       Gastrointestinal       Bad bengthome         Mother's Employer       Darents       Others (specify who       Nausea/vomiting/darrhea       Blood/Lymph         Child care situation<                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                       |                                                       | check any cu | rrent problems     |  |
| Diabetes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                       |                                                       | 2            |                    |  |
| Other:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                       |                                                       | -            |                    |  |
| COCIAL HISTORY       Discharge: penis or vagors of vagor | Other                                                 | sweating                                              |              |                    |  |
| SOCIAL HISTORY       Musculoskeletal         Who lives at home?       Squinting/"crossed" eyes/<br>asymmetric gaze       Musculoskeletal         Name       Age       Relationship       Highest Education Level       Skin         Image: Second Seco                                                                                                                                  |                                                       |                                                       | Discharg     | ge: penis or vagin |  |
| Name       Age       Relationship       Highest Education Level       Squinting/*crossed* eyes/<br>asymmetric gaze       Skin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | OCIAL HISTORY                                         | -                                                     |              |                    |  |
| Name       Age       Relationship       Highest Education Level       asymmetric gaze       Skin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Who lives at home?                                    |                                                       | Muscle/      | oint pain          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Name Age Relationship Highest Education Level         |                                                       |              |                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                       | Ears/Nose/Throat                                      |              | moles              |  |
| Mouth breathing/snoring       Hay fever/itchy eyes         Are your child's parents       Married       Unmarried         Separated       Divorced       Problems with teeth/gums       Headaches         If divorced or separated, when?       Tires easily with exertion       Clumsiness         Mother's Occupation       Speech problems       Anxiety/stress         Mother's Employer       Respiratory       Sleep issues         Father's Employer       Cough/wheeze       Depression         Father's Employer       Gastrointestinal       Bad temper/breath hold igalousy         Child care situation       Parents       Others (specify who and how often)       Blood/Lymph         Blood in bowel movement       Unexplained lumps       Blood/Lymph                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                       |                                                       | Allerov      |                    |  |
| Are your child's parents       Married       Unmarried       Frequent runny nose       Neurological         Separated       Divorced       Problems with teeth/gums       Headaches         If divorced or separated, when?       Clumsiness       Clumsiness         Mother's Occupation       Speech problems       Anxiety/stress         Mother's Employer       Respiratory       Sleep issues         Father's Occupation       Cough/wheeze       Depression         Father's Employer       Cough/wheeze       Depression         Child care situation       Parents       Others (specify who and how often)       Nausea/vomiting/diarrhea         Blood in bowel movement       Blood in bowel movement       Blood in bowel movement       Blood Lymph                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                       | •                                                     |              | er/itchy eyes      |  |
| Are your child's parents       Married       Unmarried       Problems with teeth/gums       Headaches         Separated       Divorced       Cardiovascular       Clumsiness         If divorced or separated, when?       Shortness of breath       Psychiatric/Emotional         Mother's Occupation       Fainting       Anxiety/stress         Mother's Employer       Respiratory       Sleep issues         Father's Occupation       Cough/wheeze       Depression         Father's Employer       Chest pain       Nail biting/thumb suckir         Bad temper/breath hold       jealousy       Nausea/vomiting/diarrhea         Child care situation       Parents       Others (specify who       Blood in bowel movement         and how often)       Unexplained lumps       Blood/Lymph                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                       |                                                       | Neurological |                    |  |
| Separated       Divorced       Cardiovascular       Clumsiness         If divorced or separated, when?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Are your child's parents Married Unmarried            |                                                       |              |                    |  |
| If divorced or separated, when?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Separated Divorced                                    | Cardiovascular                                        |              |                    |  |
| Mother's Occupation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | If diverged or separated when?                        |                                                       |              | motional           |  |
| Mother's Employer       Anxiety/stress         Father's Occupation       Sleep issues         Father's Cocupation       Depression         Father's Employer       Cough/wheeze       Depression         Child care situation       Parents       Others (specify who and how often)       Gastrointestinal         Blood in bowel movement       Blood in bowel movement       Blood/Lymph                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | •                                                     |                                                       | Speech       | problems           |  |
| Father's Occupation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                       | •                                                     |              |                    |  |
| Father's Employer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                       | Cough/wheeze                                          | Depress      | ion                |  |
| Child care situation       Parents       Others (specify who and how often)       Gastrointestinal       jealousy         Blood /Lymph       Blood in bowel movement       Unexplained lumps                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ·                                                     | Chest pain                                            |              |                    |  |
| and how often) Blood in bowel movement Unexplained lumps                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                       |                                                       |              |                    |  |
| Blood in bowel movement Unexplained lumps                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                       |                                                       |              |                    |  |
| Concerns about your child: Alcohol use Tobacco Easy bruising/bleeding                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                       |                                                       |              |                    |  |