Rocky Mountain
Associated Physicians
Specializing in Weight Loss Surgery since 1979

After watching the entire series of our online Risk and Benefits Seminar, please take this online post-test that provides confirmation you have completed Step 1 of the surgical weight loss process.
Please submit this test with your Patient Information Form and Medical History

1. What medical conditions are related to obesity?
    a. Type 2 diabetes
    b. High blood pressure
    c. Sleep apnea
    d. Reflux disease
    e. All of the above

2. Rocky Mountain Associated Physicians offer which of the following weight loss surgeries (Circle all that apply.)
    a. Gastric Band (including the LAB-BAND system and REALIZE band system)
    b. Sleeve Gastrectomy
    c. Gastric Bypass
    d. Duodenal Switch

3. Which of the following statements is true regarding weight loss surgery? (Circle all that apply.)
    a. Weight loss surgery is an easy fix for weight loss
    b. Weight loss surgery is a tool to help patients make positive lifestyle changes for long-term weight loss success
    c. You cannot regain weight following weight loss surgery
    d. Weight loss surgery has risks and I must evaluate the benefits and decide if it's right for me.

4. What changes must weight loss surgery patients make for long-term weight loss success?
    a. Eat 70% protein, 30% vegetables, low carbohydrate diet after surgery. Eat three meals a day.
    b. Eliminate soda, coffee and alcohol from diet.
    c. Exercise 30-50 minutes a day.
    d. Follow lifetime vitamin regiment as directed by your surgeon, which typically includes a multivitamin, B-12 and calcium.
    e. Patient should follow all of the above guidelines for long-term success.

I have watched the Risk and Benefits of Bariatric Surgery video and understand that bariatric surgery has risks. I have researched this decision and believe that this is the right direction for me and my health.

Signature: _____

Printed Name: _____

Date: _____

RMAP Patient Information Form (*Please Fill Out Completely*)

Surgeon Selected: __Steven C. Simper MD, FACS __Rodrick D. McKinlay MD, FACS ___Nicholas J. Paulk, MD, FACS

Please check one: ___Self Pay ___Insurance Pay

Procedure: ___Gastric Bypass ___Gastric Sleeve ___Duodenal Switch ___Gastric Banding ___Revision Other _____

Name (First) (Middle) (Last)			*Date of Birth*	*Sex*	*Marital Status*
Address			*Phone (include area code)* ( )		*Cell Phone (include area code)* ( )
City	*State*	*Zip*	*Patient Email*		*Social Security #*
Occupation	*Employer*				*Your Ethnicity*
Employment Address			*Work Phone (include area code)* ( )		

Spouse / Guardian Information

Name (First) (Middle) (Last)		*Date of Birth*	*Relationship to Patient*	
Address	*City*	*State*	*Zip Code*	*Phone (include area code)* ( )
Employer	*Employment Address*			*Phone(include area code)* ( )
Emergency Contact (First) (Last)		*Relationship*	*Phone (include area code)* ( )	
Address		*City*	*State*	*Zip*
Primary Care Physician	*Address*		*Phone (including area code)* ( )	
Referring Physician	*Address*		*Phone (including area code)* ( )	

How did you hear about our clinic?

☐ *Physician*	☐ *Internet*	☐ *Radio*	☐ *TV*	☐ *Facebook*	☐ *Pinterest*	
☐ *Hospital*	☐ *Patient/Friend*	☐ *Billboard*	☐ *Work*	☐ *Insurance Company*	☐ *Yellow Pages*	☐ *Other* _____

PRIMARY HEALTH INSURANCE COMPANY (fill in completely)

Name of Insured (employee) _____

Name of Insurance Company _____

Address of Insurance Company _____

_____

Phone Number of Insurance Company ( ) _____

Employer's Name _____

Policy or ID Number of Employee _____

Group Number _____

Effective date of Coverage _____ /Copay_____

SECONDARY HEALTH INSURANCE COMPANY (fill in completely)

Name of Insured (employee) _____

Name of Insurance Company _____

Address of Insurance Company _____

_____

Phone Number of Insurance Company ( ) _____

Employer's Name _____

Policy or ID Number of Employee _____

Group Number _____

Effective date of Coverage _____ /Copay_____

It is my responsibility to pay any deductible amount, co-insurance or any other balance not paid by my insurance. Finance charges (at an annual rate not to exceed 18%) may be added when my account becomes 90 days past due. I understand that I may receive text messages or emails relating to my account. If it becomes necessary for my account to be turned over to a collection agency, I understand that an additional collection fee of up to 40% may be added to my balance. I understand I will be responsible to pay all collection fees, attorney fees and court costs. Confidential Record: Information contained here will not be released except when you have authorized us to do so. Note: This form will be submitted to your insurance company with the letter of medical necessity and your medical records.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to: **Steven C. Simper M.D., Rodrick D. McKinlay M.D., or Nicholas J. Paulk M.D.** This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including medical history and medical records, to my insurance company and immediate family.

Signed _____ Date:_____ Date Revised or Updated: _____

Patient/ Responsible Party

Rocky Mountain Associated Physicians Inc.

Medical History

Surgeon You Have Selected: ___**Dr. Simper** ___**Dr. McKinlay** ___**Dr. Paulk**

Date: _____ Date Revised or Updated: _____

Name: _____ Date of Birth:_____

Height_____ Weight _____

Describe your present symptoms briefly:

_____

_____

Chief Complaint: _____

Past Medical History

Previous Weight Loss Surgeries

Procedure	Hospital	Year	Procedure	Hospital	Year
1.			2.		

Previous Other Surgeries

Procedure	Year	Procedure	Year
1.		4.	
2.		5.	
3		6.	

Hospitalizations: List any diseases you have had that required hospitalization (approximate year)

_____ _____

_____ _____

Allergies: Drugs Other

_____ _____

_____ _____

Have **YOU**, or **ANY FAMILY MEMBER** had: (**Circle and give relationship**)

Stroke	Cancer
High blood pressure	Tuberculosis
Diabetes	Bleeding tendency
Heart attack	Deep Vein Thrombosis (DVT)
Pulmonary Embolism (Blood Clot)	Problems with Anesthesia

Details regarding the above question (if any):

_____

_____

_____

_____

_____

Current Medication:

_____ Dose _____ Frequency_____ Condition_____
_____ Dose _____ Frequency_____ Condition_____
_____ Dose _____ Frequency_____ Condition_____
_____ Dose _____ Frequency_____ Condition_____
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_____ Dose _____ Frequency_____ Condition_____
_____ Dose _____ Frequency_____ Condition_____
_____ Dose _____ Frequency_____ Condition_____

Family Medical History:

Health Challenges (if any)

	Age	Indicate if Obese (100 lbs +overweight)	If deceased Cause	Age
Father				
Mother				
Brothers				
Sisters				
Husband/ Wife				
Sons				
Daughters				

REVIEW OF SYSTEMS

Musculoskeletal

Do you have problems with your back?... Yes No
- Under physician care?..... Yes No
- Hip pain?..... Yes No
- Arthritic?..... Yes No
- Under physician care?..... Yes No

Swelling in the ankles?..... Yes No
Knee pain?..... Yes No
- Arthritic?..... Yes No
- Under physician care?..... Yes No

Have you ever had a problem with bleeding from a minor cut or tooth extractions?..... Yes No

Cardiovascular

Have you ever had chest pain or tightness….

- When exerting yourself?……..Yes No
- When excited or upset?……..Yes No
- After heavy meals?……..Yes No
- Do you have palpitations?……..Yes No
- Do you have heart problems?.....Yes No
- Under a physician's care?……..Yes No
- For how many years?..... _____
- Blood Clot……..Yes No

Does the chest pain……

- Radiate down the arm?……..Yes No
- Occur only at rest?……..Yes No
- Disappear if you rest?……..Yes No
- Describe the chest pain _____
- Do you have high blood pressure? Yes No
- For how many years? ……_____
- Under a physicians care? ……Yes No
- Deep Vein Thrombosis…… Yes No

Pulmonary

Have you had shortness of breath:

- Doing normal work?…… Yes No
- Climbing a flight of stairs?……Yes No
- Under a physician's care? ……Yes No

Do you have a chronic cough?……Yes No

Do you need more than one pillow to sleep? Yes No

Experience Asthma? ……..Yes No

- For how many years? ……_____
- Under a physician's care? …….. Yes No
- Experience Obstructive Sleep Apnea? Yes No
- For how many years? ……_____
- Under a physician's care? …….. Yes No

Gastrointestinal

Have you ever had pain in the stomach which..

- Occurs one or two hours after a meal? Yes No
- Is brought on by eating fried, greasy foods? Yes No
- Awakens you at night?……Yes No
- Is relieved by eating?…….. Yes No
- Is relieved by antacid medications?……Yes No
- Occurs while eating or immediately after? Yes No
- Is relieved by a bowel movement?…. . Yes No

Do you have …

- Abdominal Cramps…… Yes No
- Alternating diarrhea and constipation…Yes No
- Pain during or after bowel movement…Yes No
- Blood in the stool?…… Yes No
- Black stools?…….. Yes No
- Need for laxative or enemas? …….. Yes No
  How often?_____
- Do you have Acid reflux? ……Yes No
- For how many years? …… _____
- Under a physician's care? ……..Yes No

Genitourinary

Have you ever had..

Burning when urinating?……Yes No

Loss of control of bladder?……Yes No

Blood in the urine?……Yes No

Trouble starting to urinate?…… Yes No

Trouble holding the urine?…….. Yes No

Frequency/awakening at night?…….. Yes No

Passed a kidney stone?…… Yes No

Reproductive

Men: Have you ever had…….

Prostate problems?……Yes No

Prostate cancer?..... Yes No

Loss of sexual function?……..Yes No

Women:

Are you still having monthly menstrual periods? Yes No

Are your periods: Irregular__ Heavy__ Painful__

Have you ever had bleeding between periods? Yes No

Date of last period_____

Have you ever taken birth control pills? Yes No

Number of pregnancies __ Live births __Miscarriages ___

C- sections ___ Stillbirths ____ Premature births___

Complications?_____

Neurological

Have you ever fainted? ……Yes No

Have you ever had a convulsion?…….. Yes No

Double vision?…….. Yes No

Do you have severe headaches?……Yes No

- Do they occur on one side of the head? Yes No

Weakness in arms or legs? …….. Yes No

General

Do you have diabetes? .....Yes No
- For how many years? ....._____
- Under physicians care?.....Yes No
- Is it controlled with medication?.....Yes No

Do you experience extreme weakness or fatigue? Yes No
- For how many years? ....._____
- Under a physician's care? ..... Yes No

Hernia:
- Hiatal..... Yes No
- Umbilical..... Yes No
- Inguinal..... Yes No
- Untreated..... Yes No

Psychosocial

Do you experience any of the following conditions?
Bipolar disorder .....Yes No
Anxiety/panic disorder .....Yes No
Personality disorder .....Yes No
Psychosis .....Yes No
Depression .....Yes No
- Under a physicians care? ..... Yes No
- Controlled with medication? .....Yes No

Personal Habits: (Check)

Tobacco Use
__None __Rare __Occasional __Frequent
How many years did/have you smoked? _____
If so when did you quit?_____

Alcohol Use
__None __Rare __Occasional __Frequent

Substance Abuse (Prescription/Illegal)
__None __Rare __Occasional __Frequent

WEIGHT MANAGEMENT HISTORY: This form is submitted to your insurance company with your letter of medical necessity. Approval or denial of your request for surgery depends on meeting the criteria put forth by your insurance company. Failure of multiple attempted dietary programs is a standard requirement. **Please fill out in detail.**

Please Indicate Approximate Weights – How many years have you been morbidly obese?_____

	Normal	Obese	Morbidly obese (100 pounds over ideal weight)
Childhood 1-10 years			
Adolescence 11-18 years			
Young Adult 18-30 years			
Adult 30-60 years			

Number of visits yearly to your physician for medical problems (asthma, hypertension, heart problems, joints, arthritis, respiratory, circulation, etc.) related to obesity. _____

Doctors who are following, or have followed, your weight problems: *NAME*	*Diet programs your doctor has you trying, or has had you try:*	**WT LOST**	**WT REGAINED**	**LENGTH OF PROGRAM**	**Est. Cost**

Please provide to the best of your knowledge any Weight Loss Program you have tried over the years. This information is key to surgery authorization. Do your best to provide as much info as possible.

PROGRAM	YEAR	WT. LOSS	WT. REGAINED	LENGTH OF PROGRAM	EXPENSE
WEIGHT WATCHERS					
TOPS					
OVEREATERS ANONYMOUS					
DIET CENTERS					
Jenny Craig Nutri System					
Quick Weight Loss Center					
LA Weight Loss					
BEHAVIOR MODIFICATION					
JAWS WIRED					
APPETITE SUPPRESSANT PILLS _____					
SHOTS					
HYPNOSIS					
HOODIA					
SET FOR LIFE					
200 PLUS – DANA THORNOCK					
HOW TO LOWER YOUR FAT THERMOSTAT					
HERBAL LIFE					
SLIM FAST					
AMERICAN HEART ASSOCIATION DIET					
SLIM FOR LIFE					
RICHARD SIMMONS					
ACUPUNCTURE					
FAD DIETS					
SELF IMPOSED DIET ATTEMPTS					
OTHER					

Physical Exercise - Last 5 years (what was your normal routine?)

PROGRAM	TIME SPENT per Week	WT. LOSS	WT. REGAINED	LENGTH OF PROGRAM	EXPENSE
Bicycling					
Jogging / Walking					
Swimming					
Spa / Gym					
Aerobic/Video tapes					
Health Rider					
Home gym equip.					
Curves					
Other					

Describe the limitations (physical, emotional, employment) morbid obesity imposes on you in your daily activity:

Rocky Mountain Associated Physicians, P.C.
NOTICE OF PRIVACY PRACTICES
Effective: June 30, 2013

Patient Name: _____ Date: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Privacy Policy
We understand that your medical and health information is personal. Protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information.

How We Use Your Health Information
When you receive care from Rocky Mountain Associated Physicians, P.C. we may use your health information for treating you, billing for services, and conducting our normal business known as health care operations. Examples of how we use your information include:

Treatment – We keep records of the care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. For example, your doctor may share your health information with a specialist who will assist in your treatment. Some health records, including some confidential communications with a mental health professional and some substance abuse records, may have additional restrictions on the use and disclosure under state and federal laws.

Payment – We keep billing records that include payment information and documentation of the services provided to you. Your information may be used to obtain payment from you, your insurance company, or other third party. We may also contact your insurance company to verify coverage for your care or to notify them of upcoming services that may need prior notice or approval. For example, we may disclose information about the services provided to you to claim and obtain payment from your insurance company or Medicare.

In order for us, or for any other person or entity who provides goods or services to you in connection with this agreement, to contact you regarding servicing your account(s), including all past and current accounts, or to collect any amounts you may owe for any past or current account(s), you expressly authorize us to contact you by telephone at any telephone number, including any cellular, mobile, and other wireless telephone numbers that you have or may attain. You acknowledge that such calls could result in charges to you by your telephone carrier. You also expressly authorize us, and any other person or entity who provides goods or services to you in connection with this agreement, to contact you by sending text messages or e-mails to any of your telephone numbers or e-mail accounts. Methods of contact may include the use of pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable.

You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned your account(s) for servicing or collection. I/We have read this disclosure and agree that I/we may be contacted as described above.

Health Care Operations – We use health information to improve the quality of care, train staff and students, provide customer service, manage costs, conduct required business duties, and make plans to better serve our communities. For example, we may use your health information to evaluate the quality of treatment and services provided by our physicians, nurses, and other health care workers.

Other Uses of Your Health Information
We may also use your health information to:

- Recommend treatment alternatives;
- Tell you about health services and products that may benefit you;

- Share information with family or friends involved in your care or payment for your care, when appropriate;
- Share information with third parties who assist us with treatment, payment, and health care operations. We require our business associates to appropriately safeguard your information in accordance with law.
- Remind you of an appointment;
- Contact you or provide you with our education materials such as news letters or research participation requests.

More Information
For more information about the practices and rights described in this notice contact our office manager at the phone number and address at the bottom of this notice.

Sharing Your Health Information
There are limited situations when we are permitted or required to disclose health information without your signed authorization. These situations are:

- For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases and injuries permitted by law; reporting births and deaths; and reporting reactions to drugs and problems with medical devices;
- To protect victims of abuse, neglect, or domestic violence;
- For health oversight activities such as investigations, audits, and inspections;
- For law enforcement purposes;
- For lawsuits and similar proceedings;
- When otherwise required by law;
- When requested by law enforcement as required by law or court order;
- To coroners, medical examiners, and funeral directors;
- For organ and tissue donation;
- For research under strict federal guidelines;
- To reduce or prevent a serious threat to public health and safety;
- For workers' compensation or other similar programs if you are injured at work;
- For accreditation purposes; and
- For specialized government functions such as intelligence and national security.

We may also submit your personal health information to the Medicaid eligibility database, the Children's Health Insurance Program eligibility database, and/or other shared clinical databases or health information exchanges. All other uses and disclosures, not described in this notice, require your signed authorization. You may revoke your authorization at any time with a written statement (with limited exceptions as provided by federal regulations).

Your Individual Rights
You have the right to:

- Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restriction;
- Request that we use a specific telephone number or address to communicate with you;
- * Request to inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information and you may request a review of the denial;
- * Request corrections or additions to your health information;
- * Request an accounting of certain disclosures of your health information made by us. The accounting does not include disclosures made for treatment, payment, and health care operations and some disclosures required by law. Your request must state the period of time desired for the accounting, which must be within the six years prior to your request and exclude dates prior to April 14, 2003. The first accounting is free but a fee will apply if more than one request is made in a 12-month period; and
- Request a paper copy of this notice even if you agree to receive it electronically.

Requests marked with a star (*) must be made in writing. Contact the Rocky Mountain Associated Physicians office manager for the appropriate form for your request.

Our Privacy Responsibilities

Rocky Mountain Associated Physicians is required by law to:

- Maintain the privacy of your health information;
- Provide this notice that describes the ways we may use and share your health information;
- Accommodate reasonable requests to communicate your health information by alternative means or at alternative locations;
- Notify you of any reportable breaches of your unsecured health information; and
- Follow the terms of the notice currently in effect.

We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain. Current notices will be posted in our facilities and on our website, www.RMAP.com. You may also request a copy of any notice from our office manager.

Our Organization

This notice describes the privacy practices of Rocky Mountain Associated Physicians, P.C., Rocky Mountain Associated Physicians, P.C. includes physicians, employees and volunteers. This notice also describes the privacy practices of affiliated providers while they are performing services in behalf of Rocky Mountain Associated Physicians unless they provide you with a notice of their specific privacy practices. Affiliated providers are not employed by Rocky Mountain Associated Physicians but are authorized to provide services to patients. Affiliated providers may have different privacy practices from those described in this notice. For more information about the privacy practices of affiliated providers, please contact them directly.

Contact Us

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information, contact: Rocky Mountain Associated Physician's office manager at 801-268-3800.

We will investigate all complaints and will not retaliate against you for filing a complaint. You may also file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services.

I have read and understand this Privacy Notice:

I give permission for the following family members or friends to be contacted regarding my medical care (List Name and Telephone):

_____ _____

_____ _____

_____ _____

_____ _____

Patient Signature: _____

RMAP Witness: _____

Date Signed: _____

Rocky Mountain Associated Physicians

Formula
weight X 704 ÷
height (inches) ÷
height (inches)

Key
Underweight < 19 — Normal 20-25
Overweight 26-29 — Obese 30-39
Morbidly Obese > 40

Determining Your Body Mass Index (BMI)

	Weight (lbs)																																		
Height	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215	220	225	230	235	240	245	250	255	260	265	270	275	280	285	290	295	300	305	310	315	320
5'0"	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	84	55	56	57	58	59	60	61	62	62
5'1"	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	60
5'2"	27	27	28	29	30	31	32	33	34	35	36	37	37	38	39	40	41	42	43	44	45	46	47	48	48	49	50	51	52	53	54	55	56	57	58	59
5'3"	26	27	27	28	29	30	31	32	33	34	35	35	36	37	38	39	40	41	42	43	43	44	45	46	47	48	49	50	50	51	52	53	54	55	56	57
5'4"	25	26	27	27	28	29	30	31	32	33	33	34	35	36	37	38	39	39	40	41	42	43	44	45	45	46	47	48	49	50	51	51	52	53	54	55
5'5"	24	25	26	27	27	28	29	30	31	32	32	33	34	35	36	37	37	38	39	40	41	42	42	43	44	45	46	47	47	48	49	50	51	52	52	53
5'6"	23	24	25	26	27	27	28	29	30	31	31	32	33	34	35	36	36	37	38	39	40	40	41	42	43	44	44	45	46	47	48	48	49	50	51	52
5'7"	23	23	24	25	26	27	27	28	29	30	31	31	32	33	34	34	35	36	37	38	38	39	40	41	42	42	43	44	45	45	46	47	48	49	49	50
5'8"	22	23	24	24	25	26	27	27	28	29	30	30	31	32	33	33	34	35	36	36	37	38	39	40	40	41	42	43	43	44	45	46	46	47	48	49
5'9"	21	22	23	24	24	25	26	27	27	28	29	30	30	31	32	32	33	34	35	35	36	37	38	38	39	40	41	41	42	43	44	44	45	46	47	47
5'10"	21	22	22	23	24	24	25	26	27	27	28	29	29	30	31	32	32	33	34	34	35	36	37	37	38	39	39	40	41	42	42	43	44	44	45	46
5'11"	20	21	22	22	23	24	24	25	26	26	27	28	29	29	30	31	31	32	33	33	34	35	36	36	37	38	38	39	40	40	41	42	43	43	44	45
6'0"	20	20	21	22	22	23	24	24	25	26	26	27	28	28	29	30	31	31	32	33	33	34	35	35	36	37	37	38	39	39	40	41	41	42	43	43
6'1"	19	20	20	21	22	22	23	24	24	25	26	26	27	28	28	29	30	30	31	32	32	33	34	34	35	36	36	37	38	38	39	40	40	41	42	42
6'2"	19	19	20	21	21	22	22	23	24	24	25	26	26	27	28	28	29	30	30	31	31	32	33	33	34	35	35	36	37	37	38	39	39	40	40	41
6'3"	18	19	19	20	21	21	22	22	23	24	24	25	26	26	27	27	28	29	29	30	31	31	32	32	33	34	34	35	36	36	37	38	38	39	39	40
6'4"	18	18	19	19	20	21	21	22	23	23	24	24	25	26	26	27	27	28	29	29	30	30	31	32	32	33	33	34	35	35	36	37	37	38	38	39

Height	325	330	335	340	345	350	355	360	365	370	375	380	385	390	395	400	405	410	415	420	425	430	435	440	445	450	455	460	465	470	475	480	485	490	495	500
5'0"	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97
5'1"	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	76	77	78	79	80	81	82	83	84	85	85	86	87	88	89	90	91	92	63	94
5'2"	59	60	61	42	63	64	65	66	67	68	69	70	70	71	72	73	74	74	75	76	77	78	79	80	81	82	83	84	85	85	86	87	88	89	90	91
5'3"	58	58	59	60	61	62	63	64	65	66	66	67	68	69	70	71	71	72	73	74	75	76	77	77	78	79	80	81	82	83	84	85	85	86	87	88
5'4"	56	57	58	58	59	60	61	62	63	64	64	65	66	67	68	69	69	70	71	72	72	73	74	75	76	77	78	78	79	80	81	82	83	84	84	85
5'5"	54	55	56	57	57	58	59	60	61	62	62	63	64	65	66	67	67	68	69	69	70	71	72	73	74	74	75	76	77	78	79	79	80	81	82	83
5'6"	52	53	54	55	56	56	57	58	59	60	61	61	62	63	64	65	65	66	66	67	68	69	70	71	71	72	73	74	75	75	76	77	78	79	79	80
5'7"	51	52	52	53	54	55	56	56	57	58	59	60	60	61	62	63	63	64	65	65	66	67	68	69	68	71	70	71	72	73	74	75	75	76	77	78
5'8"	49	50	51	52	52	53	54	55	55	56	57	58	59	59	60	61	61	62	63	63	64	65	66	66	67	68	69	69	70	71	72	73	74	74	75	76
5'9"	48	49	49	50	51	52	52	53	54	55	55	56	57	58	58	59	59	60	61	62	62	63	64	65	65	66	67	67	68	69	70	71	72	72	73	74
5'10"	47	47	48	49	50	50	51	52	52	63	54	55	55	56	57	57	58	58	59	60	60	61	62	63	64	65	65	66	67	67	68	69	69	70	71	71
5'11"	45	46	47	47	48	49	50	50	51	52	52	53	54	54	55	56	56	57	57	58	59	59	60	61	62	62	63	64	65	66	66	67	67	68	69	69
6'0"	44	45	45	46	47	47	48	49	50	50	51	52	52	53	54	54	55	55	56	56	57	58	59	59	60	61	61	62	63	63	64	65	65	66	67	67
6'1"	43	44	44	45	46	46	47	47	48	49	49	50	51	51	52	52	53	53	54	54	55	56	57	57	58	58	59	60	60	61	62	62	63	63	64	64	65
6'2"	42	42	43	44	44	45	46	46	47	48	48	49	49	50	51	51	52	52	53	53	54	55	56	57	57	58	58	59	59	60	61	61	62	63	63	64
6'3"	41	41	42	42	43	44	44	45	46	46	47	47	48	49	49	50	50	51	51	52	53	53	54	55	55	56	57	57	58	58	59	60	60	61	62	62
6'4"	40	40	41	41	42	43	43	44	44	45	46	46	47	47	48	49	49	49	50	51	51	52	52	53	53	54	54	55	56	57	58	59	59	60	61	61