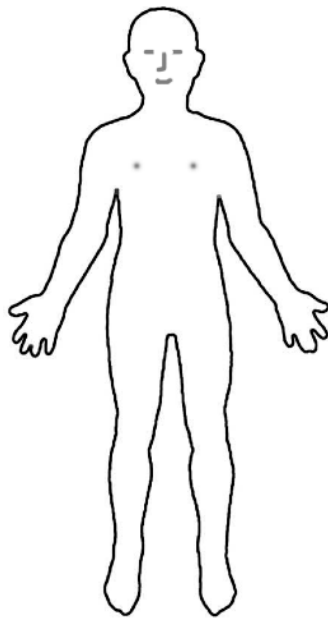


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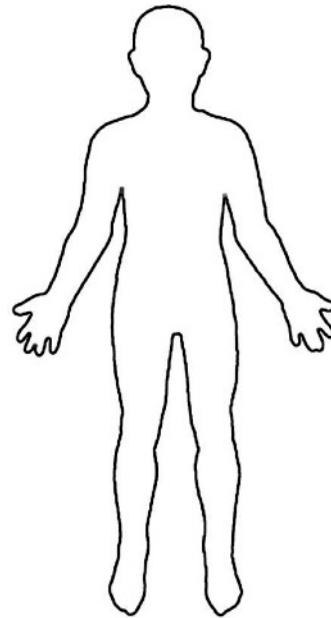
Please mark the drawings to show where you hurt. Circle the words that describe your pain.

Numb Tingly Sharp Deep Ache Burns or, in your own words _____

Front View



Back View



Women's Health
 Information: O = occasionally F = frequently C = constantly

Problem	O, F, C	Problem	O, F, C
Irregular menses		Vaginal discharge	
Profuse flow		Yeast infections	
Menstrual pain		Lumps on Breast	
PMS		Painful Breast cysts	
Menopausal problems		Birth Control Method	

Date of last Menses ____/____/____ Date of most recent gyne exam ____/____/____