New Patient Form:

RATIONAL MEDICINE

Name:_____

Phone Number_____

Address_____

E-Mail _____

Date of birth:_____ Blood Type:____

Present Complaints:

Medications/Supplements:

Symptoms (please note current symptoms and any chronic problems)

Headaches

Scalp/Hair

Eyes

Ears

Nose/Sinuses

Teeth/Mouth

Throat

Respiratory

Heart/BP

Stomach

Abdomen

Bowels

Bladder/Kidney

Genitals

Menses

Joints

Muscles

Sleep

Patient Medical History

TypeYear

Surgeries

Accidents

Illnesses

Vaccinations

Emotional Traumas

Family Medical History (please note any serious illness)

Maternal

Paternal

Siblings