



DR. PEARL YOUTH & BEAUTY INSTITUTE

195 North Second Avenue,
Upland, Ca 91786
909.946.6444 Fax 909.946.1099
www.yehcenter.com

PATIENT INFORMATION – PLEASE PRINT

PERSONAL INFORMATION:

Name: _____ Phone: Day() _____ - _____
Date of Birth: _____ Eve () _____ - _____

Street Address: _____ Apt/condo#: _____
City: _____ State: _____ Zip Code: _____

Age: _____ Height: _____ Weight: _____ Sex: M F
Marital Status: _____ Number of Children: _____

Who may we thank for referring you? _____

WORK INFORMATION:

Company Name: _____ Employer's Name: _____
Address: _____ Occupation: _____
City: _____ State: _____ Zip Code: _____

EMERGENCY:

In Case of Emergency Contact: _____ Relationship: _____
Address: _____ Phone: () _____ - _____
City: _____ State: _____ Zip Code: _____

In Case of Emergency Contact: _____ Relationship: _____
Address: _____ Phone: () _____ - _____
City: _____ State: _____ Zip Code: _____

PHYSICIAN:

Physician Name: _____ Specialty: _____
Address: _____ Phone: () _____ - _____
City: _____ State: _____ Zip Code: _____

MEDICAL HISTORY:

Reason For Your Visit Today: _____

Primary Illness: _____
How did this condition develop? _____

Secondary Illness: _____
How did this condition develop? _____

MEDICAL HISTORY CONTINUED:

When was the first time you were aware of your primary illness? _____

When was the first time you were aware of your secondary illness? _____

Have you ever had these conditions or similar conditions before? Yes No

If yes, please explain: _____

Have you ever received any treatments for these conditions? Yes No

If yes, Where? _____

When? _____

For How Long? _____

By Whom? _____

What Was The Diagnosis? _____

Lab Test to Verify Diagnosis? _____

Results of Treatment? _____

Are you experiencing physical or mental stress? Yes No

If yes, please explain: _____

How was conditions affected the following?

Home Life: _____

Job Performance: _____

Social Life: _____

Ability to Exercise: _____

Rest and Sleep: _____

Others: _____

What drug medications are you presently taking?

Dosage:

What supplements are you presently taking?

Dosage:

PAST MEDICAL HISTORY:

Birth: (Anything significant about your birth?) _____

Vaccination History: (Any reactions that you remember?) _____

Surgeries: (Please list the surgeries that you have had – include dates) _____

Additional Comments: _____
