YOLANDA C. HOLMES, M.D. P.C.
MEDICAL & COSMETIC DERMATOLOGY

1140 CONNECTICUT AVE NW, SUITE 675
WASHINGTON, DC 20036
P 202-737-6800
F 202-737-4984
WWW.YOLANDAHOLMESMD.COM

PATIENT INFORMATION

We want your experience at Yolanda C. Holmes, M.D. P.C. and Yolanda C. Holmes, M.D. P.C. to be pleasant and relaxing. **Please be courteous towards others waiting for appointments by turning sound off cell phones**. Please inform our front desk staff if you have any special needs or concerns and allow us to ensure your time spent with us is a memorable experience. **Thank you for choosing Yolanda C. Holmes, M.D. P.C.!**

PATIENT INFORMATION		
Name:	DOB:	Today's Date:
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email Address:		
Sex: O Male O Female	Race:	
Emergency Contact:	Emergency Contact Phone:	
Who is your Primary Care Physician?		
How did you hear about Yolanda C. Holmes, M.D. P.C.?		
INSURANCE INFORMATION		
Primary Carrier:	Member Number:	
Secondary Carrier:	Member Number:	
PHARMACY INFORMATION		
Pharmacy Name:	Phone:	
Address:		
City:	State:	Zip:

☐ I have read and agree to the Acknowledgement of Policies and the Patient Privacy Notice

Patient Signature:_____ Date:_____

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MEDICAL HISTORY

PATIENT INFORMATION

Name:	DOB:	Today's Date:
Address:		

MEDICAL HISTORY

Do you have a history of the following:	Yes	No	Description:
Are you pregnant?			If yes, due date: Breastfeeding? O No O Yes
Diabetes			
Thyroid			
Kidney Trouble / Urinary Problems			
Stomach / Colon Disorder			
Cardiovascular:			
High Blood Pressure			
Heart Trouble (Attack, Murmur, Irregular)			
Chest Pain			
Pacemaker			
Phlebitis			
Blood Clots			
Cancer			
Arthritis			
Melanoma			
Convulsions / Epilepsy / Seizures			
Psoriasis			
* If you have psoriasis, have you had a TB test this year?			
*If you have psoriasis, have you been treated with a biologic?			
Hepatitis or Liver Trouble			
Asthma/ Frequent or Chronic Cough			
Stroke			
Problems Scarring (Keloids) / Problems Healing			
Family History of: O Hypertension O Cancer O Diabetes O Heart Disease			
Do you have family history of skin cancer			
Have you been exposed to HIV(AIDS)			
Psychiatric Care			
Others Not Listed			

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IMPORTANT QUESTIONS

Please answer the following questions:	Yes	No	Description:
Have you had the flu shot for the current flu season?			
* If YES, please provide the date of your flu vaccine			
Have you had the pneumococcal vaccine?			
*If YES, please provide the name (i.e. PCV13, Prevnar13, PPSV23, or Pneumovax23) and date of your vaccine			
Do you have a living will?			
Do you have a power of attorney or healthcare proxy?			

MEDICATIONS

Are you taking any of the following:	Yes	No	Description:
Blood thinners			
Steroids			
Aspirin or aspirin-containing meds			
Ibuprofen (Motrin, Advil)			*How Often?*

Please list the medications you are **currently** taking:

SURGERY HISTORY

Have you had surgery in the past 10 years? O No O Yes Description:

If yes, please describe:

ALLERGIES & SENSITIVITIES

Any history of skin reaction or other illness after contact with:	Yes	No	Description:
Antibiotics			
Lidocaine, Prilocaine (local anesthesia)			
Adhesive tape/Latex			
Medication / Food / Environmental			

SOCIAL HISTORY

Do you smoke?			*How much?*
Do you drink?			*How much?*
Do you use recreational drugs?			*How much?*

☐ I have read this questionnaire and disclosed my medical history to the best of my knowledge.

Patient Signature:_____ Date:_____

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COSMETIC QUESTIONNAIRE

Our goal is to make every patient look and feel as radiant as possible. Yolanda C. Holmes, M.D. P.C. is committed to a no-pressure atmosphere where we work with you to achieve your idea of healthy, happy skin.

I am interested in:

- ☐ Acne Treatments
- ☐ Age Spots/Liver Spots/Pigmentation
- ☐ Botox/Jeuveau
- ☐ Chemical Peels
- ☐ Cosmetic Fillers
- ☐ Hyperpigmentation
- ☐ Fat Reduction
- ☐ Microdermabrasion
- ☐ Remove Dark Spots
- ☐ Laser Hair Removal
- ☐ Rosacea/Broken Capillaries
- ☐ Skincare Advice & Products
- ☐ Facials & Peels
- ☐ Body Contouring
- ☐ Anti-Aging Procedures
- ☐ HydraFacial

Do you use Sunscreen? ☐ No ☐ Yes, If Yes SPF # _____

Share with us any specific concerns or areas for improvement:

_____

_____

What are your current skincare products?

***AM** Regimen*:

Cleanser: _____

Serum: _____

Moisturizer: _____

SPF: _____

Topical Rx: _____

***PM** Regimen*:

Cleanser: _____

Serum: _____

Moisturizer: _____

Eye Cream: _____

Topical Rx: _____