



## 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: <input type="radio"/> Male <input type="radio"/> 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: \_\_\_\_\_



## 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: <span style="float: right;">Breastfeeding? <input type="radio"/> No <input type="radio"/> Yes</span>
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:	<input type="radio"/> Hypertension <input type="radio"/> Cancer <input type="radio"/> Diabetes <input type="radio"/> Heart Disease		
Do you have family history of skin cancer			
Have you been exposed to HIV(AIDS)			
Psychiatric Care			
Others Not Listed			



**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, Prevnar 13, 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)						<i>How Often?</i>

Please list the medications you are currently taking:

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**SURGERY HISTORY**

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

If yes, please describe:

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**ALLERGIES & SENSITIVITIES**

Any history of skin reaction or other illness after contact with:

	Yes	No	Description:
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Antibiotics			
Lidocaine, Prilocaine (local anesthesia)			
Adhesive tape/Latex			
Medication / Food / Environmental			

**SOCIAL HISTORY**

Do you smoke?			<i>How much?</i>
Do you drink?			<i>How much?</i>
Do you use recreational drugs?			<i>How much?</i>

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

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## 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:

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

Do you use Sunscreen?  No  Yes, If Yes SPF # \_\_\_\_\_

Share with us any specific concerns or areas for improvement:

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What are your current skincare products?

AM Regimen:

PM Regimen:

Cleanser: \_\_\_\_\_

Cleanser: \_\_\_\_\_

Serum: \_\_\_\_\_

Serum: \_\_\_\_\_

Moisturizer: \_\_\_\_\_

Moisturizer: \_\_\_\_\_

SPF: \_\_\_\_\_

Eye Cream: \_\_\_\_\_

Topical Rx: \_\_\_\_\_

Topical Rx: \_\_\_\_\_

