



Dr. Yolanda C. Holmes
 Cosmetic- Medical Dermatology
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 (We are at the Farrgut-West Metro
 One Block from Farrgut-North)

COSMETIC INTEREST QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

HEALTH ISSUES, PROCEDURES, OR PRODUCTS OF INTEREST TO YOU: (PLEASE CHECK ALL THAT APPLY)

- | | |
|--|--|
| <input type="checkbox"/> BOTOX Cosmetic | <input type="checkbox"/> Facial Fullness |
| <input type="checkbox"/> Parentheses Around Mouth | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Skin Care Advice/Products | <input type="checkbox"/> Abdominal Area |
| <input type="checkbox"/> Facial Fine Lines/Wrinkles | <input type="checkbox"/> Facial Hair |
| <input type="checkbox"/> Eyelashes: longer, Fuller, Darker | <input type="checkbox"/> Body Hair |
| <input type="checkbox"/> Facial Folds | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Thin Lips | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Blotchy Skin | <input type="checkbox"/> Waxing |
| <input type="checkbox"/> Facial Veins | <input type="checkbox"/> Facials |
| <input type="checkbox"/> Facial Redness | |
| <input type="checkbox"/> Body Veins | |
| <input type="checkbox"/> Liver Spots/Age Spots | |
| <input type="checkbox"/> Brow Sculpting | |

PLEASE ANSWER THE FOLLOWING QUESTIONS ON A SCALE OF 1 TO 5 BY CIRCLING THE APPROPRIATE NUMBER:

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age:

Younger Than		True Age		Older Than
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

IF YOU COULD IMPROVE ANYTHING ABOUT YOUR APPEARANCE, WHAT WOULD IT BE? _____

HOW DID YOU HEAR ABOUT US?

My Physician: (Full Name) _____

My Insurance Company Provider: (Name) _____

Magazine: (Specify Name of Magazine) _____

A Friend Or Family Member: (Name) _____

The Internet: _____

Our Website:

Seminar: (Specify Seminar/Date) _____

Other: _____

ARE YOU INTERESTED IN MEETING WITH ONE OF OUR PROFESSIONAL COSMETIC CONSULTANTS IN ORDER TO CREATE A PERSONAL TREATMENT PLAN DESIGNED TO MEET YOUR COSMETIC NEEDS?

Yes No Thanks

APPROVAL TO CONTACT YOU:

APPROVAL TO SEND YOU PRODUCT AND SERVICE INFORMATION (INCLUDING SPECIAL OFFERS):

BEST PHONE NUMBER TO CONTACT YOU: _____

EMAIL ADDRESS: _____

PATIENT SIGNATURE: _____

FOR OFFICE USE ONLY

Physician (Provider) Name: _____

FOLLOW-UP: _____ DATE: _____ COMPLETED BY (NAME): _____

Follow-Up Call: _____

Free Consultation: _____

Procedure Scheduled: _____

Procedure Completed: _____

Comments: _____

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Free \$25 Gift Certificate...

Our gift to you when you refer a friend or sign up for our monthly email promotions.