WELCOME!

DATE_____

NAME_____

PHONE _____

EMAIL _____

What brings you to Eos, The Medical Spa?

_____
_____
_____

How did you find out about us? (Please check all that apply)

- Internet _____
- TV _____
- Magazine_____
- Radio _____
- Newspaper _____
- EOS Client _____
- Other _____

THANK YOU FOR CHOOSING EOS, THE MEDICAL SPA FOR ALL OF YOUR HEALTH AND BEAUTY NEEDS!

Medical History Form

Today's Date _____/_____/_____ Date of Birth _____/_____/_____

Name: (Mr.) (Ms) (Mrs.) _____

Address: _____
_____
_____

Home Phone (_____)_____ Email: _____

Employer: _____ Occupation_____

Source of Referral: _____

Are you now or have you been under care of a physician within the last two years? ( ) Yes ( ) No
(If yes, please provide the physician's name, address, and phone number:
_____

Emergency Contact Information:
NAME_____
PHONE _____
RELATIONSHIP_____

List all medications you are currently taking, including, Retin A, Glycolic Acid, and Acutane:

Allergies: (Include any soap, makeup, cleanser)
_____

Have you recently undergone a skin peel? ( ) Yes ( ) No *if yes, date and type*_____

List any products you are currently using on your skin. Please include over the counter products and make-up brands:
_____

Do you have or have you had any of the following conditions(answer Yes or No)

____Herpes Simplex	____ Dry Eye	____Cold Sores	____Corneal Abrasions
____ Hemophilia	____ Blepharoplasty	____ Cancer	____ Prolonged Bleeding
____ Epilepsy	____ Chemotherapy	____ Radiation	____ Visual Disturbances
____ Diabetes	____ Hepatitis	____ Cataracts	____ Tumors/Growth/Cysts
____ Glaucoma	____ Fainting Spells	____ Dizziness	____ Contact Lens?
____ Pregnant?	____ High or Low Blood Pressure		

____ Are you using any eye drops or other ocular medication?
____ Have you ever experienced hyper pigmentation from an injury?
____ Are you currently taking aspirin or ibuprofen?

*(Optional) Ethnic background*_____

Signature_____ Date _____

Diagnostic Sheet

3660 Flat Shoals Rd, Suite 180, Decatur, GA 30034
Lynette Stewart, M.D.
Fermin Stewart, M.D.

Date: _____

Name: _____

Patient's Goals:

_____
_____
_____
_____

Price: _____

Treatment(s):

_____
_____
_____
_____
_____
_____
_____
_____

Procedure Notes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply.

o Skin care advice	o Facial veins	o Neck wrinkles
o Skin care products	o Facial redness	o Breast size
o Injectable treatments	o Brown spots/age spots/freckle	o Abdominal area
o Juvederm/Restylane/Radiesse	o Drooping eyelids	o Hips
o Facial fine lines/wrinkles	o Nose size or shape	o Legs
o Thin lips	o Facial fullness/drooping	o Facial contouring
o Blotchy Skin	o Mole removal	o Unwanted hair
o Chemical Peel	o Scar revision	o Length/Fullness of Eyelashes
o Make up		

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

Comments:

FOR STAFF USE ONLY

Follow-Up	Date	Completed by
o Initial inquiry (phone f/up)		
o Contact in future-give date		
o Products		
o Free Consultation		
o Procedure Schedule		
o Procedure Completed		

3660 Flat Shoals Rd Suite 180, Decatur, GA 30034
Lynette Stewart M.D., F.A.C.O.G
Fermin Stewart, M.D.

Consent to Photograph for Medical Documentation

I hereby authorize the above named physician(s) to photograph or permit others to photograph my image/likeness while under the care of the above physician, and agree that he/she will use the prints prepared there from for such purpose and in such as may be deemed necessary for medical documentation.

Date _____

Print Name _____

Signature _____

Witness _____

Consent to Photograph for Marketing/Public Relations

I hereby authorize the above named physician(s) to photograph or permit other persons to use my image/likeness as marketing tool for brochures/magazines.

Date _____

Name _____

Signature _____

Witness _____