



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 _____



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

<input type="checkbox"/> Skin care advice <input type="checkbox"/> Skin care products <input type="checkbox"/> Injectable treatments <input type="checkbox"/> Juvederm/Restylane/Radiesse <input type="checkbox"/> Facial fine lines/wrinkles <input type="checkbox"/> Thin lips <input type="checkbox"/> Blotchy Skin <input type="checkbox"/> Chemical Peel <input type="checkbox"/> Make up	<input type="checkbox"/> Facial veins <input type="checkbox"/> Facial redness <input type="checkbox"/> Brown spots/age spots/freckle <input type="checkbox"/> Drooping eyelids <input type="checkbox"/> Nose size or shape <input type="checkbox"/> Facial fullness/drooping <input type="checkbox"/> Mole removal <input type="checkbox"/> Scar revision	<input type="checkbox"/> Neck wrinkles <input type="checkbox"/> Breast size <input type="checkbox"/> Abdominal area <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Facial contouring <input type="checkbox"/> Unwanted hair <input type="checkbox"/> Length/Fullness of Eyelashes
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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
<input type="checkbox"/> Initial inquiry (phone f/up)		
<input type="checkbox"/> Contact in future-give date		
<input type="checkbox"/> Products		
<input type="checkbox"/> Free Consultation		
<input type="checkbox"/> Procedure Schedule		
<input type="checkbox"/> Procedure Completed		



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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 _____