About Face Medspa & Wellness. Date: ___/___/___

Name:_____ Date of birth__/__/__ Allergies:_____

We will be doing all promotions via email. If you would like to participate, please list your email address so we can add it in our system. Email Address: _____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work/Other Phone:_____

Occupation:_____ Referred by:_____

Emergency Contact Name: _____ Number: _____ Relationship:_____

May we communicate with them regarding appointments, RX's, and lab results? Yes ☐ No ☐

Preferred Number that we contact you: ☐ Cell ☐ Home ☐ Work/Other

May we leave a message: Yes ☐ No ☐

Health History

Please circle any that apply:

Migraine headaches	Self	Family History	Lung Disease	Self	Family History
Cancer	Self	Family History	Kidney Disease	Self	Family History
Diabetes	Self	Family History	Stomach Disease	Self	Family History
Heart disease	Self	Family History	Bowel Disease	Self	Family History
Arthritis	Self	Family History	Alcoholism	Self	Family History
Liver Disease	Self	Family History	Gout	Self	Family History
Psychiatric illness	Self	Family History	Hepatitis	Self	Family History
Auto immune disease	Self	Family History	Anemia	Self	Family History
Thyroid disorder	Self	Family History	Colitis	Self	Family History
High blood pressure	Self	Family History	Epilepsy	Self	Family History
Stroke, seizures	Self	Family History			
Parkinson's disease	Self	Family History			

Primary care physician:_____ Are you pregnant or nursing: Yes or No

Have you had any surgery within the past 2 years: Yes or No Reason:_____

Please list all medications that you are currently taking, including hormones:

Please note—if you are being treated with either Methadone or Suboxone at a clinic, it is illegal for you to seek Phentermine while you are being treated.

Name:_____ Dose (mg)_____ Times a day___

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These questions refer to your current status:

Alcohol consumption: Drinks/week____ Do you smoke? Yes or No Packs per day____

Coffee: Cups/day Diet drinks or other drinks with Aspartame/day____ Water, 8oz/day

Are you currently taking any vitamins, minerals or herbs on a regular basis? If so, please list:

_____

What are your most important expectations as a patient:_____

_____

_____

Do you crave sweets? Yes ☐ No ☐

Do you eat a lot of potatoes, bread, etc? Yes ☐ No ☐

Do you have occasional irregularity? Yes ☐ No ☐

Do you need an "extra boost" to your metabolism? Yes ☐ No ☐

Controlled Substance Agreement

I fully understand that Phentermine is a controlled substance and it is punishable by law to receive the same controlled substance from more than one facility in a 30-day period.

I also understand that my information may be searched in the controlled substance database, and if it is found that I am seeking this or any other controlled substance from more than one practitioner that I will be turned in to the proper authorities.

I have come to About Face to start on the weight management program, which may include Phentermine. I hereby acknowledge that I am not seeking this prescription from any other weight management clinic and will not do so while I am a patient of About Face. If it is found that I am doing so, I will be immediately released from the program and reported.

_____ _____

ID or Driver's License Number Date of Birth

_____ _____

Patient Signature Date