League City Spine and Sports Medicine PLLC
Weight Loss Evaluation Form

Patient information:

Name: _____ Date: _____

Primary Phone number: _____ Email address: _____

Impairments: Check if you have any of the following:

____Physical Impairment ____ Visual Impairment _____ Hearing Impairment

Please mark the participating factors that pertain to you:

□Inactivity □Overeating □Sedentary Job □Age □Injury □Childbirth □Stress □Depression □Medication
□Hysterectomy □Blood Pressure □Cholesterol □Diabetes □Infection □Allergy □Asthma □Other
(specify)_____

Have you ever participated in a medical weight loss program before? _____Yes _____No
Have you ever taken prescribed weight loss medications? If yes, list all: _____

Lifestyle Information:

- **Check all that apply**: Yes or No If yes, how often:
  - Tobacco (smoke, chew, or snuff) _____ _____
  - Alcohol (beer, wine, liquor) _____ _____
  - Caffeine (cola drinks, tea or coffee) _____ _____
- **Exercise:** Do you exercise regularly? _____Yes _____No
  - If yes, describe your routine & how often: _____
- **Diet:** describe your typical daily food intake:
  - First Meal:
    _____
  - Second Meal:
    _____
  - Third Meal:
    _____
  - Snacks:
    _____

Is there a certain diet that you follow or have followed in the past?
□WW □Paleo □Keto □Intermittent Fasting □Low Carb □Calorie Counting□
□Other: _____

Medical conditions/diseases and Past Medical History Please check all that apply:

□Heart disease (Congestive Heart Failure)	□ Lung Conditions (Asthma, COPD, etc.)	□ Thyroid disease/dysfunction
□High cholesterol or lipids (Hyperlipidemia)	□Diabetes	□Cancer Type: _____
□High blood pressure (Hypertension)	□ Arthritis or Joint Problems	□Headaches/migraines
□Depression	□Ulcers (Stomach, Esophagus)	□Epilepsy
□Hormonal Related Issues	□Eye disease (Glaucoma, etc.)	□Blood clotting problems
□Obesity	□Fatigue	

Other non-listed medical issues: _____

Past Surgical History:

□Back Surgery □Breast Augmentation □C-Section □Gall Bladder □Gastric Stapling □Hernia □Hysterectomy
□Laparoscopy □Liposuction □None □Other (specify)_____

Family History:

□Adopted □Cancer □Depression □Diabetes □Heart Disease □High Blood Pressure □Obesity □Stroke
□Other (specify) _____

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Females Only

- When is the first day of your last cycle? _____
- Typical length of cycle? _____
- Have you had a hysterectomy? _____Yes _____No
  - If yes, Date of Surgery?_____
- Have you had tubal ligation? _____Yes _____No
- Are you currently breastfeeding? _____Yes _____No

□ Cervical Cancer □ Infertility □ Menopause □PCOS

Allergies

Please check all that apply - list reaction (hives, rash, etc.) and when it occurred:

Penicillin_____ Dye Allergy:_____ Morphine_____
Codeine_____Nitrate Allergy_____ Aspirin _____
Sulfa Drug_____ Pet Allergy_____ Food Allergy_____
Seasonal Pollen_____ None_____ Other_____

Over the counter (OTC) Information

Please circle all products that are used occasionally or regularly:

Pain reliever	Combination product (cold&cough) (Triaminic)	Decongestant (Sudafed)
Aspirin	Sleep aides (Excedrin PM, Unisom, Sominex, etc.)	Antihistamine (Chlor-Trimeton)
Cough suppressant	Antidiarrheal (Imodium, Peptobismol, etc.)	Acetaminophen (Tylenol)
Ibuprofen (Motrin IB)	Laxatives, stool softeners (Doxidan, Correctal, etc.)	Ketoprofen (Orudis KT)
Naproxen (Aleve)	Diet aids/weight loss products (Dexatrim)	Other (Please list):
Antacids (Maalox, Mylanta)	Acid blockers (Pepcid AC, Zantac, etc.)	_____

Nutritional/natural supplements

Please identify and list the products you are using:

Vitamins (multiple or single vitamins; B Complex, E, C, Beta carotene, etc.):
_____
Minerals (Calcium, magnesium, chromium, colloidal minerals, etc.):
_____
Herbs (Ginseng, Ginkgo Biloba, Echinacea, herbal teas, tinctures, remedies, etc.):
_____
Enzymes (digestive formula, papaya, Bromelain, Coenzyme Q10, etc.):
Cough suppressant
_____
Nutrition/protein supplements (Shark cartilage, protein powders, amino acids, fish oils, etc.):
_____
Others (Glucosamine, etc.):
_____

Other: _____

Prescription Medications

Please list prescription medications you are currently using including mail order or physician samples you are receiving:

Medication:	Dose:	Times a day:	Doctor:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Height: _____ Approximate Weight: _____

Bone Size: Small Medium Large

Body Type: Androgenic (Narrow hips, fat carried in abdomen) Estrogenic (Pear shape, larger hips/thighs)