Kaleida Health

DOWNTIME ☐ Entered into electronic record after downtime

date _____ time _____

initials _____

BARIATRIC APPLICATION PACKET 1 OF 2

Patient ID Area

COMPREHENSIVE WEIGHT LOSS MANAGEMENT APPLICATION

This form to be completed by patient.
It must be received before you can be scheduled for your initial visit.

The Center for Minimally Invasive Surgery
Buffalo General Medical Center
100 High Street, Buffalo NY, 14203
Attn: D3 CWL Clinic Application Office

Application Information Phone: (716) 859-2067 Application Fax: (716) 859-3352
Applications can be mailed or faxed to the address or fax number above.

Patient Name _____ Date of Birth _____

Telephone Number (home) _____ (cell) _____ (work) _____

Height _____ (inches) Weight _____ (pounds)

Sex ☐ Male ☐ Female Transgender ☐ Male to Female ☐ Female to Male

Address _____

_____

Primary Medical Doctor _____

Insurance Company and ID number _____

At what age did you first consider yourself overweight? _____

What was your heaviest documented weight? _____

Which diet plans have you attempted in your lifetime?

☐ Jenny Craig ☐ South Beach Diet ☐ Cabbage Soup Diet ☐ App-based Diet Plan
☐ Weight Watchers ☐ Slim Fast ☐ Dietician Directed Plan ☐ Nutrisystem
☐ Atkin's Diet ☐ Grapefruit Diet ☐ Physician Directed Plan ☐ Intermittent Fasting
☐ Keto Diet ☐ Paleo Diet ☐ Other _____

Which exercise plans have you attempted?

☐ Curves for Women ☐ Richard Simmons Tape ☐ Gold's Gym ☐ Video Workout ☐ Peloton
☐ Personal Trainer ☐ Buffalo Athletic Club ☐ Beachbody ☐ Walking ☐ iFit
☐ Gym Membership ☐ Other _____

Which medications/dietary supplements have you used to lose weight?

☐ Phen-Fen (phentermine and fenfluramine) ☐ Xenical (orlistat) ☐ Saxenda ☐ Topomax
☐ Meridia (sibutramine) ☐ Amphetamine ☐ Ozempic
☐ Other _____

(over)

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BARIATRIC APPLICATION PACKET 2 OF 2

Patient ID Area

Several medical problems can be related to weight. Do you have any of the conditions listed below?

☐ High blood pressure ☐ High cholesterol ☐ Shortness of breath on exertion ☐ Sleep apnea
☐ Asthma ☐ Diabetes ☐ Acid reflux (GERD) ☐ Bladder problems ☐ Joint pain ☐ Depression
☐ Other _____

Please provide an accurate and complete medication list including dosage and frequency. An attached list is sufficient.

Medication	Dose	Frequency

List all medical and environmental allergies and your corresponding allergic reaction _____

_____

_____

Have you ever had surgery? (please list) _____

_____

_____

Do you smoke? ☐ No ☐ Yes How much per day? _____ For how many years? _____

Do you drink alcoholic beverages? ☐ No ☐ Yes How much, and how often? _____

Do you use any illicit/recreational drugs? ☐ No ☐ Yes (explain details) _____

_____

Have you ever had a drug or alcohol problem? ☐ No ☐ Yes (explain details) _____

_____

Signature _____ Date _____ Time _____

Print Name _____

Relationship to Patient (if not completed by patient) _____