Kaleida Health

DOWNTIME
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date _____ time _____
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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)

Address _____

_____

Primary Medical Doctor _____

Insurance Company and ID number _____

Which diet plans have you attempted in the last 10 years?

☐ Jenny Craig ☐ South Beach Diet ☐ Grapefruit Diet
☐ Weight Watchers ☐ Slim Fast ☐ Cabbage Soup Diet
☐ Atkin's Diet ☐ Dietician Directed Plan ☐ Physician Directed Plan
☐ Other _____

Which exercise plans have you attempted?

☐ Curves for Women ☐ Richard Simmons Tape ☐ Gold's Gym
☐ Personal Trainer ☐ Buffalo Athletic Club
☐ Other _____

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

☐ Phen-Fen (phentermine and fenfluramine) ☐ Xenical (orlistat) ☐ Ephedra
☐ Meridia (sibutramine) ☐ Amphetamine ☐ Metabolife
☐ 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?

Condition	Medication	Dose
High blood pressure		
High cholesterol		
Shortness of breath with exercise		
Sleep apnea		
Asthma		
Diabetes		
Acid reflux (GERD)		
Bladder problems		
Joint pain		
Depression		
Other		

Do you have any allergies? (please list) _____

_____

_____

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) _____