**Synergy Bariatrics Registration Form**

| **Patient Information** | | | | | |
|---|---|---|---|---|---|
| First Name: | Last Name: | | MI: | Date of Birth: | Age: |
| Address: | City: | | State: | Zip: | |
| Home Phone: | Cell Phone: | | Work Phone: | | |
| Email: | SSN: | | Preferred Language: | | |
| Height: | Weight: | BMI: | Sex: ☐ Male ☐ Female ☐ Transgender (F to M) ☐ Transgender (M to F)<br>Other gender identity: | | |
| Race:<br>☐ White/Caucasian ☐ Black or African American ☐ American Indian/Alaska Native ☐ Asian<br>☐ Native Hawaiian ☐ Other ☐ No Response | | | | | |
| Ethnicity:<br>☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ No Response | | | | | |
| Marital Status:<br>☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner | | | | | |
| Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email | | | | | |
| Primary Care Provider (PCP): | | | PCP Phone:<br>PCP Fax: | | |
| Employment:<br>☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed<br>☐ Disabled | | | Occupation:<br>Employer: | | |
| **Emergency Contact** | | | | | |
| First Name: | Last Name: | | Relationship: | | |
| Address: | City: | | State: | Zip: | |
| Home Phone: | Cell Phone: | | Preferred Language: | | |
| **Insurance Information**: | | | | | |
| Primary Health Insurance: | | | Policy # | Group # | |
| Policy Holders Name (if other than self): | | | Date of Birth: | Employer: | |
| Secondary Health Insurance | | | Policy # | Group # | |
| Policy Holders Name (if other than self): | | | Date of Birth: | Employer: | |
| Prescription Coverage Plan (if applicable) : | | | ID/Rx#: | | |

**Synergy Bariatrics Registration Form**

| **Pharmacy Information** | | | |
|---|---|---|---|
| Pharmacy Name: ☐ Primary Pharmacy | | Phone Number: | |
| Pharmacy Address: | City: | State | Zip: |
| Mail Order Pharmacy Name: ☐ Primary Pharmacy | | Phone Number: | |
| Pharmacy Address: | City: | State: | Zip: |

| **Current Medication List**<br>****Please include birth control, hormone replacements, supplements, vitamins and over the counter medications** | | | |
|---|---|---|---|
| Medication Name | Dosage (mg) | # of times taken per day | Reason for Taking |
| | | | |
| | | | |
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| | | | |

| **Allergy/Reaction** (** include drug and food allergies) | |
|---|---|
| / | / |
| / | / |
| / | / |

| **Specialists** | Name: | Phone Number: |
|---|---|---|
| Cardiologist | | |
| Pulmonologist | | |
| Nephrologist | | |
| Endocrinologist | | |
| Psychiatrist | | |
| Psychologist/Counselor | | |
| Rheumatologist | | |
| Gastroenterologist | | |
| Orthopedist | | |
| Other | | |

**Synergy Bariatrics Registration Form**

| Medical History | | |
|---|---|---|
| ☐ Chest pain | ☐ Rheumatoid Arthritis | ☐ Lactose intolerance |
| ☐ Heart Attack | ☐ Osteoarthritis | ☐ Fatty Liver |
| ☐ Coronary artery disease (CAD) | ☐ Diabetes | ☐ Gallbladder disease |
| ☐ Congestive heart failure (CHF) | ☐ Prediabetes | ☐ Hepatitis (Type): _____ |
| ☐ Atrial fibrillation (afib) | ☐ Glaucoma | ☐ Cirrhosis |
| ☐ Arrhythmia | ☐ Polycystic ovarian syndrome (PCOS) | ☐ Pancreatitis |
| ☐ Valvular heart disease | ☐ Abnormal hair growth (Hirsutism) | ☐ Anxiety |
| ☐ High blood pressure (HTN) | ☐ Hypothyroidism | ☐ Depression |
| ☐ High cholesterol | ☐ Hyperthyroidism | ☐ Bipolar disorder |
| ☐ High triglycerides | ☐ Thyroid Nodule | ☐ ADHD |
| ☐ Peripheral vascular disease | ☐ Infertility | ☐ Eating disorder |
| ☐ Lower extremity swelling (edema) | ☐ Menstrual Irregularities | ☐ Anorexia |
| ☐ Lymphedema | ☐ Anemia | ☐ Bulimia |
| ☐ Venous stasis | ☐ Iron deficiency | ☐ Migraines |
| ☐ Stroke | ☐ B12 deficiency | ☐ Seizures |
| ☐ Deep vein thrombosis | ☐ Vit D deficiency | ☐ Pseudotumor Cerebri |
| ☐ Sleep Apnea | ☐ Bleeding disorder | ☐ Idiopathic intracranial hypertension |
| ☐ Shortness of breath | ☐ Sickle cell | ☐ Multiple Sclerosis |
| ☐ Asthma | ☐ Gastroesophageal reflux (GERD)/Heartburn | ☐ Lupus |
| ☐ COPD (emphysema/chronic bronchitis) | ☐ Stomach/duodenal ulcers | ☐ Abdominal wall hernia |
| ☐ Pulmonary embolism (PE) | ☐ Barrett's esophagus | ☐ Abdominal skin/pannus irritation/infection |
| ☐ Pulmonary Hypertension | ☐ Crohn's disease | ☐ Stress Incontinence |
| ☐ Back Pain | ☐ Ulcerative colitis | ☐ Kidney stones |
| ☐ Disc disease | ☐ IBS/chronic diarrhea | ☐ Chronic kidney disease |
| ☐ Fibromyalgia | ☐ IBS/constipation | ☐ Cancer |
| ☐ Gout | ☐ Celiac disease | Type: _____ |
| ☐ Arthritis | | |
| Other: | | |
| Last colonoscopy: _____ ☐ N/A | | Last mammogram: _____ ☐ N/A |

| Surgical History<br>**List all prior surgeries including year if known | |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Synergy Bariatrics Registration Form**

| Social History | |
|---|---|
| Smoking: | ☐ Never ☐ Current Smoker (____packs/day) ☐ Former Smoker (quit ___ years ago) |
| Vaping: | ☐ Never ☐ Current (____puffs/day, ____% nicotine) ☐ Former (quit ___ years ago) |
| Alcohol: | ☐ Never ☐ Occasional ☐ Regularly (___ drinks per day) |
| Marijuana: | ☐ Never ☐ Current use (____times/day) ☐ Smoking/inhaled ☐ Edibles ☐ Former use |
| Drugs: | ☐ Never ☐ Current ☐ Former use ☐ Type of drugs: _____ |
| Prior treatment for alcohol addiction/abuse: Y/N | Prior treatment for drug addiction/abuse: Y/N |
| Chewing Tobacco: ☐ Yes ☐ No | |

| Family History | |
|---|---|
| Obesity | ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son |
| Diabetes | ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son |
| Other: ☐ High blood pressure ☐ Heart disease ☐ High cholesterol ☐ High triglycerides ☐ Stroke<br>☐ Thyroid problems ☐ Anxiety ☐ Depression ☐ Bipolar Disorder ☐ Blood clots ☐ Bleeding tendencies<br>☐ Problems with anesthesia ☐ Cancer, list type(s): _____<br>☐ Other: | |

| **Gynecologic History**<br>(** applies to those assigned female at birth) | Age periods started? | Age periods ended? |
|---|---|---|
| Periods are: Regular / Irregular<br>Heavy / Normal / Light | Number of Pregnancies:<br>Number of Children: | Age of first pregnancy:<br>Age of last pregnancy: |

| Review of Systems | | |
|---|---|---|
| ☐ Recent weight loss > 10 lbs. | ☐ Mood changes | ☐ Increased appetite |
| ☐ Recent weight gain >10 lbs. | ☐ Inability to concentrate | ☐ Decreased appetite |
| ☐ Weakness/low energy | ☐ Loss of Interest | ☐ Excessive thirst |
| ☐ Fatigue/tiredness | ☐ Memory loss | ☐ Abdominal pain |
| ☐ Chest pain | ☐ Skin rashes | ☐ Heartburn |
| ☐ Palpitations | ☐ Easy bruising | ☐ Bloating/gas |
| ☐ Shortness of breath | ☐ Poor wound healing | ☐ Diarrhea |
| ☐ Difficulty lying flat | ☐ Bleeding tendency | ☐ Constipation |
| ☐ Swelling/edema of extremities | ☐ Blood clots | ☐ Blood in stool |
| ☐ Cough | ☐ Hair changes | ☐ Nausea/vomiting |
| ☐ Snoring | ☐ Acne | ☐ Vomiting blood |
| ☐ Insomnia | ☐ Cold intolerance | ☐ Difficulty swallowing |
| ☐ Dizziness | ☐ Heat intolerance | ☐ Pain with swallowing |
| ☐ Fainting/blackouts | ☐ Excessive sweating | ☐ Food intolerance |
| ☐ Headaches | ☐ Joint pain | ☐ Urinary frequency/urgency |
| ☐ Anxiety | ☐ Backpain | ☐ Slow urine flow |
| ☐ Depression | ☐ Muscle aches/pain | ☐ Nighttime urination |

**Synergy Bariatrics Registration Form**

**Patient Name**: **Date of Birth**:

## Weight History

When did you start gaining weight?
☐ Childhood ☐ Teen/Adolescence ☐ Adulthood Age: _____ ☐ Pregnancy ☐ Menopause

Highest adult weight: _____ lbs at age _____ | Lowest adult weight: _____ lbs at age _____

Life events associated with weight gain (check all that apply):
☐ Marriage ☐ Divorce ☐ Pregnancy ☐ Menopause ☐ Illness ☐ Injury ☐ Travel ☐ Job change
☐ Nightshift work ☐ Sedentary job ☐ Mental illness ☐ Alcohol ☐ Quit smoking ☐ Drugs
☐ Medication (please list: _____)

Previous diets/weight loss programs (check all that apply)

| | | | |
|---|---|---|---|
| ☐ Self-Directed | ☐ Mediterranean diet | ☐ Paleo | ☐ Vegetarian |
| ☐ High Protein | ☐ Dash Diet | ☐ Jenny Craig | ☐ LA Weight Loss |
| ☐ Calorie restriction | ☐ Flexitarian Diet | ☐ Medifast/Optavia | ☐ My Fitness Pal |
| ☐ Low carb | ☐ Zone diet | ☐ Slimfast | ☐ Noom |
| ☐ Weight Watchers | ☐ Atkins | ☐ HCG diet | ☐ Mayo Clinic Diet |
| ☐ South Beath | ☐ Keto | ☐ Ornish diet | ☐ GOLO |
| ☐ Nutrisystem | ☐ Whole30 | ☐ Flexitarian diet | ☐ Ideal You |
| ☐ Intermittent Fasting | ☐ Mind Diet | ☐ Cabbage Soup diet | ☐ Perfect Body |
| ☐ TLC diet | ☐ Pescatarian diet | ☐ Vegan | ☐ Meal Delivery Plan |

Which diet program(s) worked best? | Maximum weight loss:

What are your greatest challenges with dieting?

Weight loss Medications | Have you used medications for weight loss? Y / N (if yes check all that apply)

☐ Phentermine (Adipex) ☐ Fenfluramine/Phentermine (Fen-Phen) ☐ Meridia ☐ Xenacal/Alli ☐ Topamax
☐ Phendimetrazine (Bontril) ☐ Diethylpropion (Tenuate) ☐ Bupropion (Wellbutrin) ☐ Belviq ☐ Qsymia
☐ Contrave ☐ Saxenda ☐ Wegovy ☐ Ozempic ☐ Mounjaro
Other (including OTC supplements): _____
What worked? _____ Maximum weight lost? _____
What didn't work? _____ _____

Prior Bariatric Surgery | ☐ Sleeve ☐ Gastric Bypass ☐ Duodenal Switch ☐ Lap Band ☐ Other: _____
Weight prior to surgery: _____ Total weight loss: _____Total weight regain: _____

## Nutrition History

Do you eat breakfast: Y / N How many days/week? | # of meals you eat per day: # of snacks per day:

What beverages do you drink?

Do you get up at night to eat? Y / N If so, how often?

**Food triggers** (check all that apply): ☐ Stress ☐ Boredom ☐ Anger ☐ Insomnia ☐ Group functions ☐ Eating out ☐ Needing a reward ☐ Other (list):

**Food cravings**: ☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ High fat ☐ Fast Food ☐ Large portions

## Exercise

Exercise Type: | Duration: _____hours _____minutes _____times/week

Does anything limit you from exercising?

Synergy Bariatrics
30 N Union Rd, Suite 104
Williamsville, NY 14221
**P**:716-565-3990 **F**:716-565-3988
synergybariatrics@ecmc.edu

# Primary Care Physician Documentation for Bariatric Surgery Approval
# BRING THIS TO YOUR PRIMARY CARE DOCTOR

| | | | |
|---|---|---|---|
| Patient Name: | | Date of Birth: | |
| | | | |
| I am referring this patient to you for consideration of weight loss surgery for severe obesity. | | | |
| | | | |
| **The patient has been morbidly obese for at least five years:** | | **□ Yes** | **□ No** |
| **I have followed the patient's diet/exercise for at least 6 months** | | **□ Yes** | **□ No** |
| My patient's height is: | Inches | | centimeters |
| My patient's last recorded weight is: | pounds | | kilograms |
| My patient's BMI is: | | | |

My patient has the following co-morbidities:

| | | |
|---|---|---|
| □ Diabetes | □ Sleep apnea | □ Asthma |
| □ Hypertension | □ Depression | □ Pulmonary Disease |
| □ Arthritis | □ Degenerative Arthritis | □ GERD |
| □ Backache | □ Coronary Disease | |
| □ Other (please list): | | |
| | | |

□ There is no significant liver, kidney, or gastrointestinal disease present.
□ There is no treatable cause for obesity such as adrenal or thyroid disorder.
□ There are no cardiac or pulmonary contraindications to bariatric surgery.
□ There is no history of alcohol or substance abuse.

***** (IF ANY BOX REMAINS UNCHECKED, PLEASE ADDRESS WHY):** _____
_____ _____
_____

□ Screening Mammogram N/A No Yes (date) _____
□ Screening Colonoscopy N/A No Yes (date) _____

**TSH level (within last 6 months) _____**

**PLEASE ATTACH A COPY OF ALL RECENT LAB RESULTS**
**PLEASE ATTACH CURRENT MEDICATION LIST**

The remainder of the physical examination is:
□ Unremarkable
□ Positive for: (please list) _____

By signing this form, I believe the patient is a good candidate for surgery and would benefit from significant weight loss. I would be happy to see the patient again prior to surgery for medical clearance.

Practice Name & Address_____

Phone _____ Fax _____

Print name of Physician _____

Signature _____ Date _____

**Please fax completed form and requested information to (716) 565-3988**

Synergy Bariatrics, a Department of ECMC
30 North Union Road ○ Suite 104 ○ Williamsville NY 14221
Phone: (716) 565-3990 ○ Fax: (716) 565-3988

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