

# Weight and Wellness Center **Tufts** Medical Center

## Preliminary Application

**(Please complete and fax or mail)**

800 Washington Street, #900  
Boston, MA 02111

Phone: 617-636-6086 Fax: 617-636-2386

Date: \_\_\_\_\_

Name \_\_\_\_\_ email: \_\_\_\_\_

Address \_\_\_\_\_  
street city state zip code

Phones: home (\_\_\_\_) \_\_\_\_\_ work (\_\_\_\_) \_\_\_\_\_ cell (\_\_\_\_) \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Marital Status \_\_\_\_\_ Number of Children \_\_\_\_\_

How did you hear of this program?  TV  Radio  Newspaper  My Doctor  Another Patient  Self  Other

Current Weight or Best Estimate \_\_\_\_\_ Current Height \_\_\_\_\_ ft \_\_\_\_\_ in

Your Primary Choice (choose more than one if you're unsure):

Surgical Programs:  Gastric Bypass  Adjustable Band

Non-Surgical Programs:  Physician Supervised/Behavior Programs  Meal Replacement  Unsure

## Hospitalizations

List all inpatient hospitalizations, including any for psychiatric and substance abuse treatment.

Date	Diagnosis	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Medical and Psychiatric History

Check each of the following conditions that you are experiencing now, or have experienced in the past. List any additional conditions.

Medical  Hypertension/high blood pressure  Crohn's Disease  
 Sleep apnea C-PAP  yes  no  Diabetes  
 High cholesterol or triglycerides  Prior abdominal surgery  
 Ulcerative Colitis  Other

Psychiatric  Depression  Bipolar disorder  Eating disorder  Anorexia  Bulimia

Present Psychiatric Medications: \_\_\_\_\_

## Insurance Information

Insurance Co. Name: \_\_\_\_\_ ID #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Relationship to patient:  Self  Spouse  Child  Other

I have carefully read this Assessment and have answered the questions as truthfully as possible.

\_\_\_\_\_  
signature

\_\_\_\_\_  
date