

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 _____

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