Tufts Medical Center

Weight and Wellness Center
800 Washington St, #900
Boston, MA 02111
Phone: 617-636-6086
Fax: 617-636-2386

Preliminary Application *Please complete and fax or e-mail.*

Date _____

Name _____ **E-mail** _____

Address _____

Phones *home* _____ *work* _____ *cell* _____

Sex _____ **Date of birth** _____ **Marital status** _____ **# of children** _____

Primary Care Physician _____ **Phone #** _____

How did you hear of this program?

☐ TV ☐ Radio ☐ Newspaper ☐ My doctor
☐ Another patient ☐ Self ☐ Internet ☐ Other

Current weight _____ **Current height** _____ *ft* _____ *in* **BMI** _____
(or best estimate) *Office use only*

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

☐ Medical weight loss ☐ Surgical weight loss ☐ Jumpstart to Wellness

HOSPITALIZATIONS

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

Date	Diagnosis	Hospital

Have you had weight loss surgery before? ☐ Yes ☐ No **If yes, what type?** _____

Where? _____ **When?** _____

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
☐ Chrohn's Disease
☐ Sleep apnea
CPAP ☐ *Yes* ☐ *No*
☐ Diabetes
☐ High cholesterol or triglycerides
☐ Prior abdominal surgery
☐ Ulcerative Colitis
☐ Other: _____
_____

Psychiatric

☐ Depression
☐ Bipolar disorder
☐ Anorexia
☐ Bulimia
☐ Eating disorder

Present psychiatric medications:
_____
_____

INSURANCE INFORMATION

Insurance Co. Name _____ **ID #** _____

Name of Insured _____ **Relationship to Patient** _____