



MOUNT AUBURN HOSPITAL



Weight Management Center MOUNT AUBURN HOSPITAL

355 Waverley Oaks Road, Suite 100 Waltham, MA 02452 Phone: 781-314-7600 Fax: 781-314-7666

Preliminary Application (Please complete and fax or mail)

Date: Name: Email: Address: Phones: home work cell Sex: Date of Birth: Marital Status: Number of Children: Primary Care Physician (PCP): Phone #: Is s/he an affiliate of Harvard Vanguard Medical Associates MAPS (Mount Auburn Prof. Services) Unsure

How did you hear of this program?

TV Radio Newspaper My Doctor Another Patient Self Internet Other

Current Weight or Best Estimate: Current Height ft in BMI: Office Use Only

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

Surgical Programs: Gastric Bypass Adjustable Gastric Band Sleeve Gastrectomy Non-Surgical Programs: Medically Supervised Program Unsure

Hospitalizations

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

Table with columns: Date, Diagnosis, Hospital

Have you had any type of 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 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:

FOR OFFICE USE ONLY Appt. Type: Date: Time: Type: Date: Time: