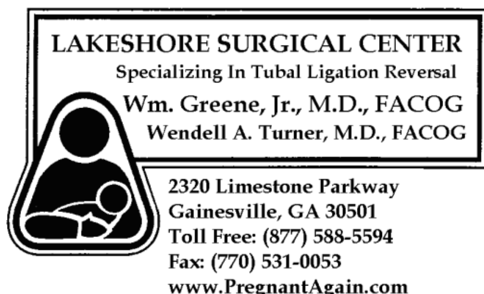

2320 Limestone Parkway
Gainesville, GA 30501
Toll Free: (877) 588-5594
Fax: (770) 531-0053
www.PregnantAgain.com

Please fill out this form in its entirety.

NAME:

First________________ Last________________ DOB __________

ADDRESS:

Street________________ City____________ State_____ Zip______

PHONE:

Cell Number _____-_____-_____ Home Number _____-_____-_____
Place of Employment________________ Work Number _____-_____-_____

Your SOCIAL SECURITY number _____-_____-_____

Email Address:________________@____________

Emergency Contact:
NAME ________________ RELATIONSHIP ____________
PHONE NUMBER____________ (Please Circle One) CELL or WORK or HOME

Do you take any medications or dietary supplements? If yes, please list. Yes or No ______

	Medication	Dosage/ How Often		Medication	Dosage/ How Often
1.			2.		
3.			4.		
5.			6.		

Do you have any allergies? (i.e. Latex, Medications, Tape etc.) Yes or No ______

	Allergy	Reaction		Allergy	Reaction
1.			2.		
3.			4.		
5.			6.		

Have you ever had any surgeries? Yes or No ______
Please list the year and type of surgery.

YEAR	TYPE OF OPERATION

PLEASE ANSWER QUESTIONS WITH A YES OR NO

1. Have you ever or are you now under a doctor's care for a medical illness? 1. ______
2. Diabetes? 2. ______
3. High Blood Pressure? 3. ______
4. Thyroid Problems? 4. ______
5. Sickle Cell Anemia? 5. ______
6. Heart Problems? 6. ______

Explain:________________

Have you ever had an allergic reaction to sutures or problems with a surgical incision? Yes or No ______
Explain:________________

Have you or your family ever had a problem with anesthetics? Yes or No ______
Explain:________________

Does anyone in your family (Parents, Brothers, Sisters, etc.) have any unusual illnesses? Yes or No ______
If YES, please explain. ________________

How old were you when you had your first menstrual period? __________ Years Old
Do your periods come every month? Yes or No _________ How many days do you bleed? ________ Days
Approximately how many days between your menses? ________ Days

Have you ever had an IUD (Intrauterine Device for Contraception)? Yes or No ________

Have you ever had a tubular (ectopic) pregnancy? Yes or No ________
If so, do you know which side? Left or Right ________

Other than yeast infections, have you ever had any serious pelvic infections? Yes or No ________
(Chlamydia, Gonorrhea, Herpes, etc.) If YES, please explain
YEAR TYPE OF INFECTION TREATMENT (shots, pills, hospital)
____
____

How many times have you been pregnant? ___________ How many miscarriages? ________
How many therapeutic abortions? _______ Any premature births? ________________
Have you had any C-Sections? _____________ How many? ________________

Did you have complications with any of your pregnancies? Yes or No _________
____
____

(Please answer the next 12 questions with YES or NO & Explain Below.)

1. Have you ever been told that you have a tipped uterus? 1. _________
2. Do you have any problems with your vision, hearing, taste or smell? 2. _________
3. Do you have loose teeth? 3. _________
4. Do you have asthma or other breathing problems? 4. _________
5. Does your heart beat irregularly (flip flops)? 5. _________
6. Do you have chest pain? 6. _________
7. Do you have stomach problems? 7. _________
8. Do you ever have blood in your bowel movements? 8. _________
9. Do you ever have back or joint pain? 9. _________
10. Have you ever had treatment for your nerves? 10. _________
11. Have you ever had clotting problems with your blood? 11. _________
12. Do you have or ever had anemia? 12. _________

PLEASE EXPLAIN ANY YES ANSWERS FROM ABOVE. Also, is there anything we did not ask that you feel we should know about you or your health?
____
____
____
____

How tall are you? _________________ How much do you weigh? ________________

I understand that failure to accurately answer these questions could make caring for me more difficult or impossible. I have answered all questions truthfully and accurately. Failure to give accurate information on height and weight could result in delay of surgery date and incur a $500.00 rescheduling fee.

I understand and agree that appointments are secured with a $1500.00 non-refundable deposit should I decide to come for surgery at Lakeshore Surgical Center. Once the appointment is made and non-refundable deposit is paid, the remaining balance is due 2 weeks prior to surgery.

I further understand and agree that there are NO REFUNDS. If I have not met my weight goal or change my mind regarding the surgery, once I have arrived, there will be no refund. If I schedule a surgery and have to reschedule, I understand there is a $500.00 rescheduling fee. Discounted surgical fee is a onetime offer and will be subject to rescheduling fee and remaining balance will be due.

I understand that if I pay my surgical fee by check and it is returned for any reason I will be responsible for the $35.00 fee to Lakeshore Surgical Center. If I am financing my surgery, no refund will be given by Lakeshore Surgical Center. All loans are non-recourse and subject to our $500.00 rescheduling fee.

SIGNATURE____DATE________________________