


LAKESHORE SURGICAL CENTER
 Specializing In Tubal Ligation Reversal
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 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. _____
- 7. Seizures? 7. _____

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 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)
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How many times have you been pregnant? _____ How many miscarriages? _____
 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. If I schedule my surgery and have to reschedule, I understand there is a \$500.00 rescheduling fee. Failure to give accurate information on height and weight could result in delay of surgery date and incur rescheduling fee.

I understand and agree that the entire fee is due 2 weeks prior to surgery. Cancellation of your procedure will result in a 50% forfeiture of your surgical fee, minus the \$1,500.00 Non-Refundable scheduling deposit. Cancellation of your procedure within 14 days of the surgical date, regardless of reason, will result in forfeiture of 100% of the surgical fee. Refunds on cancellations may take up to 45 days to process.

If I have not met my weight goal or change my mind regarding the surgery, once I have arrived, I will forfeit 100% of my surgical fee.

SIGNATURE _____ DATE _____