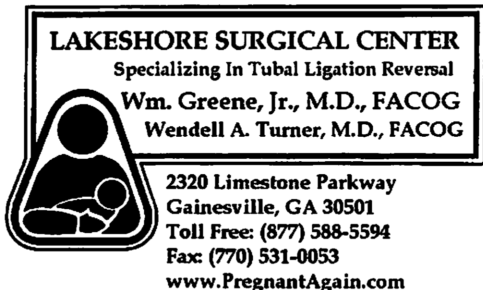

2320 Limestone Parkway
Gainesville, GA 30501
Toll Free: (877) 588-5594
Fax: (770) 531-0053
www.PregnantAgain.com

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. _____
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)

____

____

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. Cancellation without rescheduling within 2 weeks of your surgery appointment will result in your forfeiture of all fees paid.
I understand and agree that the entire fee is due 2 weeks prior to surgery.
Cancellation of your procedure within 15 to 21 days of the date of surgery 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 date surgery, 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. The Pre-Payment Plan deposit of $500.00 is Non-refundable.

SIGNATURE____DATE__________________