LAKESHORE SURGICAL CENTER
Specializing In Tubal Ligation Reversal
Wm. Greene, Jr., M.D., FACOG
Wendell A. Turner, M.D., FACOG
2320 Limestone Parkway
Gainesville, GA 30501
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Fax: (770) 531-0053
www.PregnantAgain.com

Complete all sections of this form

First and Last Name: _____ **DOB:** _____

Mailing Address: _____
_____

Cell Number: _____ **Alternate Number:** _____
Social Security Number: _____-_____-_____ **Email Address:** _____
Place of Employment: _____
Emergency Contact: (Name, Relationship, and Cell Number)
_____

Medications & Supplements

Do you take any medications, weight loss medication, or dietary supplements? Yes ☐ No ☐
Are you Diabetic? Type 1☐ Type 2☐

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

Allergies

Do you have any allergies? (Latex, Medications, Tape, etc.) Yes ☐ No ☐

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

Have you ever had allergic reaction to sutures or problems with surgical incisions? Yes ☐ No ☐
Explain: _____

Surgical History

Have you ever had any surgeries? Yes ☐ No ☐

Year _____ Type of Operation _____

Year _____ Type of Operation _____

Year _____ Type of Operation _____

Year _____ Type of Operation _____

Age at first menstrual period: _____ years old

Periods every month? Yes ☐ No ☐

How many days do you bleed? _____

Days between menses? _____

Have you ever had a tubal (ectopic) pregnancy? Yes ☐ No ☐

If yes, which side? Left ☐ Right ☐

Other than yeast infections, have you had serious pelvic infections? Yes ☐ No ☐ (Chlamydia, Gonorrhea, Herpes, etc.)

If yes, explain: Infection Type and Treatment

_____

How many times pregnant? _____ | Miscarriages? _____ | Premature births? _____ |

C-Sections? _____ How many? _____

Did you have complications with any pregnancies? Yes ☐ No ☐

Explain: _____

Medical History Questions (Please check all that apply)

Have you been or currently under a Doctor's Care for a medical illness? Yes ☐ No ☐

☐ Acid reflux/GERD	☐ Cancer:	☐ Heart Murmur/Valve Problem	☐ Seizures
☐ Anemia	☐ COPD	☐ High Cholesterol	☐ Sleep Apnea
☐ Anxiety Disorder	☐ Chest Pain	☐ High Blood Pressure	☐ Sickle Cell Anemia
☐ Arthritis	☐ Coronary Artery Disease	☐ Thyroid Problem	☐ Stroke
☐ Asthma	☐ Depression	☐ Kidney Disease	☐ Tipped Uterus
☐ Back or Joint Pain	☐ Diabetes	☐ Kidney Stones	☐ Teeth: Cracked or loose
☐ Bipolar Disorder	☐ Diverticulitis	☐ Leg/Foot Ulcers	☐ Other:
☐ Bleeding Disorder	☐ Fibromyalgia	☐ Liver Disease	☐ Other:
☐ Blood Clots (DVT or PE)	☐ Gout	☐ Migraines	☐ Other:
☐ Blood in Stools	☐ Heart Attack	☐ Osteoporosis	☐ Other:

Have you or your family ever had a problem with anesthetics? Yes ☐ No ☐

Does anyone in your family have unusual illnesses? Yes ☐ No ☐

Do you smoke cigarettes or vape? Yes ☐ No ☐

Please explain any YES answers or additional health information:

_____

_____

_____

Height: _____ Weight: _____

Surgical Agreement & Fees

I understand that providing inaccurate information may make it difficult or impossible to provide appropriate care. I have answered all questions truthfully and accurately. If I need to reschedule my surgery after it has been scheduled, I acknowledge that a $500.00 rescheduling fee will apply. Providing incorrect height or weight information may delay my surgery and result in this rescheduling fee.

If I cancel my surgery and do not reschedule within two weeks of the original appointment, I understand that all fees paid will be forfeited. I agree that the full surgical fee is due two weeks prior to the procedure date.

If I cancel my procedure between 15 and 21 days before surgery, I will forfeit 50% of the surgical fee, in addition to the $1,500.00 non-refundable scheduling deposit. If I cancel within 14 days of surgery, for any reason, I understand that 100% of the surgical fee will be forfeited. Refunds related to cancellations may take up to 45 days to process.

If I arrive for surgery without meeting my weight goal or decide not to proceed, I will forfeit 100% of my surgical fee. The $500.00 Pre-Payment Plan deposit is non-refundable, and no refunds will be issued after six months.

I understand that I will be subject to all current fees and policies in effect at the time should I need to cancel or reschedule my surgery.

Signature: _____ **Date:** _____