



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 _____