



NAME

First: _____ Last _____ DOB _____

ADDRESS

Street _____ City _____ State _____ Zip _____

PHONE NUMBERS:

Work: _____ - _____ - _____ Place of Employment: _____

Home: _____ - _____ - _____ Cell Phone: _____ - _____ - _____

Your SOCIAL SECURITY number: _____ Email Address: _____@_____

Emergency contact number other than your husband:

Name: _____ Phone Number: _____

Do you take any medications or dietary supplements? Yes No

Explain: _____

Do you have any allergies? Yes No

Explain: _____

Have you ever had any troubles with and medications? Yes No

Explain: _____

Have you had any C-Sections? How Many? _____ Yes No

Have you ever had any surgeries? Yes No

Please list the year and type of surgery.

YEAR	TYPE OF OPERATION
_____	_____
_____	_____

Please answer the following questions YES or NO.

Have you ever or are you now under a doctor's care for a medical illness? Yes No

Diabetes? Yes No

High Blood Pressure? Yes No

Thyroid Problems? Yes No

Sickle Cell Anemia or Anemia? Yes No

Heart Problems? Yes No

Explain:

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

Explain: _____

Does anyone in your family (Parents, Brothers, Sisters) have any unusual illnesses? Yes No

Explain: _____

How old were you when you had your first menstrual period? _____

Do your periods come every month?

Yes No

How many days do you bleed? _____

Approximately how many days between your menses? _____

Have you ever had an IUD (Intrauterine Device for Contraception)?

Yes No

Have you ever had a tubular (ectopic) pregnancy?

Yes No

If so, do you know which side?

Lft Rt

Other than yeast infections, have you ever had any serious pelvic infections?

(Chlamydia, Gonorrhea, Herpes, etc.)

Yes No

YEAR

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 No

Explain: _____

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

Can you chew and swallow food?

Yes No

Do you have any problems with your vision, hearing, taste or smell?

Yes No

Do you have loose teeth?

Yes No

Do you have asthma or other breathing problems?

Yes No

Does your heart beat irregularly (flip flops)?

Yes No

Do you have chest pain?

Yes No

Do you have stomach problems?

Yes No

Do you ever have blood in your bowel movements?

Yes No

Do you ever had back or joint pain?

Yes No

Have you ever had treatment for your nerves?

Yes No

Have you ever had clotting problems with your blood?

Yes No

Do you have or ever had anemia?

Yes No

Is there anything we did not ask that you feel we should know about you or your health?

Explain: _____

How tall are you? _____

How much do you weigh? _____

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 that failure to accurately answer these questions could make caring for me more difficult or impossible. I have answered all questions truthfully and accurately.

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.

When an appointment is made, the balance of \$5400.00 due 2 weeks before the surgery date and I further understand and agree that no refunds are made 6 weeks prior to the surgery date. If my surgery is scheduled within a 1-2 week period, prior to surgery date, there will be no refunds and money is due and payable, immediately. 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. I understand that 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: _____