



Reproductive Medicine Associates of New Jersey

Patient Questionnaire – Fertility Preservation

Patient Name: _____
Last First Middle

Date of Birth: ____ / ____ / ____ **Age:** _____

Social Security #: _____

Address: _____
Street Apt. or POB#

City State Zip Code + 4

Phone: (H) (____) _____ **(W)** (____) _____

E-Mail: _____ **Pharmacy:** (____) _____

Partner Name: _____
Last First Middle

Partner Social Security #: _____ **DOB:** _____ **Age:** _____

Current Gynecologist: _____ **Gynecologist's Phone** _____

Oncologist: _____ **Oncologist's Phone:** _____

Please tell us how you heard about RMA _____

It is very important that you take the time to fill out the * questions accurately

MEDICAL HISTORY

Weight _____ Height _____ Blood Type (if known) _____ **YES** **NO**

Have you lost greater than 20 lbs. in the last year?.....

Do you follow a particular food diet or have any special dietary habits?.....
If yes, specify: _____

Have you ever had an eating disorder (anorexia or bulimia).....
If yes, specify: _____

Do you have any allergies to medications?.....
If yes, please note: _____

Exercise: _____ Hrs/Week _____

Do you or have you ever had: (check **ALL** that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Ovarian Cysts |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cervical Cancer |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Hirsutism (Excess Hair Growth) | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Breast Tenderness |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Breast Soreness |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Breast Milky Discharge |
| <input type="checkbox"/> Pelvic Infection | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Neurologic Problems |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Colitis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Measles: Regular | <input type="checkbox"/> Anemia | <input type="checkbox"/> Poor Sense of Smell |
| <input type="checkbox"/> Measles: German | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid Problems | |
| <input type="checkbox"/> Nongonococcal Urethritis | | |
| <input type="checkbox"/> Breast Cancer | | |

- Loss of Balance
- Chronic Headaches
- Blood Transfusions
- Parasitic Infection
- Ovarian Cancer

Vaginitis Trichomoniasis or Yeast. # per year: _____

Other Cancers? Specify: _____

Any Allergies? List: _____

List the forms and frequency of regular vigorous exercise (swimming, cycling, running, and age you began): _____

Exercise: _____ Hrs/Wk: _____ Exercise: _____ Hrs/Wk: _____

Within the last year, have you taken any prescription medications? Please note in the chart below

Medication	Diagnosis	Dosage / Frequency	Duration

Are you taking any over-the-counter meds on a regular basis? Please note in the chart below.

Medication	Diagnosis	Dosage / Frequency	Duration

Do you or have you ever used? (check **ALL** that apply):

- Alcohol - How many glasses per week do you usually drink?
Wine: _____ Beer: _____ Cocktails: _____
- Cigarettes – Number of packs / day _____ Number of years _____
- Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) If you would feel more comfortable not writing anything down, please discuss this directly with your physician.
Specify:

MENSTRUAL HISTORY

Age at first period: _____ Date of **LAST** period: _____

Are your periods regular.....

What is the usual # of days *between* periods? Minimum _____ Maximum _____

What is the usual duration of your bleeding? Minimum _____ Maximum _____

YES **NO**

Do you have PMS?.....
 If yes, MILD MODERATE SEVERE

Do you have painful menses?.....
 If yes, MILD MODERATE SEVERE

Have you been exposed to any toxins.....

What is your ethnic origin?

<input type="checkbox"/> White non -Hispanic	<input type="checkbox"/> White Hispanic	<input type="checkbox"/> Black non -Hispanic	<input type="checkbox"/> Black Hispanic
<input type="checkbox"/> Asian non- Hispanic	<input type="checkbox"/> Asian Hispanic	<input type="checkbox"/> Native American	
<input type="checkbox"/> Unknown /Not Stated please indicate			

PREGNANCY DATA

*How many prior pre-term (<37 weeks) births have you had? _____

*How many prior full-term (>37 weeks) births have you had? _____

*How many pregnancies (including abortions) have you had? _____

*How many spontaneous abortions have you had? _____

Please fill in the chart below:

Pregnancy #	Year	End in Abortion? Spontaneous or Induced Abortion? Or Ectopic Pregnancy?	Infertility therapy required to conceive?	How long to conceive? (months)	Greater than or equal to 37 weeks Yes/No	Baby born alive ?	Is current partner the father?
1 st Pregnancy							
2 nd Pregnancy							
3 rd Pregnancy							
4 th Pregnancy							
5 th Pregnancy							

SURGICAL HISTORY

Have you ever been surgically sterilized? YES _____ NO _____

How many operations have you had? _____

SURGICAL HISTORY

Date	Hospital	Procedure	Findings	Surgeon

HISTORY OF FERTILITY THERAPY

Have you been treated for infertility before?.....

If yes, who was your physician? _____

Address: _____

What cause of infertility was diagnosed? _____

*Number of prior Fresh ART (IVF) Cycles _____

*Number of prior Frozen ART (IVF) Cycles _____

IVF HISTORY												
Cycle#	1		2		3		4		5		6	
Date												
IVF Center												
Frozen Embryo Cycle	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
Max. Start Dose												
Max. Estradiol												
# Eggs Retrieved												
# Eggs Fertilized												
ICSI: Y/N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
# Embryo(s) Transferred												
Embryo Age (Day 2, 3 or 5)												
Pregnancy: Y/N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
Delivered: Y/N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N

MALE DATA – if applicable

Name: _____
First
Last

Marriage #: _____

Number of pregnancies conceived with current partner: _____

Number of pregnancies conceived with previous partner: _____

Please give approximate dates and outcomes of any pregnancies conceived with a previous partner:

Date of Pregnancy	Pregnancy Outcome		
	Delivered	Aborted	Miscarried

Urologists: _____

Address: _____ Phone: _____

Have you ever had a semen analysis (sperm count) performed? **YES** **NO**

Date of Semen Analysis	Location of Analysis	Count (Million/ml)	Motility	Grade	Morphology

REFERRING ONCOLOGIST:

Name:

Address:

Phone:

Fax:

Email:

Cancer or Disease	Date of Diagnosis or Biopsy

DISEASE STATUS:

Cell Type:

Stage:

Size:

Grade:

Estrogen Receptor Positive

Progesterone Receptor Positive

HER2 STATUS:

Number of lymph nodes affected:

BRCA1/2: DONE NOT DONE

Result:

TREATMENT PLAN:

Surgery:

Date:

Chemotherapy Agents/Dose:

1. 2. 3. 4.

Start Date:

End Date:

Hormonal Treatment:

Start Date:

End Date:

Biological Agents/Antibodies:

Start Date:

End Date:

