



Reproductive Medicine Associates
of New Jersey

IVIRMA Global



We're glad you found us here at Reproductive Medicine Associates of New Jersey (RMANJ). Perhaps you're struggling to conceive for the first time or have experienced multiple miscarriages. Maybe you're dealing with an endocrine disorder or wondering if fertility preservation is right for you. Whatever road you're on, we can help.

For more than 20 years our expert physicians, nurses, and entire team have been helping one patient at a time find the right path to success.

To get to know you, your goals, and your health history a little better, please answer the following questions so we can make the most of your new patient consultation. We are required by our governing organization, the Society for Assisted Reproductive Technology (www.sart.org) to ask many of the following questions which improve our understanding of reproductive medicine.

Depending on your health history it should take you between five to ten minutes to complete.

Have a question along the way? Call our patient liaison team 7am-5pm M-F at 973-656-2089 or email us at patientliaison2@rmanj.com.

FEMALE DEMOGRAPHIC INFORMATION

Name (Last) _____ (First) _____ (Middle) _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Profession: _____ Employer: _____

What is your primary reason for your consultation?

Infertility Recurrent Pregnancy Loss Endocrine Disorder Fertility Preservation Other

Please tell us about some of your goals or expectations for your consultation? (fill in answer below)

HEALTH HISTORY BRIEF

How long have you been trying to conceive? (Months) _____

How old were you when you had your first period? (Age) _____

What was the date of you last period? (Month/Day) _____

Are your periods regular? Yes No

How many days between your menstrual cycles? (i.e. 21) _____

How many days do you bleed for? (i.e. 7) _____

Have you ever smoked in the past? Yes No

Do you currently smoke? (Y/N) Yes No

Packs per day? _____

How long have you been smoking? (Years) _____

How many glasses of alcohol do you drink per week? (i.e. 7) _____

Do you use recreational drugs? (i.e. marijuana) Yes No

If yes, how often? _____

Have you ever used performance enhancing steroids? Yes No

Are you allergic to any medications? (Y/N) Yes No

If yes, please list medications you are allergic to: (fill in answer below)

Please list any medical issues that require regular attention by a physician or other healthcare provider: (fill in answer below)

Please list any prescription medications you've taken in the last 12-months

DRUG NAME	REASON FOR USE	DAILY DOSE	LENGTH OF USE

PREGNANCY HISTORY

PREGNANCY #	MONTH YEAR	OUTCOME (vaginal delivery, cesarean section, miscarriage, termination)	WAS INFERTILITY TREATMENT REQUIRED? Y/N	HOW MANY MONTHS WERE YOU TRYING?	DID THE PREGNANCY EXCEED 37 WEEKS? Y/N	DID YOU HAVE A HEALTHY DELIVERY? Y/N

SURGICAL HISTORY

Have you ever had your tubes tied?

Yes

No

Have you ever had any gender confirmation surgeries?

Yes

No

Please list any surgeries you have had:

DATE (M/Y)	ISSUE/MEDICAL INDICATION	PROCEDURE PERFORMED	OUTCOME

INFERTILITY TREATMENT CYCLE HISTORY

Note: If you've had NO prior infertility treatment please proceed to the last page

Have you ever been prescribed clomid?

Yes No

If yes, how many cycles have you completed?

1 2 3 or more

Did you achieve a pregnancy?

Yes No

Did you deliver?

Yes No

Have you ever been prescribed letrozole?

Yes No

If yes, how many cycles have you completed?

1 2 3 or more

Did you achieve a pregnancy?

Yes No

Did you deliver?

Yes No

Have you ever been prescribed injectable medications?

Yes No

If yes, how many cycles have you completed?

1 2 3 or more

Did you achieve a pregnancy?

Yes No

Did you deliver?

Yes No

Have you ever had an intrauterine insemination (IUI)?

Yes No

If yes, how many cycles have you completed?

1 2 3 or more

Did you achieve a pregnancy?

Yes No

Did you deliver?

Yes No

ETHNICITY

What is your ethnicity?

Caucasian Black or African American Hispanic or Latino Asian American Indian/Alaskan Native
Native Hawaiian/Pacific Islander Other

Do you have any of the following ethnic backgrounds?

Jewish-Ashkenazi Jewish-Sephardic French Canadian Mediterranean
Cajun Middle Eastern Unsure

IN VITRO FERTILIZATION (IVF) TREATMENT HISTORY

Note: If you've had NO prior IVF treatment please proceed to the last page

Please list your most recent IVF cycles below

Please check here if you have had more than 4 IVF cycles

	CYCLE 1	CYCLE 2	CYCLE 3	CYCLE 4
CYCLE DATE (M/Y)				
PREVIOUS IVF CENTER/PHYSICIAN				
WAS THIS CYCLE A FROZEN EMBRYO TRANSFER CYCLE? (Y/N)				
MAXIMUM DAILY GONADOTROPIN DOSE (GONAL-F, MENOPUR, ETC.)				
MAXIMUM DAILY ESTROGEN DOSE				
# EGGS RETRIEVED				
# EGGS FERTILIZED				
WAS ICSI PERFORMED?				
# EGGS FROZEN				
# FROZEN EMBRYOS				
WAS EMBRYO TESTING PERFORMED (CCS/PGD)?				
# EMBRYOS TRANSFERRED				
WERE EMBRYOS TRANSFERRED BEFORE 5 OR 6 DAYS OLD?				
PREGNANCY (Y/N)				
DELIVERY (Y/N)				

Thank you for taking the time to provide your health and prior treatment information which can help us find the right path to success for you in the shortest time necessary.

Please take a few more moments to share with us any additional relevant health information, questions about fertility treatment, or any other issues you would like your physician to be aware of. (fill in answer below)



INFORMATION DECLARATION

By signing I declare that, to the best of my knowledge, all of the information that I have provided in the RMANJ Patient Intake form is accurate and truthful.

Signature

Date