



Reproductive Medicine Associates
of New Jersey

IVIRMA Global



Infertility Summary

PLEASE COMPLETE THIS SUMMARY OF YOUR INFERTILITY HISTORY SO THAT WE CAN BE SURE THAT YOUR RECORDS ARE REVIEWED PROPERLY AND THAT CORRECT INFORMATION IS PROVIDED TO YOUR INSURANCE COMPANY, IF APPROPRIATE.

Date:		
Name of Patient:	Date of Birth:	Age:
Insurance Name:		
Insurance ID#:	Group #:	
Length of time trying to conceive	Years:	Months:

PREVIOUS INFERTILITY TREATMENT	NUMBER OF CYCLES
1. Clomid Cycles	
2. IUI Cycles with Injectable Stimulation Medication	
3. Fresh IVF Cycles	
4. Frozen Embryo Transfers	
4. IVF Cycles Covered by Insurance	

PLEASE MAKE SURE THAT ALL RESULTS ARE INCLUDED IN YOUR RECORDS.

HAVE YOU HAD:	YES	NO	NORMAL	ABNORMAL
Sonohysterogram				
Hysterosalpinogram				
Semen Analysis				
Tubal Ligation			Reversal Yes	Reversal No
Vasectomy			Reversal Yes	Reversal No
Has the female partner ever been pregnant?				
Do you have a history of miscarriages?			# of losses	# of D&C's _____ Was anything abnormal found on report/s Yes No

Signature: _____ Date: _____