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.

MALE DEMOGRAPHIC INFORMATION

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

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

Profession: _____ Employer: _____

Number of years at current job: _____ Previous occupation: _____

Partner's Name (Last) _____ (First) _____ (Middle) _____

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

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 ◯

HEALTH HISTORY BRIEF

Do other members of your family have fertility problems? Yes ☐ No ☐

Relationship _____ Type _____

Relationship _____ Type _____

Relationship _____ Type _____

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

How often do you have sex? _____/month

Who is your urologist? _____

Have you ever had difficulties having or maintaining an erection? Yes ◯ No ◯

Have you ever had difficulties with ejaculation? Yes ◯ No ◯

Have you had any infections of your penis, testicles or prostate gland? Yes ◯ No ◯

Have you had an enlargement of veins in the scrotum (variocele)? Yes ◯ No ◯

Have you ever had a semen analysis? Yes ◯ No ◯

Have you ever smoked? Yes ◯ No ◯

Do you currently smoke? 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 ◯

Do you use testosterone or anabolic (body building) steroids: Yes ◯ No ◯

If yes, prescribed by? _____

If you are taking Testosterone, why are you taking the Testosterone/anabolic steroids (check as many as apply)?

◯ Low sex drive
◯ Low testosterone found by my doctors
◯ Poor energy
◯ Improve athletic ability
◯ Improve looks
◯ Other: _____

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 with prior partner? Yes ◯ No ◯

If Yes, did pregnancy result in a child? Yes ◯ No ◯

If Yes, children's ages: ____/____/____/____

Pregnancy with current partner? Yes ◯ No ◯

If Yes, did pregnancy result in a child? Yes ◯ No ◯

If Yes, children's ages: ____/____/____/____

How long have you had unprotected sex not resulting in pregnancy? _____ years

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 a vasectomy? Yes ◯ No ◯

Have you ever had a vasectomy reversal? 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

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)

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