The Source for New Beginnings
RMA
Reproductive Medicine Associates of New Jersey

Medical Intake Form
Instructions

Reproductive Medicine Associates of New Jersey, LLC

Medical Intake Form Preparation:

Each patient who visits RMANJ is directed to complete and submit a medical intake form. These medical histories allow our physicians to make the most accurate assessments of your fertility status and devise the most appropriate treatment plans. Please select the form from our website that most accurately reflects you as a patient.

For Couples:

If you are seeking our services as a couple, each partner in the couple must complete his or her own intake form. This applies to both heterosexual couples and same-sex couples. Please select the most appropriate form for each partner from our website, complete both forms, and return all forms to your primary office. While each partner should complete *all* sections on his or her own medical history, only one copy of the couple's shared infertility history (starting with page 7 on the female form, page 6 on the male form, and page 8 on the transgender form) should be submitted.

PLEASE COMPLETE THIS FORM AND RETURN IT TO OUR OFFICES **7-14 DAYS** BEFORE YOUR NEW PATIENT APPOINTMENT.

If you have any questions, please contact our New Patient Liaisons at 973-656-2089.

Forms may be faxed to 973-290-8370 or dropped off in person at any of the following office locations: Basking Ridge, Eatontown, Englewood, Morristown, Somerset, or West Orange. If you would like to send completed forms electronically, please contact our patient liaison team for a secure email link at **973-656-2089**.

Transgender Intake Form

Paul A. Bergh, MD
Michael K. Bohrer, MD
Maria Costantini-Ferrando, MD
Michael R. Drews, MD
Eric J. Forman, MD
Rita Gulati, MD
Doreen L. Hock, MD
Kathleen H. Hong, MD
Thomas J. Kim, MD
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Thomas A. Molinaro, MD
Jamie L. Morris, MD
Eli A. Rybak, MD
Richard T. Scott, MD HCLD
Shefali M. Shastri, MD

RMA Patient Questionnaire

Date: _____

Patient Name: _____ (Last) _____ (First) _____ (Middle)

Date of Birth: _____ **Age:** _____ **Social Security #** _____

Sex: _____ **Gender Identity:** _____ **Legal Relationship Status:** _____

Current Partner Name (If applicable) : _____

Are you legally married to someone *other than* the partner listed above? ☐ **YES NO** ☐

Address: _____ **Apt or PO Box** _____
Street

_____ _____ _____
City **State** **Zip Code**

_____ _____ _____
Home Phone **Work Phone** **Cell Phone**

_____
E-mail Address

Pharmacy Name:

_____ **Pharmacy Phone #** _____

Current Gynecologist:

_____ **Office Phone #** _____

Please tell us how you heard about **RMA**

- ☐ Acupuncturist
- ☐ ARC
- ☐ A-Time
- ☐ Attain
- ☐ Bonei Olam
- ☐ Direct Mail/Print
- ☐ Doctor OBGYN/PCP/Other

Name: _____

- ☐ Facebook
- ☐ Family/Friend

Name: _____

- ☐ Fertility Authority
- ☐ Fertility Direct
- ☐ Fertile Hope
- ☐ Health Club
- ☐ Helping Heroes
- ☐ Insurance Company
- ☐ Internet
  - ○ Advertisement (Non-Pandora
  - ○ Blog
  - ○ Search
- ☐ Magazine
  - ○ NJ Monthly
  - ○ Overlook View
  - ○ NJ Top Docs
  - ○ Other
- ☐ Mall Advertising
- ☐ Melissa Brisman, Esq.
- ☐ Pandora
- ☐ Previous Patient

Name: _____

- ☐ Rabbi

Name: _____

- ☐ Radio
  - ○ 1010 WINS
  - ○ General
- ☐ RESOLVE
- ☐ RMA Employee

Name: _____

- ☐ RMA Other (CT/NY/PA)
- ☐ SART/CDC
- ☐ Television
- ☐ Website (RMANJ.com)
  - ○ Other
- ☐ Word of Mouth
- ☐ Yellow Pages
- ☐ Unsure

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

Please fill out all questions that apply. Please do not indicate "See Records." If not applicable to you, write "N/A."

MEDICAL HISTORY

Weight: _____ **Height:** _____ **Blood Type (if known):** _____

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

Exercise: _____ **Hrs/Week:** _____ **Exercise:** _____ **Hrs/Week:** _____

Exercise: _____ **Hrs/Week:** _____ **Exercise:** _____ **Hrs/Week:** _____

	YES	NO
Have you lost more than 20 lbs. of weight in the last year?	☐	☐
Do you follow a particular food diet or have any specific dietary habits?	☐	☐
If yes, please specify: _____		
Have you ever had an eating disorder (anorexia or bulimia)?	☐	☐
If yes, please specify: _____		
Do you have any allergies to medications?	☐	☐
If yes, please specify: _____		

How many cups of coffee or caffeinated beverages do you drink each day? _____

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 per day: _____
Number of years: _____

☐ Anabolic Steroids Please specify: _____

☐ Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) Please specify: _____

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

- ☐ Scarlet Fever Rheumatic
- ☐ Fever Tuberculosis
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Pelvic Infection
- ☐ Chlamydia
- ☐ Herpes
- ☐ Chronic Bronchitis
- ☐ Measles: Regular
- ☐ Measles: German
- ☐ Pneumonia
- ☐ Nongonococcal Urethritis
- ☐ Breast Cancer
- ☐ Vaginitis Trichomoniasis or Yeast
  # per year: ___
- ☐ Kidney Infection Heart Disease
- ☐ Hirsutism (Excess Hair Growth)
- ☐ High Blood Pressure
- ☐ Gallbladder Problems
- ☐ Liver Problems
- ☐ Ulcers
- ☐ Appendicitis
- ☐ Colitis
- ☐ Diabetes
- ☐ Anemia
- ☐ Arthritis
- ☐ Thyroid Problems
- ☐ Ovarian Cysts
- ☐ Cervical Cancer
- ☐ Ovarian Cancer
- ☐ Other Cancer Specify:
- ☐ Breast Tenderness
- ☐ Breast Soreness
- ☐ Breast Milky Discharge
- ☐ Chicken Pox
- ☐ Neurologic problems
- ☐ Seizures
- ☐ Epilepsy
- ☐ Visual Disturbances
- ☐ Poor Sense of Smell
- ☐ Dizziness
- ☐ Loss of Balanace
- ☐ Chronic Headaches
- ☐ Blood Transfusions
- ☐ Parasitic Infection
- ☐ Endometriosis

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 medications on a regular basis? Please note in the chart below.

Medication	Diagnosis	Dosage/Frequency	Duration

Have you taken any of the following medications? (Check **all** that apply)

☐ Thyroid medication (e.g. Synthroid) ☐ Bromocriptine (e.g. Parlodel)

Have you taken hormone replacement therapy to support gender reassignment?

- If yes, please specify. _____

FEMALE TESTING (If Applicable)

Which of the following tests have you completed? (Check **all** that apply and results if known)

BLOOD TESTING

☐	AMH	Date: _____	Results: _____
☐	CBC	Date: _____	Results: _____
☐	CMV (IgG & IgM)	Date: _____	Results: _____
☐	Cystic Fibrosis	Date: _____	Results: _____
☐	Day 3 Estradiol,LH, FSH, Progesterone	Date: _____	Results: _____
☐	Fragile X	Date: _____	Results: _____
☐	HBsAg	Date: _____	Results: _____
☐	HCV core antibody	Date: _____	Results: _____
☐	HIV 1	Date: _____	Results: _____
☐	HIV 2	Date: _____	Results: _____
☐	HTLV 1/2	Date: _____	Results: _____
☐	Prolactin (fasting)	Date: _____	Results: _____
☐	Rubella	Date: _____	Results: _____
☐	RPR (Syphilis)	Date: _____	Results: _____
☐	SMA-SMN1 Dosage Analysis (Spinal Muscular Atrophy)	Date: _____	Results: _____
☐	Type & Rh Factor	Date: _____	Results: _____
☐	TSH and/or additional Thyroid testing	Date: _____	Results: _____
☐	Varicella-Zoster IgG	Date: _____	Results: _____

UTERINE CAVITY EVALUATION

☐	Hysterosalpingogram *(HSG)*	Date: _____	Results: _____
☐	Saline Sonogram	Date: _____	Results: _____
☐	Hysteroscopy (surgery)	Date: _____	Results: _____

ADDITIONAL TESTING

☐	Genetic Counseling	Date: _____	Results: _____
☐	Genetic Testing	Date: _____	Results: _____
☐	Habitual Loss Panel	Date: _____	Results: _____
☐	Hemoglobin Electrophoresis	Date: _____	Results: _____
☐	Insulin resistance testing	Date: _____	Results: _____
☐	Jewish Heritage Panel	Date: _____	Results: _____
☐	Tay Sachs	Date: _____	Results: _____
☐	Sickle Cell	Date: _____	Results: _____
☐	Karyotype (Chromosome Analysis)	Date: _____	Results: _____
☐	2 Hour Glucose Tolerance Test (GTT)	Date: _____	Results: _____
☐	Toxoplasmosis	Date: _____	Results: _____
☐	Laparoscopy	Date: _____	Results: _____
☐	Endometrial Biopsy	Date: _____	Results: _____

☐ Mammogram	Date: _____	Results: _____
☐ Mycoplasma	Date: _____	Results: _____
☐ Gonorrhea Culture	Date: _____	Results: _____
☐ Chlamydia Culture	Date: _____	Results: _____
☐ PAP Smear	Date: _____	Results: _____
☐ Postcoital Test	Date: _____	Results: _____
☐ Chest X-Ray (CXR)	Date: _____	Results: _____
☐ Electrocardiogram (EKG)	Date: _____	Results: _____
☐ Prep cycle	Date: _____	Results: _____
☐ Other: _____	Date: _____	Results: _____

GYNECOLOGICAL HISTORY (If Applicable)

Age of first period: _____

Date of last period: _____

	YES	NO
Are your periods regular?		
- What is the usual number of days between periods? Minimum _____ Maximum _____	☐	☐
- What is the usual duration of your bleeding? Minimum _____ Maximum _____		
Do you have PMS?	☐	☐
- If yes, please specify: ☐ Mild ☐ Moderate ☐ Severe		
Do you have painful menses?	☐	☐
- If yes, please specify: ☐ Mild ☐ Moderate ☐ Severe		
Do you take pain medication for cramps?	☐	☐
- If yes, please specify: _____		
Do you bleed or spot between periods?	☐	☐
If you've ever taken oral contraceptives, were your periods regular after stopping the pill?	☐	☐
Did your mother have any difficulty with contraception or pregnancy?	☐	☐
Did your mother take diethylstilbestrol (DES) when she was pregnant with you?	☐	☐
- At what age did your mother begin menopause? _____		
Is there a family history of infertility?	☐	☐
- If yes, who/ relationship: _____		
Is there a history of hormonal disorders in your family?	☐	☐
- If yes, who/ relationship: _____		
Is there a family history of birth defects?	☐	☐
- If yes, who/ relationship: _____		
Is there a family history of habitual pregnancy loss?	☐	☐
- If yes, who/ relationship: _____		
Have you ever used an intrauterine device (IUD)?	☐	☐
- If yes, specify type/# of years: _____		
Have you ever had Pelvic Inflammatory Disease (PID)?	☐	☐
- If yes, describe: _____		
Is vaginal intercourse painful?	☐	☐
- If yes, please specify: ☐ Mild ☐ Moderate ☐ Severe		

	YES	NO
Do you use lubricants for vaginal intercourse?	☐	☐
- If yes, which brand(s): _____		
Do you douche before or after vaginal intercourse?	☐	☐
Have you ever had unprotected vaginal intercourse with a male partner?		
- How many times per week? _____		
- Did a pregnancy ever result? _____	☐	☐
- For how many months have you been having unprotected vaginal intercourse? _____		
- How many months have you been actively trying to get pregnant? _____		
Have you used Basal Body Temperature (BBT)?	☐	☐
- If yes, what day did you ovulate: _____		
Have you used an Ovulation Predictor Kit (OPK)?	☐	☐
- If yes, what day did you ovulate: _____		

MALE TESTING (If Applicable)

Which of the following tests have you completed? (Check **all** that apply and results if known)

BLOOD TESTING

☐	CBC	Date: _____	Results: _____
☐	CMV (IgG & IgM)	Date: _____	Results: _____
☐	Cystic Fibrosis	Date: _____	Results: _____
☐	HBsAg	Date: _____	Results: _____
☐	HCV core antibody	Date: _____	Results: _____
☐	HIV 1	Date: _____	Results: _____
☐	HIV 2	Date: _____	Results: _____
☐	HTLV 1/2	Date: _____	Results: _____
☐	RPR (Syphilis)	Date: _____	Results: _____
☐	SMA-SMN1 Dosage Analysis (Spinal Muscular Atrophy)	Date: _____	Results: _____

Semen Testing

			Results:
☐	Semen analysis	Date: _____	Concentration: _____ Motility: _____ Morphology: _____
☐	Antisperm antibodies	Date: _____	Results: _____

ADDITIONAL TESTING

☐	Genetic Counseling	Date: _____	Results: _____
☐	Genetic Testing	Date: _____	Results: _____
☐	Hemoglobin Electrophoresis	Date: _____	Results: _____
☐	Jewish Heritage Panel	Date: _____	Results: _____
☐	Tay Sachs	Date: _____	Results: _____
☐	Sickle Cell	Date: _____	Results: _____
☐	Karyotype (Chromosome Analysis)	Date: _____	Results: _____
☐	Testosterone	Date: _____	Results: _____
☐	Y-Microdeletion	Date: _____	Results: _____
☐	Postcoital Test	Date: _____	Results: _____
☐	FSH	Date: _____	Results: _____

☐ Gonorrhea/Chlamydia Cultures Date: _____ Results: _____

☐ Other: _____ Date: _____ Results: _____

UROLOGICAL HISTORY (If Applicable)

Do you or have you ever had any difficulties with (check **all** that apply):

	YES	NO
Erection		
- If yes, please explain: _____	☐	☐
Ejaculation		
- If yes, please explain: _____	☐	☐
Have your genitals ever been exposed to excessive heat?	☐	☐
Have you had any serious injuries to your genitals?	☐	☐
Have you had any infections of your penis, testicles or prostate gland?	☐	☐
Have you ever been diagnosed with variocele?	☐	☐
Have you ever been diagnosed with Mumps?	☐	☐
Is there any history of birth defects in your family?	☐	☐
Is there any history of recurrent miscarriage in your family?	☐	☐
Have you ever had unprotected vaginal intercourse with a female partner?	☐	☐
- How many times per week? _____		
- Did a pregnancy ever result? : _____		
- For how many months have you been having unprotected vaginal intercourse? _____		
- How many months have you been actively trying to get pregnant? _____		
Do you take vitamins?		
- If yes, what kind and how much: _____	☐	☐
Have you been exposed to any toxins?		
- If yes, what kind and how much: _____	☐	☐

Patient Race:

☐	American Indian or Alaska Native	☐	Asian	☐	Black or African American	☐	Hispanic or Latino
☐	Native Hawaiian/Other Pacific Islander	☐	White	☐	Two or more races	☐	Other : _____

Ethnic Origin - Do you have any of the following ethnic backgrounds?

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

SURGICAL HISTORY

	YES	NO
Have you ever had a tubal ligation?	☐	☐
Have you ever had a vasectomy?	☐	☐
Have you ever had a vasectomy reversal?	☐	☐
Have you ever had any gender confirmation surgeries?		
- If yes, please be specific: _____	☐	☐

How many surgical procedures have you had? _____

Date	Hospital	Procedure	Findings	Surgeon

PREGNANCY DATA (If Applicable)

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 chart below:

Pregnancy	Year	End in Abortion (Spontaneous or Induced) or Ectopic pregnancy?	Infertility therapy required to conceive?	How long to conceive? (Months)	37 weeks or more?	Baby born alive?	Egg/Sperm source?
First							
Second							
Third							
Fourth							
Fifth							

HISTORY OF FERTILITY THERAPY

Have you received fertility treatments before? YES ☐ NO ☐

- If yes, who was your physician: _____

Address: _____

_____

Diagnosis: _____

INFERTILITY CYCLE HISTORY (If your partner has already completed this section, please do not fill out again)

Clomiphene Citrate

Dates	# of Cycles	Max Starting Dose	Max Follicles	# with Insemination	# of Cycles Resulting in Pregnancy

- **Number of prior Gonadotropin Cycles:** _____

Gonadotropin (Follistim, Gonal-F, etc.)

Dates	# of Cycles	Max Starting Dose	Max Estradiol	Max Follicles	# with Insemination	# of Cycles Resulting in Pregnancy

- **Number of prior Fresh ART (IVF) Cycles including Third Party Cycles (donor eggs, donor sperm, gestational carrier):** _____
- **Number of prior Frozen ART (IVF) Cycles including Third Party Cycles (donor eggs, donor sperm, gestational carrier):** _____

IVF History

	Cycle 1		Cycle 2		Cycle 3		Cycle 4		Cycle 5		Cycle 6	
Date												
IVF Center												
Donor eggs?	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐
Donor sperm?	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐
Frozen Embryo Cycle?	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐
Max Start Dose												
Max Estradiol												
# Eggs Retrieved												
# Eggs Fertilized												
ICSI?	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐
# Embryos Transferred												
Embryo Age (day 2, 3, 5, or 6)												
Pregnancy?	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐
Delivered?	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐	YES ☐	NO ☐

PATIENT COMMENTS

What do you understand about your reproductive status and possible treatment options?

Please use this space to add any additional comments or information you feel your physician should know.

INFORMATION DECLARATION

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

Signature Date