



Reproductive Medicine Associates of New Jersey

**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.**

**Please Print**

|  |                          |                          |                                       |                                      |
|--|--------------------------|--------------------------|---------------------------------------|--------------------------------------|
| <b>Date:</b>   |                          |                          |                                       |                                      |
| <b>Name of Patient:</b>  |                          | <b>Date Of Birth:</b>    |                                       | <b>Age:</b>                          |
| <b>Ethnicity (please circle):</b> White non-Hispanic / White Hispanic / Black non-Hispanic<br>Black Hispanic / Asian non-Hispanic / Asian Hispanic / Other |                          |                          |                                       |                                      |
| <b>Insurance Name:</b>   |                          |                          |                                       |                                      |
| <b>Insurance ID#:</b>  |                          | <b>Group #:</b>          |                                       |                                      |
| <b>Length of time trying to conceive</b>   |                          | <b>Years:</b>            | <b>Months:</b>                        |                                      |
|  |                          |                          |                                       |                                      |
| <b>Previous Infertility Treatment</b>  |                          |                          | <b>Number of Cycles:</b>              |                                      |
| 1. Clomid Cycles   |                          |                          |                                       |                                      |
| 2. IUI Cycles with injectable stimulation medication   |                          |                          |                                       |                                      |
| 3. Fresh IVF Cycles  |                          |                          |                                       |                                      |
| 4. Frozen embryo transfers   |                          |                          |                                       |                                      |
| 4. IVF Cycles covered by Insurance   |                          |                          |                                       |                                      |
|  |                          |                          |                                       |                                      |
| <b><i>Please make sure that all results are included in your records.</i></b>  |                          |                          |                                       |                                      |
| <b>Have You Had:</b>   | <b>Yes</b>               | <b>No</b>                | <b>Normal</b>                         | <b>Abnormal</b>                      |
| Sonohysterogram  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>              | <input type="checkbox"/>             |
| Hysterosalpinogram   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>              | <input type="checkbox"/>             |
| Semen Analysis   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>              | <input type="checkbox"/>             |
| Tubal Ligation   | <input type="checkbox"/> | <input type="checkbox"/> | Reversal Yes <input type="checkbox"/> | Reversal No <input type="checkbox"/> |
| Vasectomy  | <input type="checkbox"/> | <input type="checkbox"/> | Reversal Yes <input type="checkbox"/> | Reversal No <input type="checkbox"/> |
| Has the female partner ever been pregnant?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>              | <input type="checkbox"/>             |

**Patient Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_