



Paul A. Bergh, MD
Michael Bohrer, MD
Michael R. Drews, MD
Rita Gulati, MD
Doreen Hock, MD

Thomas J. Kim, MD
Thomas A. Molinaro, MD
Jamie L. Morris, MD
Richard T. Scott, Jr., MD, HCLD
Shefali Mavani Shastri, MD

RMA Patient Questionnaire

Date: _____

Patient Name _____
Last First Middle

Date of Birth _____ Age _____ Social Security # _____

Address _____
Street Apt. or POB#
City State Zip Code

Home Phone _____ Work Phone _____

Email _____ Pharmacy Phone _____

Partner Name _____
Last First Middle

Date of Birth _____ Age _____ Social Security # _____

Current Gynecologist _____ Office Phone _____

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Bus | <input type="checkbox"/> Media
Name _____ | <input type="checkbox"/> RMA Donor Program |
| <input type="checkbox"/> CDC Report | <input type="checkbox"/> Newspaper | <input type="checkbox"/> RMA Genetics |
| <input type="checkbox"/> Current Gynecologist | <input type="checkbox"/> New Jersey Commuter Rail | <input type="checkbox"/> RMA GC Program |
| <input type="checkbox"/> Friend
Name _____ | <input type="checkbox"/> Patricia Mandell | <input type="checkbox"/> RMA Seminar |
| <input type="checkbox"/> Insurance Referral | <input type="checkbox"/> Primary Care Provider
Name _____ | <input type="checkbox"/> RMA Employee
Name _____ |
| <input type="checkbox"/> Internet | <input type="checkbox"/> Rabbi Jacobwitz | <input type="checkbox"/> Word of Mouth |
| <input type="checkbox"/> Melissa Brisman | <input type="checkbox"/> Radio | <input type="checkbox"/> Yellow Pages |

Patient Advocacy Groups:

- American Fertility Association (AFA)
- American Reproductive Association (ARC)
- Fertile Hope
- Fertility Direct (IntegraMed)
- INCIID
- Resolve

Previous Patient of:

- RMA
- Morristown Memorial Hospital
- Robert Wood
- St. Barnabas Medical Center

Pharmacy/Company:

- Serono
- Organon
- Schrafts
- Other
Name _____

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

MEDICAL HISTORY

Weight _____ Height _____ Blood Type (if known) _____

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

Exercise _____ Hrs/Week _____ Exercise _____ Hrs/Week _____

- | | YES | NO |
|---|--------------------------|--------------------------|
| Have you lost more than 20 lbs. of weight in the last year? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you follow a particular food diet or have any specific dietary habits? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, specify: _____ | | |
| Have you ever had an eating disorder (anorexia or bulimia)? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, specify: _____ | | |
| Do you have any allergies to medications? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, specify: _____ | | |

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

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

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

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 _____
- Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) – If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify:

MENSTRUAL HISTORY

Age at first period _____ Date of **last** period _____

	YES	NO
Are your periods regular?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Do you have painful menses?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Do you take pain medication for cramps?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: _____		
Do you bleed or spot between periods?	<input type="checkbox"/>	<input type="checkbox"/>
If you've ever taken oral contraceptives, were your periods regular after stopping the pill? ..	<input type="checkbox"/>	<input type="checkbox"/>
Did your mother have any difficulty with contraception or pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
Did your mother take diethylstilbestrol (DES) when she was pregnant with you?	<input type="checkbox"/>	<input type="checkbox"/>
At what age did your mother begin menopause? _____		
Is there a family history of infertility?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who/ relationship: _____		
Is there a history of hormonal disorders in your family?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who/ relationship/type: _____		
Is there a family history of birth defects?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who/ relationship: _____		
Is there a family history of habitual pregnancy loss?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, who/ relationship: _____		
Have you ever used an intrauterine device (IUD)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify type/# of years: _____		
Have you ever had Pelvic Inflammatory Disease (PID)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, describe: _____		
Is intercourse painful?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, specify: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe		
Do you use lubricants for intercourse?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, which brand: _____		
Do you douche before or after intercourse?	<input type="checkbox"/>	<input type="checkbox"/>
How many times per week do you and your partner have intercourse? _____		
* How many months has it been since you discontinued methods of birth control? _____		
* How many months have you been trying to get pregnant? _____		

YES NO

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: _____

Do you take vitamins?

 If yes, what kind and how much: _____

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

Have you been exposed to any toxins?

 If yes, what kind and how much: _____

Patient Ethnic Origin:

- White Non-Hispanic White Hispanic Black Non-Hispanic Black Hispanic
- Asian Non-Hispanic Asian Hispanic Native American
- Unknown/Other, please specify: _____

PREGNANCY DATA

- * 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?	Is current partner the father?
First							
Second							
Third							
Fourth							
Fifth							

SURGICAL HISTORY

Have you ever been surgically sterilized? YES NO

How many operations have you had? _____

Date	Hospital	Procedure	Findings	Surgeon

HISTORY OF FERTILITY THERAPY

Have you been treated for infertility before? YES NO

If yes, who was your physician: _____

Address: _____

Diagnosed cause of infertility: _____

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

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

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

- | | | | | |
|--|------|---------|----------|-------|
| <input type="checkbox"/> Postcoital Test | Date | ___/___ | Results: | _____ |
| <input type="checkbox"/> Day3 FSH, Estradiol | Date | ___/___ | Results: | _____ |
| <input type="checkbox"/> Endometrial Biopsy | Date | ___/___ | Results: | _____ |
| <input type="checkbox"/> Hysterosalpingogram | Date | ___/___ | Results: | _____ |
| <input type="checkbox"/> Antisperm Antibodies | Date | ___/___ | Results: | _____ |
| <input type="checkbox"/> Laparoscopy | Date | ___/___ | Results: | _____ |
| <input type="checkbox"/> Hysteroscopy | Date | ___/___ | Results: | _____ |
| <input type="checkbox"/> Mycoplasma/Chlamydia Cultures | Date | ___/___ | Results: | _____ |
| <input type="checkbox"/> Thyroid Tests | Date | ___/___ | Results: | _____ |
| <input type="checkbox"/> Rubella | Date | ___/___ | Results: | _____ |
| <input type="checkbox"/> HIV | Date | ___/___ | Results: | _____ |
| <input type="checkbox"/> PAP Smear | Date | ___/___ | Results: | _____ |
| <input type="checkbox"/> Mammogram | Date | ___/___ | Results: | _____ |
| <input type="checkbox"/> Sickle Cell | Date | ___/___ | Results: | _____ |
| <input type="checkbox"/> Tay Sachs | Date | ___/___ | Results: | _____ |
| Other – Specify: _____ | Date | ___/___ | Results: | _____ |

INFERTILITY CYCLE HISTORY

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: _____

* Number of prior Frozen ART (IVF) Cycles: _____

IVF History

	Cycle 1		Cycle 2		Cycle 3		Cycle 4		Cycle 5		Cycle 6	
Date												
IVF Center												
Frozen Embryo Cycle	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Max Start Dose												
Max Estradiol												
# Eggs Retrieved												
# Eggs Fertilized												
ICSI?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
# Embryos Transferred												
Embryo Age (day 2, 3 or 5)												
Pregnancy?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Delivered?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>

MALE DATA, if applicable

Name: _____
First Last

Marriage #: _____

Number of pregnancies
 conceived with
 current partner: _____

Number of pregnancies
 conceived with
 previous partners: _____

Pregnancies Conceived with a Previous Partner

Date of Pregnancy	Pregnancy Outcome		
	Delivered	Aborted	Miscarried

Urologist: _____ Phone: _____

Address: _____

Male Ethnic Origin:

- White Non-Hispanic
 White Hispanic
 Black Non-Hispanic
 Black Hispanic
 Asian Non-Hispanic
 Asian Hispanic
 Native American
 Unknown/Other,
 please specify: _____

Have you ever had a semen analysis (sperm count) performed? YES NO

Date of Semen Analysis	Location of Analysis	Count (Million/ml)	Motility	Grade	Morphology

Do you have any medical problems unrelated to your fertility?

Nature of Problem (Diagnosis)	Treatment	Physician

MALE SURGICAL HISTORY

Have you ever had surgery? If yes, please specify:

Date	Hospital	Procedure	Findings	Surgeon

Do you take any medications? If yes, please specify:

Medication	Diagnosis	Dosage/Frequency	Duration

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 _____
- Illicit or Recreational Drugs (Marijuana, Cocaine, etc.) – If you would feel more comfortable not writing anything down, please discuss this directly with your physician. Specify:

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

- Erection If yes, please explain:

- Ejaculation If yes, please explain:

- | | YES | NO |
|---|--------------------------|--------------------------|
| Have your genitals ever been exposed to excessive heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any serious injuries to your genitals? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any infections of your penis, testicles or prostate gland? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there any history of birth defects in your family? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there any history of recurrent miscarriage in your family? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any allergies to medications? | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, specify: _____

