Medical Intake Form
Instructions

Reproductive Medicine Associates of Southern California

Medical Intake Form Preparation:

Each patient who visits RMASOCAL 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 424-293-8841.

The Source for New Beginnings
RMA
Reproductive Medicine Associates of Southern California
IVI RMA Global

Patient Questionnaire – Fertility Preservation

Patient Name: _____ _____ _____
Last First Middle

Date of Birth: _____ / _____ / _____ **Age:** _____

Social Security #: _____

Address: _____ _____
Street Apt. or POB#

_____ _____ _____
City State Zip Code + 4

Phone: (H) (____)_____ **(W) (____)**_____

E-Mail: _____ **Pharmacy: (____)** _____

Partner Name: _____ _____ _____
Last **First** **Middle**

Partner Social Security #: _____ **DOB:** _____ **Age:** _____

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

Current Gynecologist:_____Gynecologist's Phone_____

Oncologist: _____Oncologist's Phone:_____

Please tell us how you heard about RMA_____

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

MEDICAL HISTORY

Weight_____Height_____Blood Type (if known)_____

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

Exercise:_____Hrs/Week_____

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

- ❑ Scarlet Fever
- ❑ Rheumatic Fever
- ❑ Tuberculosis
- ❑ Hepatitis
- ❑ Syphilis
- ❑ Gonorrhea
- ❑ Pelvic Infection
- ❑ Chlamydia
- ❑ Herpes
- ❑ Chronic Bronchitis
- ❑ Measles: Regular
- ❑ Measles: German
- ❑ Pneumonia
- ❑ Nongonococcal Urethritis
- ❑ Breast Cancer
- ❑ Kidney Infection
- ❑ Heart Disease
- ❑ Hirsutism (Excess Hair Growth)
- ❑ High Blood Pleasure
- ❑ Gallbladder Problems
- ❑ Liver Problems
- ❑ Ulcers
- ❑ Appendicitis
- ❑ Colitis
- ❑ Diabetes
- ❑ Anemia
- ❑ Arthritis
- ❑ Thyroid Problems
- ❑ Ovarian Cysts

- ❑ Cervical Cancer
- ❑ Endometriosis
- ❑ Breast Tenderness
- ❑ Breast Soreness
- ❑ Breast Milky Discharge
- ❑ Neurologic Problems
- ❑ Seizures
- ❑ Epilepsy
- ❑ Visual Disturbances
- ❑ Poor Sense of Smell
- ❑ Dizziness
- ❑ Loss of Balance
- ❑ Chronic Headaches
- ❑ Blood Transfusions
- ❑ Parasitic Infection
- ❑ Ovarian Cancer

Vaginitis Trichomoniasis or Yeast. # per year: _____
Other Cancers? Specify:_____
Any Allergies? List: _____

List the forms and frequency of regular vigorous exercise (swimming, cycling, running, and age you began): _____
Exercise: _____ Hrs/Wk:_____ Exercise: _____ Hrs/Wk: _____

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 meds 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 / 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:

_____

_____

_____

	YES	NO

MENSTRUAL HISTORY

Age at first period:_____ Date of **LAST** period: _____	❑	❑
Are your periods regular……		
What is the usual # of days *between* periods? Minimum_____ Maximum_____		
What is the usual duration of your bleeding? Minimum_____ Maximum_____		
Do you have PMS?.....	❑	❑
If yes, ….. □MILD □MODERATE □SEVERE		
Do you have painful menses?.....	❑	❑
If yes, ….. □MILD □MODERATE □SEVERE		
Have you been exposed to any toxins……	❑	❑

What is your ethnic origin?

□ White non -Hispanic	□ White Hispanic	□ Black non -Hispanic	□ Black Hispanic
□ Asian non- Hispanic	□ Asian Hispanic	□ Native American	
□ Unknown /Not Stated please indicate			

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 the chart below:

Pregnancy #	Year	End in Abortion? Spontaneous or Induced Abortion? Or Ectopic Pregnancy?	Infertility therapy required to conceive?	How long to conceive? (months)	Greater than or equal to 37 weeks Yes/No	Baby born alive ?	Is current partner the father?
1st Pregnancy							
2nd Pregnancy							
3rd Pregnancy							
4th Pregnancy							
5th Pregnancy							

SURGICAL HISTORY

Have you ever been surgically sterilized? YES_____NO_____

How many operations have you had? _____

SURGICAL HISTORY

Date	Hospital	Procedure	Findings	Surgeon

HISTORY OF FERTILITY THERAPY

Have you been treated for infertility before?.....

If yes, who was your physician? _____

Address:_____

What cause of infertility was diagnosed? _____

_____

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

IVF HISTORY

Cycle#	**1**		**2**		**3**		**4**		**5**		**6**	
Date												
IVF Center												
Frozen Embryo Cycle	❑ Y	❑ N	❑ Y	❑ N	❑ Y	❑ N	❑ Y	❑ N	❑ Y	❑ N	❑ Y	❑ N
Max. Start Dose												
Max. Estradiol												
# Eggs Retrieved												
# Eggs Fertilized												
ICSI: Y/N	❑ Y	❑ N	❑ Y	❑ N	❑ Y	❑ N	❑ Y	❑ N	❑ Y	❑ N	❑ Y	❑ N
# Embryo(s) Transferred												
Embryo Age (Day 2, 3 or 5)												
Pregnancy: Y/N	❑ Y	❑ N	❑ Y	❑ N	❑ Y	❑ N	❑ Y	❑ N	❑ Y	❑ N	❑ Y	❑ N
Delivered: Y/N	❑ Y	❑ N	❑ Y	❑ N	❑ Y	❑ N	❑ Y	❑ N	❑ Y	❑ N	❑ Y	❑ N

MALE DATA – if applicable

Name: _____ _____
First Last

Marriage #: _____

Number of pregnancies conceived with current partner: _____
Number of pregnancies conceived with previous partner: _____

Please give approximate dates and outcomes of any pregnancies conceived with a previous partner:

Date of Pregnancy	Pregnancy Outcome		
	Delivered	Aborted	Miscarried
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

Urologists: _____
Address: _____ Phone: _____

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

REFERRING ONCOLOGIST:

Name:

Address:

Phone: Fax: Email:

Cancer or Disease	Date of Diagnosis or Biopsy

DISEASE STATUS:

Cell Type: Stage: Size: Grade:

☐Estrogen Receptor Positive ☐Progesterone Receptor Positive

HER2 STATUS:

Number of lymph nodes affected:

BRCA1/2: ☐ DONE ☐ NOT DONE

Result:

TREATMENT PLAN:

Surgery: Date:

Chemotherapy Agents/Dose:

1. 2. 3. 4.

Start Date: End Date:

Hormonal Treatment:

Start Date: End Date:

Biological Agents/Antibodies:

Start Date: End Date:

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 RMASOCAL Patient Intake form is accurate and truthful.

Signature Date