Cleveland Clinic

NextGen® Sperm Bank Questionnaire

Date: _____

Recorded by: _____

Demographics

Patient Name _____ CCF #: _____
(Please Print) (First) (MI) (Last)

Age: _____ Date of Birth: _____ SSN: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

In Case of Emergency Contact

Name: _____ Address: _____

Relationship: _____ _____

Phone: _____

Andrology Lab and Reproductive Tissue Bank
Cleveland Clinic
10681 Carnegie Avenue, Desk X11
Cleveland OH 44195
Tel: 216.444.8182
Fax: 216.445.6049

Diagnosis

Reason for Storage

□ Fertility Preservation
□ Leukemia
□ Hodgkin's
□ Other (please specify) _____
□ Testicular Cancer
□ Lymphoma
□ Travelling Husband

Symptoms: _____

Date of Diagnosis: _____

Surgery or Chemotherapy Dates(s): _____
(Previous Dates)

Surgery/Chemotherapy to begin: _____
(Date)

Treatment Plan: _____

History

Marital Status: □ Single □ Married Spouse's Name_____

Children Fathered (age & sex)_____

Sexually Active: □ Yes □ No Frequency (weekly): □ 1-2 □ 3-4 □ 5 or more

Sexually Transmitted Diseases: _____

Storage Plan:

□ Long Term □ Short Term □ Unknown

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Referring Doctor

Cleveland Clinic Doctor: □ Yes □ No

Doctor's Name: _____

Address: _____

_____

Phone: _____

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