Fairfax Cryobank

Client Questionnaire			
Reason for Storing Semen	☐ Chemo/Radiation ☐ Cycle Backup ☐ Gender Affirming Hormone Therapy (GAHT) ☐ Testosterone Therapy or ☐ Other: _____ ☐ Military ☐ Surgery ☐ Vasectomy ☐ Other, please explain:		
Have you ever been diagnosed with any of the following?	Hepatitis B, C, Other ☐ YES ☐ NO HIV/AIDS ☐ YES ☐ NO	If YES, provide details:	
In the last 30 days, have you:	had an HIV/AIDS test?	☐ YES ☐ NO	If YES, provide details:
	had a blood transfusion?	☐ YES ☐ NO	
List medications and supplements you are currently taking (or write in "none"):			

Intended Use of Samples		

Will the semen sample be used with your sexually intimate partner?
 	
Explanation:
• *Sexually intimate partner: someone you are sexually intimate with who will carry the resulting baby*
• *Non-sexually intimate partner:*
  ○ *Gestational carrier: a friend or acquaintance who will carry a baby resulting from your sperm, your partner's egg, or an egg donor's egg*
  ○ *Surrogate: A friend or acquaintance who would serve as an egg donor and carry the resulting baby*
	☐ YES
	☐ NO
	☐ UNSURE
		If no or unsure to any questions listed to the left, you must discuss with the Cryobank, as additional paperwork, screening and testing may be required.
		Following discussion with the Cryobank:
		☐ Client will proceed in Directed Donor – Intended Parent program and has been given paperwork for that process.
		☐ Client has declined Directed Donor testing and is aware of the possibility that the samples may not qualify for future use with a non-sexually intimate partner per FDA guidelines without this testing, but has chosen to proceed as a Client Depositor.
		Client Initial/Date: _____
		Staff initial/Date: _____

If you have discussed fertility treatments with your physician, please indicate the preference for preparation method.	☐ Intra-uterine Insemination (IUI) ☐ Intracervical insemination (ICI) ☐ In vitro fertilization (IVF) ☐ ICSI (Intracytoplasmic Sperm Injection) ☐ Other (describe) _____ ☐ Have not discussed with a fertility treatment specialist or currently have no preference	

I certify that the information contained in this questionnaire, to be the best of my knowledge, is true and complete.

Name _____ Signature_____ Date _____

Account # _____