eurofins | Biomnis

Order form

Preventative health testing

Juvenalis
WELLNESS TESTING
BY EUROFINS BIOMNIS

INTERNATIONAL DIVISION
Tel.: +33 (0)4 72 80 23 85 • Fax: +33 (0)4 72 80 73 56 • international@biomnis.eurofinseu.com

REFERRING PHYSICIAN

Last name: ..... First name: .....
Address: .....
Postal code: _ _ _ _ _ City: .....
Country .....
E-mail: .....

or affix the Physician's stamp here

Laboratory stamp or barcode label

Compulsory Stick your laboratory identification sticker here

PATIENT

First name(s)*: .....
Surname*: .....
Date of birth*: D D M M Y Y Y Y Biological gender*: ☐ F ☐ M
Tel. : _ _ _ _ _ _ _ _ _ _
E-mail*: .....
Address*: .....
Postal code*: ..... **City*:** .....
Country*: .....
For MyEndoCheck: date of 1st day of last menstrual period D D M M Y Y

Date of sample collection:
D D M M Y Y
at _ _ **h** _ _ **min**

** compulsory fields*

CHOICE OF PREVENTATIVE HEALTH TESTING

Preventative health testing	Analysis code
☐ MiniCheck	MINI
☐ BasicCheck	BASIC
☐ AgeCheck Woman	AAFEM
☐ AgeCheck Man	AAMAS
☐ FertiCheck Woman	FERTF
☐ FertiCheck Man	FERTH
☐ MyEndoCheck**	ENDO
☐ OxyCheck	OXYC
☐ DigestCheck	DIGES
☐ VeggieCheck	VEGAN
☐ ImmuCheck	IMMU
☐ SopioCheck	SOPIO

Preventative health testing	Analysis code
☐ Vitamins	VITAM
☐ Minerals	MINER
☐ Intestinal microbiota	JBIOT
☐ Erythrocyte fatty acids	GRAEJ

Food intolerances analyses - Nutritol™	Analysis code
☐ 25 foods	PAG25
☐ 50 foods	PAG50
☐ 50 foods VEGAN	PA50V
☐ 100 foods	PA100
☐ 287 foods	PA287

Details of preventative health testing :

The sample must be taken on an empty stomach.

Other analyses: .....

JU-B47-INTGB - May 2024

eurofins | Biomnis

Health Questionnaire

Optional questionnaire that allows for a better Interpretation of the results by the biologist

Juvenalis
BIOLOGIE PRÉVENTIVE
PAR EUROFINS BIOMNIS

Surname	
First name	
Date of birth	

Weight (kg)	
Height (cm)	

Do you suffer from any of the following issues? *(Strike out the inapplicable text / Specify in free text 3when necessary)*	Never	Sometimes	Often
Digestive disorders (discomfort, diarrhoea / constipation ...)			
Headaches, migraines, vertigo…			
Sleep disorders ► Please specify			
Insomnia, anxiety, stress, fatigue			
Problems with memory, concentration			
Weight problems ► Please specify			
Recurrent infections ► Please specify			
Respiratory, digestive allergies?			
► Please specify			
Hair loss, brittle nails, skin problems...			
► Please specify			
Other chronic pains ► Please specify:			
Known / suspected food intolerances? ► Please specify:			

Do you suffer from chronic diseases?	☐ YES	☐ NO
Autoimmune disease(s)?	☐ YES	☐ NO
If yes, which one(s)?		
Other chronic disease(s)?	☐ YES	☐ NO
If yes, which one(s)?		

Are you in the care of a health professional?	☐ YES	☐ NO
If yes, which speciality?		
Are you under medical treatment?	☐ YES	☐ NO
If yes, please specify the medication?		

Do you follow a particular dietary regime?	☐ YES	☐ NO
If yes, please elaborate?		

Do you take dietary supplements (vitamins, trace elements...)?	☐ YES	☐ NO
If yes, which ones?		

Do you play sports regularly?	☐ YES	☐ NO
Do you smoke?	☐ YES	☐ NO

Woman: Are you post-menopausal?	If no, day of menstrual cycle:	☐ YES	☐ NO
Do you use contraception?	If yes, which?	☐ YES	☐ NO
Are your cycles regular?		☐ YES	☐ NO

What are your reason(s) for doing this analysis? : .....

.....

.....