Patient data **In Block Letters Please!**

☐ Man ☐ Woman

First Name (name in full)

Last name

Date of birth

Street, number

Postcode, city

Country

__ __ __ __ | __ __ | __ __
Sampling Date

__ __ : __ __ h ☐ am ☐ pm
Sampling time

☐ Test report in duplicate

biovis' DIAGNOSTIK

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REQUEST FORM

SPH-5-EN

Barcode or practise stamp

PLEASE PRINT OR USE ADDRESS LABEL !
DO NOT USE ANY PAPER CLIPS, STAPLES OR STICKERS !

! Express shipping: samples must reach the laboratory within 24 h!
Shipping Mo - Thur: Please do not send samples on Fridays or before public holidays!

Saliva Analysis Hormone Profile

Individual profiles		Material
Hormone examination Woman		
☐ 0120	Cortisol, DHEA, Progesterone, Testosterone, Estradiol	T905
Hormone examination Man		
☐ 0110	Cortisol, DHEA, Progesterone, Testosterone, Estradiol	T905
Individual parameters		
☐ 0310	Cortisol	T905
☐ 0320	DHEA	T905
☐ 0330	Progesterone	T905
☐ 0340	Estradiol	T905
☐ 0350	Testosterone	T905
☐ 0355	Estriol	T905

Note: If we do not have any information on the cycle anamnesis, an individualised assessment cannot be made.

Menstrual Cycle anamnesis

Sampling at ..... menstrual cycle day

☐ **Regular menstrual cycle**
average length .....

☐ **Irregular menstrual cycle**
Length from ..... to .....
☐ Menopause

☐ **No menstrual cycle**
☐ Menopause
☐ uterus removal

☐ **Pregnancy** week .....

☐ **Breastfeeding**

Have you ever had or are you currently having:

☐ **Tumour** (benign or malignant cancer)
if so, which:
.....
Hormone dependent: ☐ yes ☐ no

☐ PAP diagnosis:
.....

☐ Prostate enlargement

What contraception do you use?

☐ **None**
☐ **Pill**
☐ **Hormonal IUD**
☐ **Copper IUD**
☐ **Other:** .....

Are you currently under medication?

☐ **Preparations containing hormones**
if so, which: .....

☐ **Psychotropic drugs / antidepressants / antiepileptic drugs**
☐ **Thyroid drugs**
if so, which: .....

☐ **High blood pressure medication**
☐ **Gastric acid blockers**
☐ **Cholesterol inhibitors**
☐ **Cortisone**
☐ **Other**
if so, which: .....

Have you had any medical interventions?

if so, which: .....

Do you drink alcohol?

If so, how much: .....

Current and previous disorder in the last 6 months

Disorders	Weak	Strong
Premenstrual syndrome	☐	☐
Stress and exhaustion	☐	☐
Sleep disorders	☐	☐
Joint pain	☐	☐
Osteoporosis, osteopenia	☐	☐
Hot flushes	☐	☐
Vaginal disorders *(e.g. dryness, itching, burning)*	☐	☐
Repeated urinary tract infections	☐	☐
Hashimoto	☐	☐
Hyperthyroidism	☐	☐
Hypothyroidism	☐	☐
Lump sensation, Throat pressure	☐	☐
Inexplicable weight gain	☐	☐

Other current or chronic diseases:
.....

If you need more space for answers to specific questions, please attach a supplementary sheet.

SPH-5-1