

Suggested Collection Times	Relevant Food Intake
Morning/Fasting (6-8am) ____ : ____ AM/PM	6-8 hour fast
Noon (11am-1pm) ____ : ____ AM/PM	Last meal or snack ____ : ____ AM/PM
Afternoon (4-5pm) ____ : ____ AM/PM	Last meal or snack ____ : ____ AM/PM
Midnight/Bedtime (10pm-Midnight) ____ : ____ AM/PM	Last meal or snack ____ : ____ AM/PM
H vial - Required (See instructions) ____ : ____ AM/PM	

Cortisol - other (If ordered) ____ : ____ AM/PM	Last meal or snack ____ : ____ AM/PM
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Date samples collected: _____

Do you have bleeding gums or have you ever been diagnosed with gingivitis? ☐ Yes ☐ No

Do you work a swing shift, night shift or have an unusual sleep/wake cycle? ☐ Yes ☐ No

If yes: For how long? _____

Please consult with your provider to determine your collection schedule.

Did you perform the Carbohydrate Stimulation Test? ☐ Yes ☐ No

Please see description in Specimen Collection Instructions

Females: Do you have a menstrual cycle? ☐ Yes ☐ No

If yes, on what day of your cycle were samples collected? _____

What is your average cycle length? _____

If you are using any of the following substances, **please consult with your provider prior to collection** since they may interfere with or alter certain test results. *Please do not call the lab since we are only able to take medication and supplement calls directly from healthcare providers.*

If continued use is necessary, please indicate the type, dose, frequency and date last taken below:

Medication	Name	Dose	Frequency	Date & Time Last Taken
Progesterone/Pregnenolone				
DHEA				
Prednisone/Prednisolone				
Dexamethasone				
Steroid inhaler/nasal spray/eye drops				
Corticosteroid cream/hemorrhoid cream				
Hydrocortisone cream				
Hydrocortisone lip balm				
Antihistamine				
Decongestant				
Antidepressant				
Anti-anxiety medication				
Adrenal glandular				
Other				

Patient Comments: _____

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