## 4 Important Patient Information (Please complete all of the following)

**Dates**

Date of Sample 1 collection (freeze upon collection): _____Date of Sample 2 collection: _____

Please indicate which collection schedule you followed (see Specimen Collection Instructions): ○ Schedule 1 ○ Schedule 2 ○ Schedule 3

**Additional Information**

Were both samples collected at approximately the same time of day (plus or minus one hour)?.... ○ Yes ○ No
If yes, please indicate approximate time of day collected: _____
Do you have bleeding gums or have you ever been diagnosed with gingivitis?..... ○ Yes ○ No
Height: _____ Weight: _____
Do you have a regular cycle?..... ○ Yes ○ No
When was the first day of your last menstrual period? _____
Have you lost weight in the last three months?..... ○ Yes ○ No
Have you used hormonal birth control within the last six months?..... ○ Yes ○ No
If yes, please indicate type used: ○ Pill ○ Patch ○ Ring ○ Other: _____
Have you had a hysterectomy?..... ○ Yes ○ No
Are your ovaries intact?..... ○ Yes ○ No
Please indicate the reason for testing:
☐ Peri/postmenopausal symptoms
☐ BHRT monitoring
☐ Fertility study
☐ Baseline health
☐ Other: _____

**Medications**

**Note: Please see the Specimen Collection Instruction pamphlet** for guidance on how to modify dosing of hormones prior to testing.

If you are using any of the following substances, or if you have taken them within the past three months, please **consult with your provider prior to collection since they may interfere with or alter certain test results.** Do not call the lab. If continued use is necessary, please indicate the type, dose, frequency, and date last taken:

| Medication | Type | Dose | Frequency | Date Last Taken |
|---|---|---|---|---|
| Progesterone | | | | |
| Estrogens | | | | |
| Testosterone | | | | |
| DHEA | | | | |
| Other hormones (Please specify) | | | | |
| | | | | |
| | | | | |
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Patient Comments

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