4 Important Patient Information (Please read instructions before collection)

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

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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