

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
30 Minutes (after awakening) ___ : ___ AM/PM	Continued fast
60 Minutes (after awakening) ___ : ___ AM/PM	Continued 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	

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 the Collection Instructions

Females: Do you have a menstrual cycle? Yes No

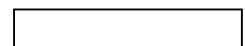
If yes, on what day of your cycle were samples collected? _____

What is your average cycle length? _____

If you are using any of the following, **please consult with your provider prior to collection.** 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: _____



ASI-CAR

