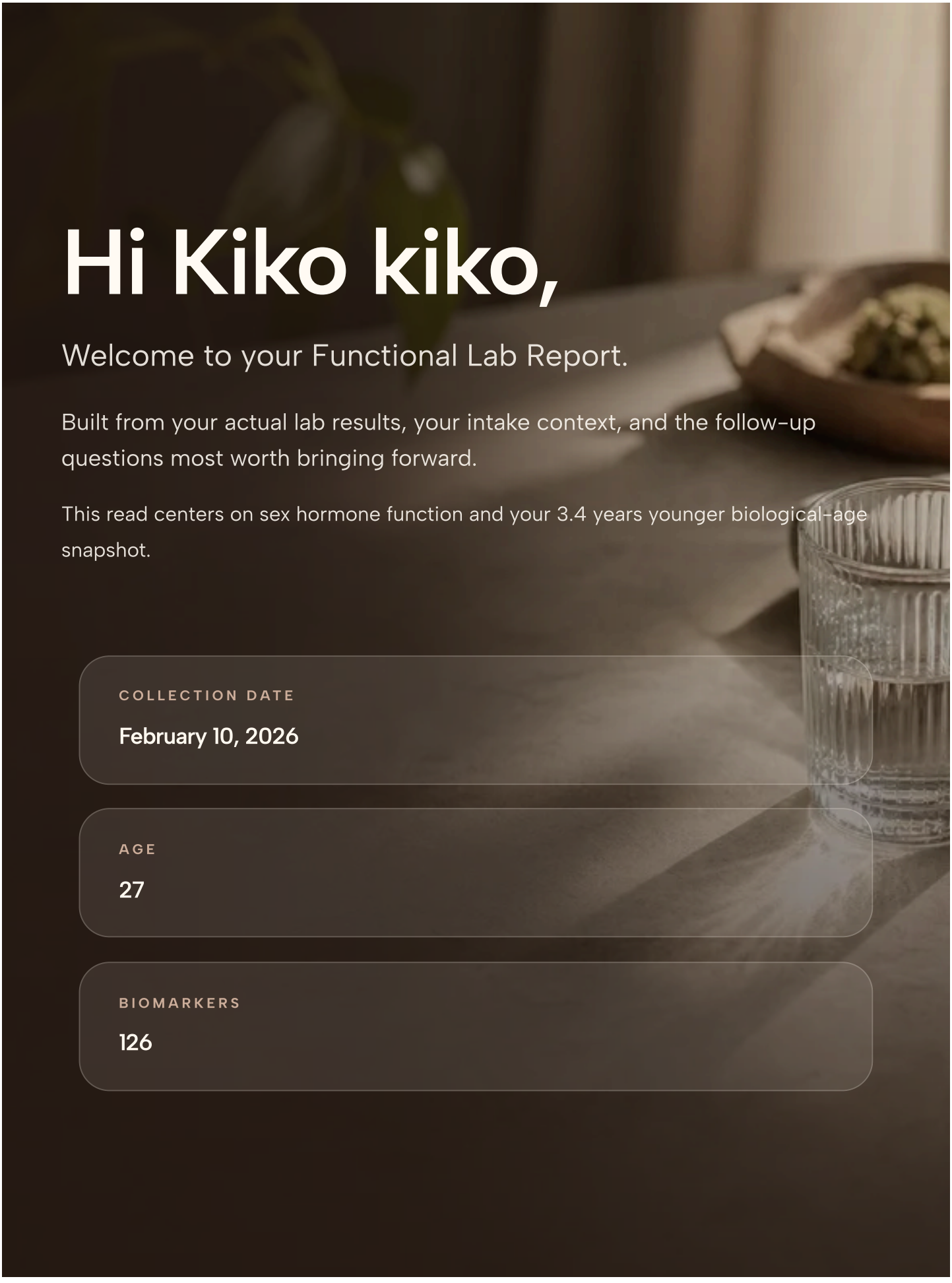


Hi Kiko kiko,

Welcome to your Functional Lab Report.

Built from your actual lab results, your intake context, and the follow-up questions most worth bringing forward.

This read centers on sex hormone function and your 3.4 years younger biological-age snapshot.

COLLECTION DATE

February 10, 2026

AGE

27

BIOMARKERS

126

VITALS VAULT FUNCTIONAL HEALTH REPORT

Table of Contents

Kiko kiko

FUNCTIONAL HEALTH REPORT

A Note Before You Begin

Dear Kiko,

This report turns 126 biomarkers from your February 10, 2026 collection into a systems-level read of what looks resilient, what deserves attention, and what is most useful to follow next.

Use the early pages for the big picture, then move into the system chapters and lab appendix when you want the evidence behind each recommendation.

WHAT LOOKS STRONG

Vitamin D Need. This is a steady background signal in the February 10, 2026 snapshot.

Vitamin B6 Need. This February 10, 2026 snapshot does not show a strong signal for increased vitamin B6 need.

Folate Need. This is a comparatively steady nutrient signal within a report that otherwise contains active inflammation, iron-availability, endocrine, and electrolyte follow-up threads.

WHAT DESERVES ATTENTION

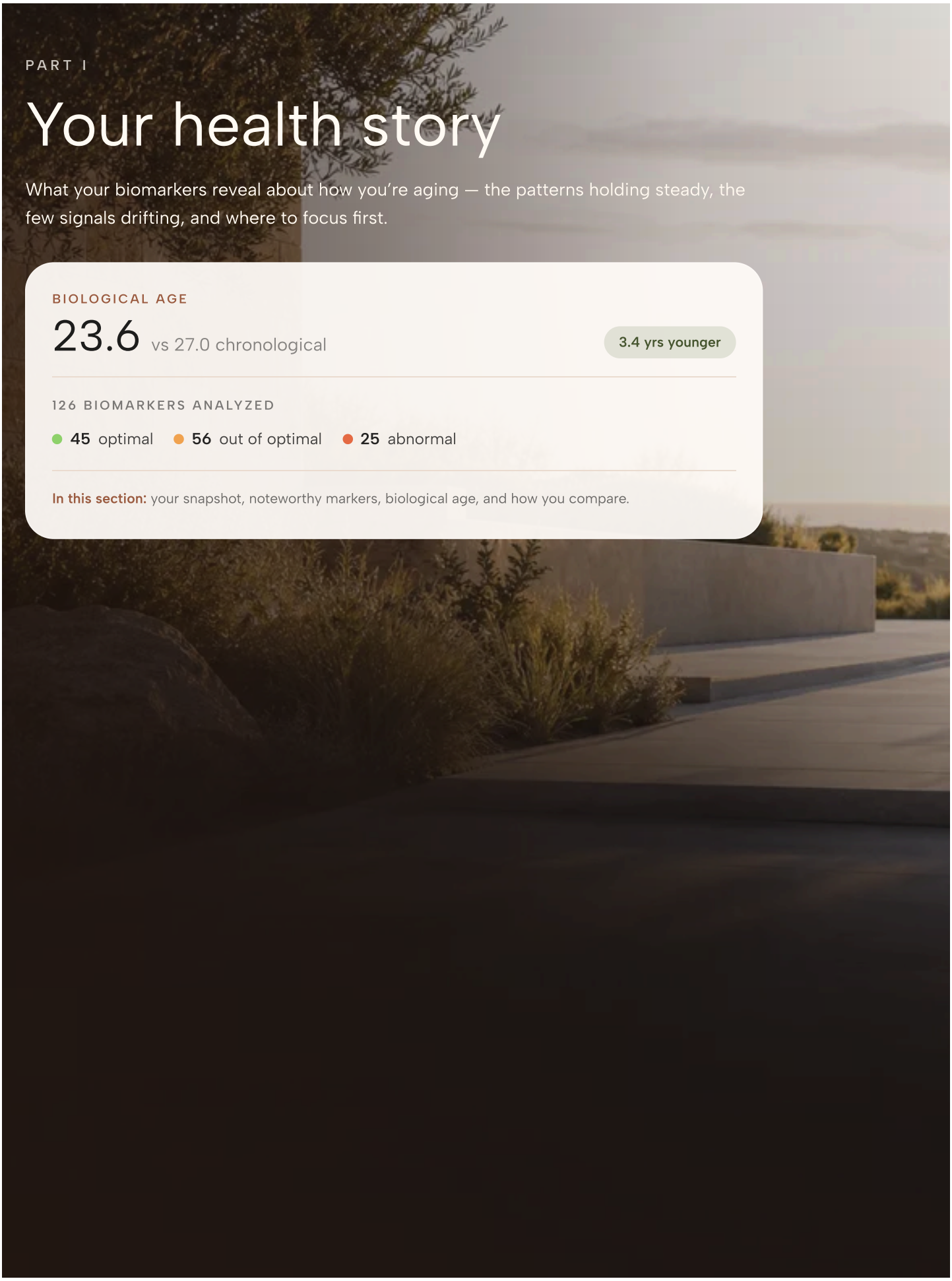
DHEA Need. On the February 10, 2026 collection, low DHEA sulfate is the single driver of this high-priority DHEA Need signal.

Sex Hormone Function. The February 10, 2026 sample shows low total and free testosterone, low DHEA-S and progesterone, with high SHBG and elevated estradiol.

Cardiovascular Function. This snapshot combines fasting glucose of 116 and hemoglobin A1c of 5.8 with elevated LDL cholesterol, apolipoprotein B, and lipoprotein(a), plus hs-CRP of 18.5 mg/L and ferritin of 729 ng/mL.

This is not a diagnosis or medical advice. It is a structured interpretation of your available laboratory and intake data.

The Vitals Vault Clinical Intelligence Team



PART I

Your health story

What your biomarkers reveal about how you're aging — the patterns holding steady, the few signals drifting, and where to focus first.

BIOLOGICAL AGE

23.6 vs 27.0 chronological

3.4 yrs younger

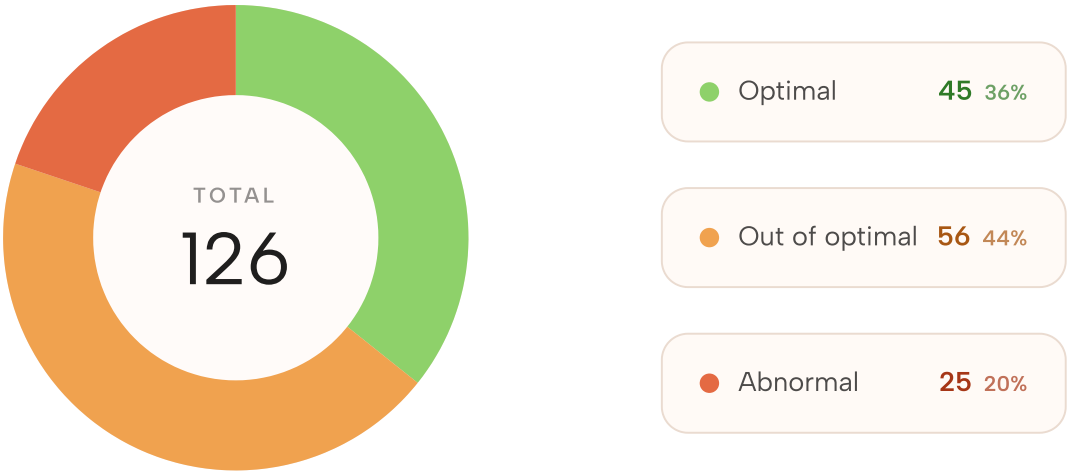
126 BIOMARKERS ANALYZED

- **45** optimal
- **56** out of optimal
- **25** abnormal

In this section: your snapshot, noteworthy markers, biological age, and how you compare.

Let's begin with a current snapshot of your biomarkers.

Before we follow individual clues, it helps to step back and see the full pattern: what is holding steady, what is drifting, and what is asking for closer attention.



Noteworthy markers

The deep dive separates supportive markers from the findings most likely to change clinical decisions. It is not a diagnosis, and the flagged markers should be interpreted together rather than ranked by a single result alone.

Supportive Biomarkers

EGFR ● STRONG

WHAT IS EGFR?

eGFR estimates how efficiently the kidneys filter blood, using creatinine with demographic factors. It is interpreted with creatinine and other kidney-related findings rather than alone.

Why this supports your baseline

eGFR is a calculated estimate of kidney filtration and is marked strong in this snapshot. Along with creatinine and BUN, it offers useful baseline context while the low potassium and higher chloride pattern is reviewed separately.

Your strong eGFR supports preserved filtration context in this snapshot. It does not explain the low potassium, which remains a separate clinician-level electrolyte question.

VITAMIN D,25-OH,TOTAL,IA ● STRONG

WHAT IS VITAMIN D,25-OH,TOTAL,IA?

25-OH vitamin D is the circulating storage form used to assess vitamin D status. Vitamin D participates in calcium regulation, bone metabolism, and immune signaling.

Why this supports your baseline

25-OH vitamin D is the main circulating measure of vitamin D status and is marked strong here. This provides supportive context for bone and immune-related interpretation while calcium, albumin, and magnesium remain flagged separately.

Your vitamin D result is a relative strength amid low calcium and albumin. It narrows the mineral discussion by showing that vitamin D status is not the main flagged signal in this report.

HDL CHOLESTEROL ● STRONG

WHAT IS HDL CHOLESTEROL?

HDL cholesterol measures cholesterol carried in high-density lipoprotein particles. It is one component of a broader lipid and cardiometabolic picture.

Why this supports your baseline

HDL cholesterol is marked strong and sits alongside strong triglyceride and cholesterol-ratio results. These are favorable lipid-context features, though they do not remove the need to review LDL cholesterol, apolipoprotein B, glucose, and inflammation together.

Your HDL result helps anchor a mixed cardiovascular pattern. It is most informative alongside LDL cholesterol, apolipoprotein B, glucose, A1c, ferritin, and hs-CRP.

The Drifters

FERRITIN

DISCUSS WITH CLINICIAN

WHAT IS FERRITIN?

Ferritin is a protein that stores iron and also behaves as an acute-response marker during inflammatory activity. Its meaning changes when considered with serum iron, binding capacity, saturation, and inflammatory markers.

WHY IT MATTERS

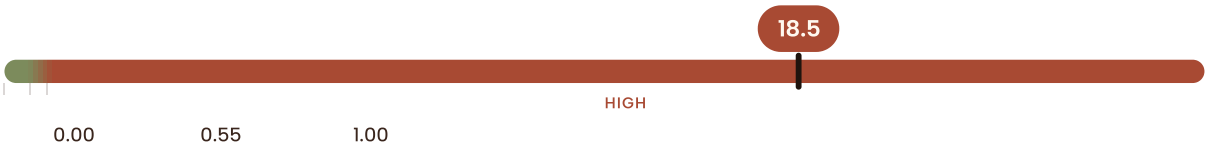
Your ferritin is paired with lower serum iron and high hs-CRP, creating a pattern that needs clinician interpretation. This has high decision value because it connects inflammatory, iron-handling, immune, and cardiovascular sections.

Why this needs attention

Ferritin is markedly elevated and intersects with inflammation, liver-related interpretation, oxidative stress, and iron availability. The concurrent lower serum iron and elevated hs-CRP make confirmation and clinical context more informative than any standalone iron-focused conclusion.

HS CRP

DISCUSS WITH CLINICIAN



WHAT IS HS CRP?

High-sensitivity C-reactive protein is a liver-produced protein that rises with inflammatory signaling. It is commonly used as a broad marker of inflammatory activity, not a locator of its cause.

WHY IT MATTERS

Your elevated hs-CRP changes the interpretation of ferritin and the cardiometabolic findings. Because no symptoms or recent-context details were reported, repeat and clinician assessment are especially important.

Why this needs attention

hs-CRP is a clinically flagged inflammation signal that may influence how ferritin, glucose, protein markers, and cardiovascular risk context are read. With no reported symptoms or lifestyle context, this single collection-date result should be evaluated and trended rather than assumed to represent a chronic baseline.

Priority Focus

TESTOSTERONE, TOTAL, MS

PRIORITY

WHAT IS TESTOSTERONE, TOTAL, MS?

Total testosterone measures the overall circulating amount of testosterone, including protein-bound and unbound fractions. Free testosterone and SHBG help clarify how much may be available to tissues.

WHY IT MATTERS

Your total testosterone result aligns with low free testosterone and high SHBG, making the pattern more coherent than one isolated hormone result. The absence of reported hormone exposure makes direct clinical interpretation particularly important.

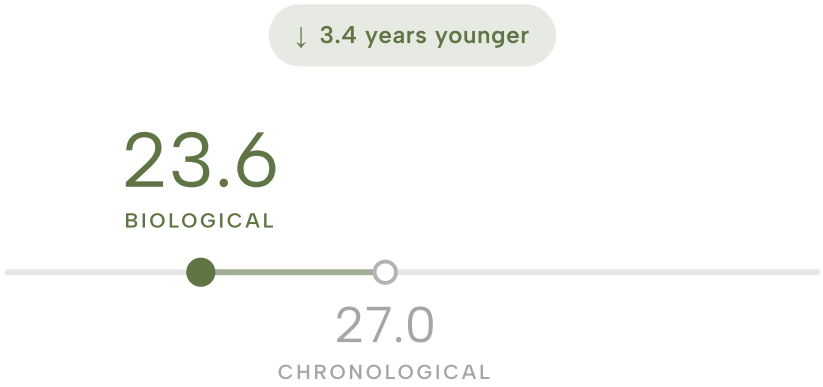
Why this leads the list

Total testosterone is the most actionable focal marker because it anchors the report's lead sex-hormone pattern and is concordant with low free testosterone, low DHEA sulfate, high SHBG, and elevated estradiol. This is a two-system issue, linking sex-hormone interpretation with adrenal and cardiometabolic context, so it merits clinician-level confirmation rather than isolated optimization.

Your biological age is

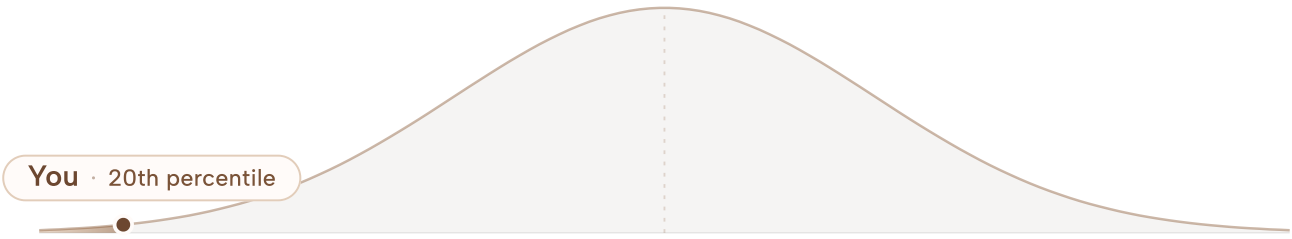
Your biological age is 23.6, which is 3.4 years below your chronological age of 27.0.

A lower biological age is generally a favorable resilience signal: your current physiology looks younger than expected for your age. The goal now is to protect the habits driving this and keep the trend durable over time.



How you Compare

Compared against 20–29 male peers



LOWER PERCENTILE COHORT AVERAGE HIGHER PERCENTILE

You're ahead of **20%** of 20–29 male peers in this comparison.

Room to Improve

A result here means your biology is carrying more cumulative load than is ideal right now, not that anything is "failing." It is often responsive to focused changes, and steady improvement over the next testing cycles is what matters most.

Aging Drivers

Which signals seem to be pushing older or younger in this snapshot.

How this is calculated: we look only at the nine markers behind your PhenoAge biological-age estimate, weight each by how far it sits from its optimal range, and use the Morgan–Levine model to decide whether it is pushing your age older or younger. Your total age gap is then shared across these signals in proportion.

Helping you age younger

These are the top signals currently protecting your age trajectory.

These contribute a similar amount — about 0.5 years younger apiece — so your result reflects broad, distributed resilience rather than one standout signal.

RDW

RDW contributed 0.63 younger years to the biological-age model, despite being clinically flagged at 17%. RDW reflects variation in red-blood-cell size, so this favorable clock contribution should not be read as resolving the separate red-cell and iron-handling pattern that includes low MCHC, lower serum iron, high ferritin, and normal hemoglobin.

ALBUMIN

Albumin contributed 0.54 younger years in the biological-age algorithm, even though the measured value of 3.5 g/dL is flagged as a priority in this report. Albumin is a circulating protein involved in fluid balance and transport, and its clinical interpretation here belongs with total protein, globulin, hs-CRP, and ferritin rather than with the biological-ag...

HS CRP

HS CRP contributed 0.5 younger years to the model, while its 18.5 mg/L result is clinically flagged for discussion. Because hs-CRP is a broad inflammation marker and ferritin is also high on the February 10 snapshot, the favorable clock direction does not reduce the need to clarify possible short-term or persistent inflammatory load.

GLUCOSE

Glucose contributed 0.5 younger years to the biological-age model, despite a clinically flagged value of 116 mg/dL and A1c of 5.8%. This illustrates why biological age is a composite estimate: the younger overall score can coexist with a glucose pattern that deserves direct follow-up in cardiovascular, thyroid, and metabolic context.

What This Means

AGE GAP

Kiko, your current age gap is 3.4 years younger than your chronological baseline. In practical terms, your systems are currently showing less cumulative wear than expected for your age.

WHY IT MATTERS

This metric matters because it reflects how well your body is balancing repair, inflammation control, and metabolic efficiency.

PERSONAL CONTEXT

As this metric improves over future tests, it often corresponds with better day-to-day energy, recovery, and resilience.

How to protect this advantage

01 Use clinician-guided repeat testing to determine whether the February hormone and thyroid patterns persist.

02 Prioritize prompt review of potassium alongside the broader electrolyte and adrenal-related pattern.

03 Track future biological age against repeated hs-CRP, ferritin, glucose, A1c, and hormone results.

Your Lifestyle, at a glance

The available intake data identify a few contextual factors that reduce obvious confounding, while the absent lifestyle details remain important to complete before trend interpretation.

Already supporting your trajectory

No smoking or vaping was reported.

This removes one reported exposure that can complicate inflammatory and cardiovascular interpretation. It does not explain the elevated hs-CRP, so that marker still needs direct follow-up.

> **Supporting evidence:** The intake flag for smoking or vaping was reported as false.
>
> **Related markers:** HS CRP, LDL-CHOLESTEROL, HDL CHOLESTEROL

No current hormone exposure was reported.

This provides cleaner context for interpreting the sex-hormone cluster. The laboratory pattern remains substantial enough to warrant clinician review and confirmation.

> **Supporting evidence:** The intake flag for current hormone exposure was reported as false.
>
> **Related markers:** TESTOSTERONE, TOTAL, MS, TESTOSTERONE, FREE, ESTRADIOL, SEX HORMONE BINDING GLOBULIN

Heavy training was not reported.

This removes one reported source of short-term training-related laboratory variability. It does not establish why inflammatory or hormone-related markers were flagged on the collection date.

> **Supporting evidence:** The intake flag for heavy training was reported as false.
>
> **Related markers:** HS CRP, FERRITIN, CORTISOL, TOTAL

Lifestyle areas worth tuning next

Sleep, stress, activity, alcohol, and hydration patterns are not yet documented.

These missing variables limit interpretation of biological age and several cross-system findings. Capturing them before future testing will make changes in glucose, inflammation, and hormone markers more interpretable.

> **Supporting evidence:** All listed lifestyle fields were recorded as null in the intake.
>
> **Related markers:** GLUCOSE, HEMOGLOBIN A1c, HS CRP, CORTISOL, TOTAL

Current weight is 167 lb, with a desired weight of 185 lb.

This creates a useful goal context for future trends, but the report does not provide dietary intake or body-composition data to explain the current pattern. Any weight-focused plan should therefore be individualized with clinician or qualified nutrition context.

> **Supporting evidence:** Foundational health intake lists current weight at 167 lb and desired weight at 185 lb.
>
> **Related markers:** GLUCOSE, HEMOGLOBIN A1c, TESTOSTERONE, TOTAL, MS, ALBUMIN

PART II · 13 SYSTEMS ASSESSED

Functional Health Systems

IN THIS SECTION

How your biomarkers connect to key body systems

Sex Hormone Function

REVIEW

DHEA SULFATE | ESTRADIOL | TESTOSTERONE, FREE | TESTOSTERONE, TOTAL, MS | SEX HORMONE BINDING GLOBULIN | PROGESTERONE

Cardiovascular Function

REVIEW

GLUCOSE | FERRITIN | HS CRP | LDL-CHOLESTEROL | HEMOGLOBIN A1C | ESTRADIOL | TESTOSTERONE, TOTAL, MS | TESTOSTERONE, FREE | LIPOPROTEIN (A) | TRIGLYCERIDES | INSULIN | APOLIPOPROTEIN B | CHOLESTEROL, TOTAL | HDL CHOLESTEROL | HOMOCYSTEINE | VITAMIN D,25-OH,TOTAL,IA

Adrenal Function

REVIEW

DHEA SULFATE | POTASSIUM | CORTISOL, TOTAL | CHLORIDE | SODIUM

Thyroid Function

REVIEW

T4 (THYROXINE), TOTAL | TSH | T3 UPTAKE

Blood Sugar Regulation

REVIEW

GLUCOSE | DHEA SULFATE | HEMOGLOBIN A1C | LDL-CHOLESTEROL | INSULIN | TRIGLYCERIDES | HDL CHOLESTEROL | CHOLESTEROL, TOTAL

Prostate Function

REVIEW

DHEA SULFATE | TESTOSTERONE, TOTAL, MS | MONOCYTES | PSA, TOTAL | CREATININE

GI Function

REVIEW

GLOBULIN | PROTEIN, TOTAL | ALBUMIN | CALCIUM | ALKALINE PHOSPHATASE | IRON, TOTAL | CHLORIDE | WHITE BLOOD CELL COUNT | UREA NITROGEN (BUN) | MCV | EOSINOPHILS | BASOPHILS | CREATININE

Liver Function

REVIEW

GLOBULIN | FERRITIN | ALBUMIN | PROTEIN, TOTAL | ALKALINE PHOSPHATASE | IRON, TOTAL | ALT | AST | GGT | BILIRUBIN, TOTAL | UREA NITROGEN (BUN) | CHOLESTEROL, TOTAL

Red Blood Cell Function

REVIEW

RDW | MCHC | RED BLOOD CELL COUNT | HEMOGLOBIN | HEMATOCRIT | MCV | MCH

Gallbladder Function

REVIEW

ALKALINE PHOSPHATASE | TRIGLYCERIDES | GGT | CHOLESTEROL, TOTAL | ALT | BILIRUBIN, TOTAL

Kidney Function

REVIEW

POTASSIUM
CHLORIDE
UREA NITROGEN (BUN)
CREATININE
EGFR
URIC ACID
SODIUM
AST

Bone Health

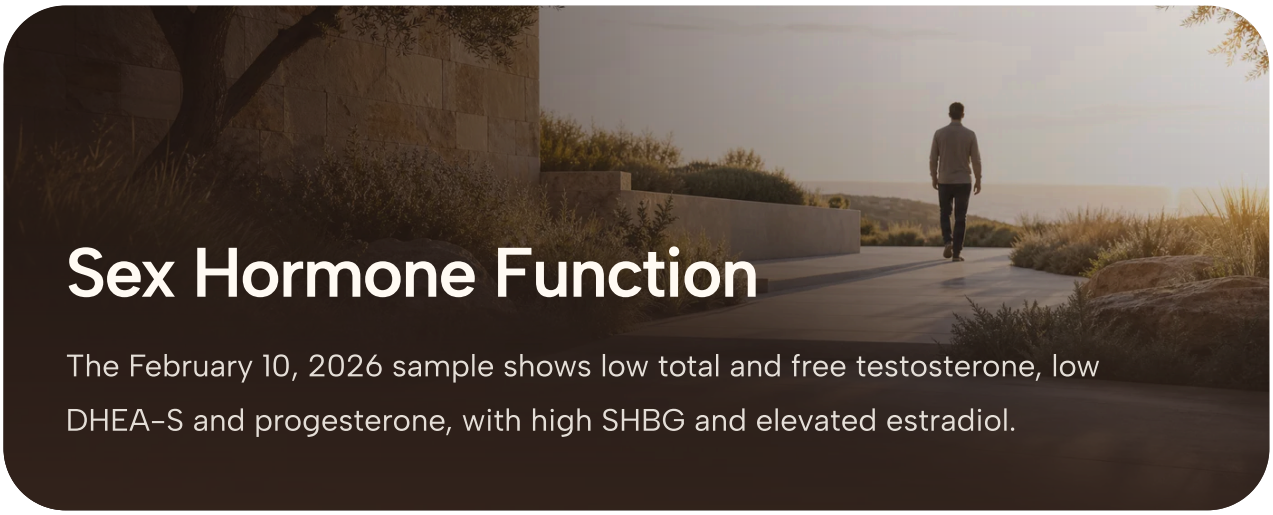
OPTIMIZE

GLOBULIN
CALCIUM
ALBUMIN
ALKALINE PHOSPHATASE
MAGNESIUM, RBC
VITAMIN D,25-OH,TOTAL,IA

Immune Function

MONITOR

GLOBULIN
FERRITIN
NEUTROPHILS
LYMPHOCYTES
MONOCYTES
ABSOLUTE LYMPHOCYTES
ALBUMIN
WHITE BLOOD CELL COUNT
ABSOLUTE MONOCYTES
ABSOLUTE NEUTROPHILS
ALKALINE PHOSPHATASE
EOSINOPHILS
BASOPHILS
VITAMIN D,25-OH,TOTAL,IA



Sex Hormone Function

The February 10, 2026 sample shows low total and free testosterone, low DHEA-S and progesterone, with high SHBG and elevated estradiol.

What is Sex Hormone Function?

Sex hormones coordinate reproductive function, body composition, bone health, and signaling in many tissues. Testosterone availability depends not only on total testosterone production, but also on binding proteins such as SHBG and conversion to related hormones.

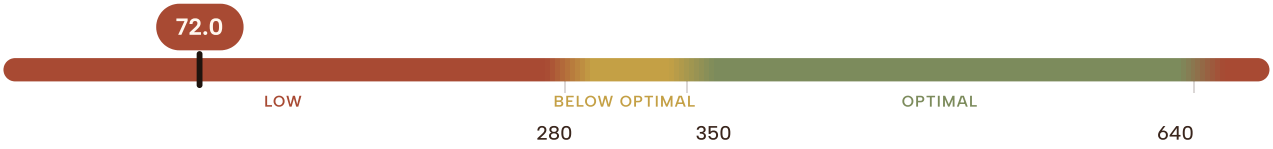
RISK SCORE

Current label
Discuss with clinician

What your results are showing

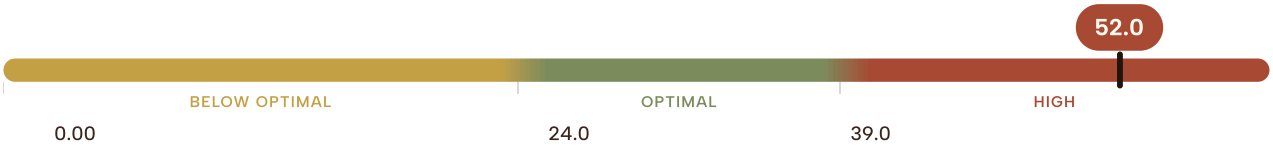
DHEA SULFATE

Current value: 72 mcg/dL



ESTRADIOL

Current value: 52 pg/mL



TESTOSTERONE, FREE

Current value: 1.2 pg/mL

TESTOSTERONE, TOTAL, MS

Current value: 20 ng/dL

What this may mean

The February 10, 2026 sample shows low total and free testosterone, low DHEA-S and progesterone, with high SHBG and elevated estradiol. High SHBG provides a coherent explanation for why free testosterone is low, while the low DHEA-S links this pattern to the separate adrenal-hormone reserve signal. Because the blood was collected at 5:09 PM, timing is especially important before assigning durable meaning to the androgen results.

What this is not

This does not establish a hormone disorder or indicate that hormone treatment is appropriate. A single late-afternoon measurement cannot distinguish a persistent pattern from timing and other unrecorded context.

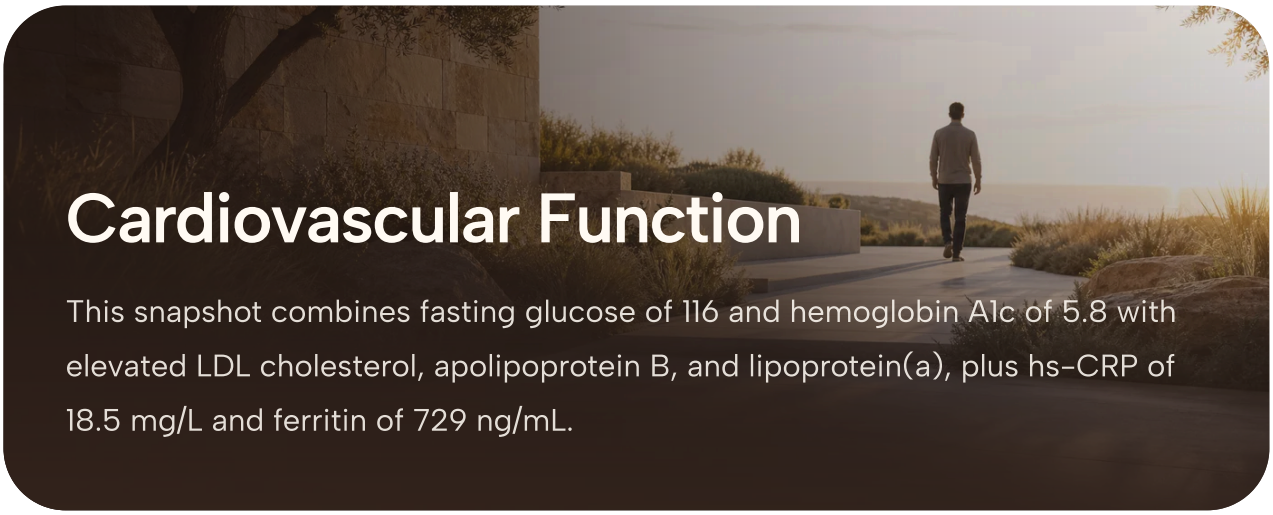
What to do next

Within the next 7 days, schedule a clinician review and bring the collection time, the full hormone panel, and a complete list of any medications or supplements if that information becomes available

For 14 days before any repeat test, record sleep timing, major exercise sessions, alcohol intake if any, and any acute illness or unusual stress, so the repeat result can be interpreted against real context

Choose one habit to focus on (sleep timing and stress recovery) and follow it consistently for the next 2 weeks.

Set a retest date and track DHEA SULFATE plus one related marker to confirm trend direction.



Cardiovascular Function

This snapshot combines fasting glucose of 116 and hemoglobin A1c of 5.8 with elevated LDL cholesterol, apolipoprotein B, and lipoprotein(a), plus hs-CRP of 18.5 mg/L and ferritin of 729 ng/mL.

What is Cardiovascular Function?

Cardiovascular function reflects the long-term interaction of blood sugar regulation, arterial lipoproteins, inflammation, and blood-vessel biology. These processes often reinforce one another over time, so a cluster is more informative than a single cholesterol or glucose result.

RISK SCORE

Current label
Discuss with clinician

What your results are showing

FERRITIN

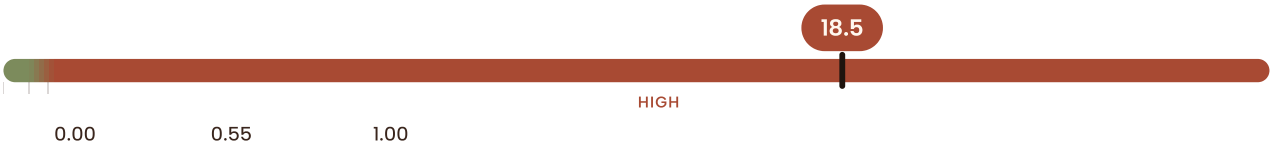
Current value: 729 ng/mL

GLUCOSE

Current value: 116 mg/dL

HS CRP

Current value: 18.5 mg/L



LDL-CHOLESTEROL

Current value: 111 mg/dL (calc)

What this may mean

This snapshot combines fasting glucose of 116 and hemoglobin A1c of 5.8 with elevated LDL cholesterol, apolipoprotein B, and lipoprotein(a), plus hs-CRP of 18.5 mg/L and ferritin of 729 ng/mL. Here, ferritin is most useful as part of an inflammatory-context question alongside hs-CRP, rather than as a standalone measure of iron status. Estradiol is included in this system but is more directly addressed in the hormone priority.

What this is not

This pattern does not diagnose cardiovascular disease, , or an inflammatory condition. It is also not evidence that the abnormalities are chronic, because there are no earlier measurements and no acute-health context from the collection date.

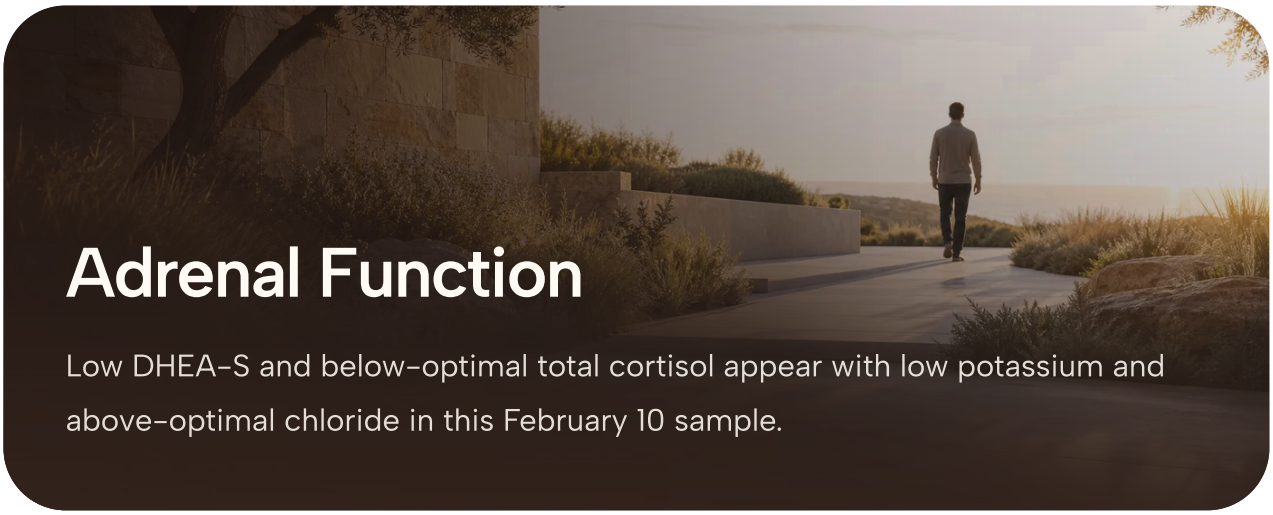
What to do next

Book a clinician visit within the next 1 to 2 weeks to review hs-CRP, ferritin, glucose, A1c, apoB, and lipoprotein(a) together rather than addressing each result separately

For the next 14 days, keep a simple dated log of meal timing before any future fasting draw, physical activity, sleep timing, alcohol if any, and illness or injury, then use the same preparation for repeat testing whenever feasible

Choose one habit to focus on (meal quality and daily movement) and follow it consistently for the next 2 weeks.

Set a retest date and track GLUCOSE plus one related marker to confirm trend direction.



Adrenal Function

Low DHEA-S and below-optimal total cortisol appear with low potassium and above-optimal chloride in this February 10 sample.

What is Adrenal Function?

The adrenal glands make cortisol, DHEA-related hormones, and signals that help regulate sodium, potassium, blood pressure, and stress responses. Cortisol and DHEA-S are related but not interchangeable, and cortisol interpretation depends strongly on collection time.

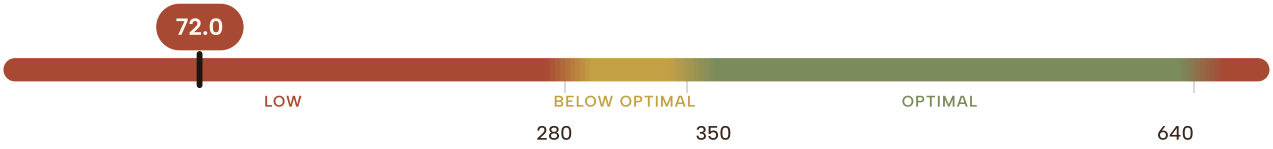
RISK SCORE

Current label
Discuss with clinician

What your results are showing

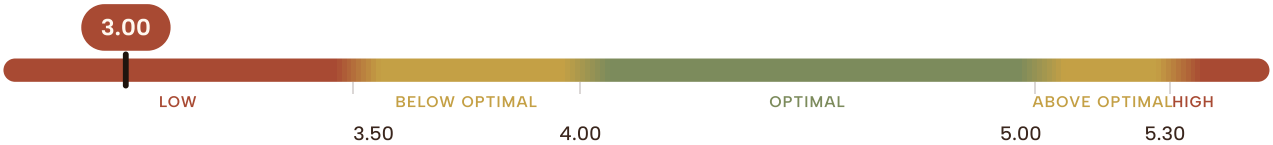
DHEA SULFATE

Current value: 72 mcg/dL



POTASSIUM

Current value: 3 mmol/L



CHLORIDE

Current value: 107 mmol/L

CORTISOL, TOTAL

Current value: 9.8 mcg/dL

What this may mean

Low DHEA-S and below-optimal total cortisol appear with low potassium and above-optimal chloride in this February 10 sample. This is a cross-system signal: DHEA-S overlaps with the sex-hormone pattern, while potassium and chloride raise a separate mineral-balance question. The 5:09 PM collection time limits interpretation of total cortisol, which normally changes substantially over the day.

What this is not

This does not diagnose adrenal insufficiency, chronic stress, or a mineralocorticoid disorder. The term "adrenal function" is a systems grouping and should not substitute for clinical assessment of low potassium or time-dependent hormone testing.

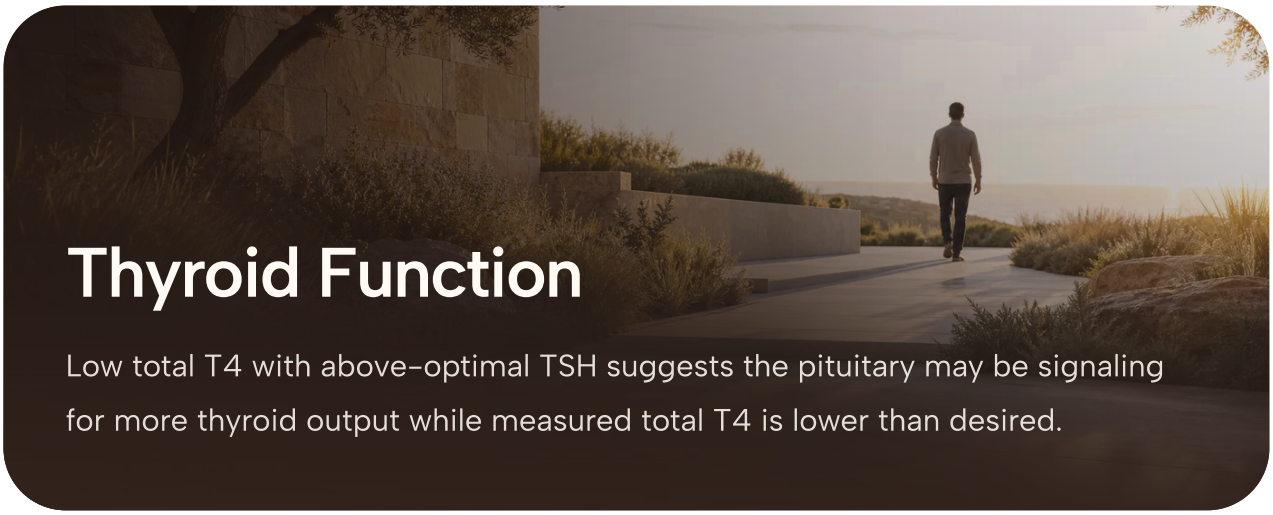
What to do next

Within the next few days, contact your clinician or the ordering service to review the potassium result and ask whether repeat testing is needed before waiting for a routine follow-up

Until reviewed, do not start potassium, DHEA, or cortisol-targeted supplements based on this panel alone. Instead, document the date and timing of any future blood draw and any relevant hydration, illness, or exercise context

Choose one habit to focus on (sleep timing and stress recovery) and follow it consistently for the next 2 weeks.

Set a retest date and track DHEA SULFATE plus one related marker to confirm trend direction.



Thyroid Function

Low total T4 with above-optimal TSH suggests the pituitary may be signaling for more thyroid output while measured total T4 is lower than desired.

What is Thyroid Function?

The thyroid system helps regulate energy use, temperature regulation, heart rate, digestion, and growth and repair. TSH is a pituitary signal to the thyroid, while T4 supplies hormone that tissues can convert and use.

RISK SCORE

86

Current label
Discuss with clinician

What your results are showing

T4 (THYROXINE), TOTAL

Current value: 3.3 mcg/dL

TSH

Current value: 4.32 mIU/L

T3 UPTAKE

Current value: 35 %

What this may mean

Low total T4 with above-optimal TSH suggests the pituitary may be signaling for more thyroid output while measured total T4 is lower than desired. T3 uptake at 35% is a steadier result in this report, but it does not replace free T4 or thyroid antibody testing when a TSH and total-T4 pattern needs clarification. This thyroid thread may also be relevant to the glucose, lipid, and hormone patterns, but the present data cannot determine whether it is upstream of them.

What this is not

This does not diagnose hypothyroidism or autoimmune thyroid disease. Total T4 can be affected by hormone-binding proteins, and the available panel lacks the free thyroid measurements needed for a more complete interpretation.

What to do next

Within 1 to 2 weeks, arrange a clinician review focused on confirming the thyroid pattern with the missing free-hormone measurements rather than relying on total T4 alone

Before that visit, compile any prior thyroid laboratory results and a complete list of medications and supplements if available, including start dates, since these details materially affect interpretation of repeat testing

Choose one habit to focus on (sleep, movement, and meal quality) and follow it consistently for the next 2 weeks.

Set a retest date and track T4 (THYROXINE), TOTAL plus one related marker to confirm trend direction.

ACCESSORY SYSTEMS · 6 SYSTEMS ASSESSED

Accessory Health Systems

IN THIS SECTION

How your biomarkers connect to accessory systems

Oxidative Stress

REVIEW

FERRITIN · GLOBULIN · ALBUMIN · LYMPHOCYTES · ABSOLUTE LYMPHOCYTES · LDL-CHOLESTEROL · NEUTROPHILS · IRON, TOTAL · GGT · URIC ACID · CHOLESTEROL, TOTAL · PLATELET COUNT · BILIRUBIN, TOTAL · HDL CHOLESTEROL · HOMOCYSTEINE

Inflammation

REVIEW

HS CRP · FERRITIN · RDW · LYMPHOCYTES · ALBUMIN · WHITE BLOOD CELL COUNT · TRIGLYCERIDES · IRON, TOTAL · SED RATE BY MODIFIED WESTERGREN · HOMOCYSTEINE · URIC ACID · CHOLESTEROL, TOTAL · HDL CHOLESTEROL · BASOPHILS · VITAMIN D,25-OH,TOTAL,IA · ALT

Toxicity

REVIEW

GLOBULIN · LYMPHOCYTES · ABSOLUTE LYMPHOCYTES · MCHC · GGT · ALT · AST · BILIRUBIN, TOTAL · CREATININE · URIC ACID · CHOLESTEROL, TOTAL · HDL CHOLESTEROL · PLATELET COUNT · MCH · HOMOCYSTEINE

pH Balance

MONITOR

POTASSIUM · CALCIUM · ALBUMIN · CHLORIDE · CARBON DIOXIDE · SODIUM

Lipid Panel

MONITOR

LDL-CHOLESTEROL · TRIGLYCERIDES · NON HDL CHOLESTEROL · APOLIPOPROTEIN B · LIPOPROTEIN (A) · CHOLESTEROL, TOTAL · HDL CHOLESTEROL

Allergy

STRONG

ABSOLUTE EOSINOPHILS · NEUTROPHILS · WHITE BLOOD CELL COUNT · ABSOLUTE NEUTROPHILS · EOSINOPHILS · BASOPHILS · ABSOLUTE BASOPHILS

Oxidative Stress

The same ferritin and hs-CRP thread is a major source of near-term decision value across the report, including cardiovascular risk context.

What is Oxidative Stress?

Oxidative stress describes the balance between oxidant burden generated during normal metabolism and the body's antioxidant and repair capacity. Inflammation, immune activation, nutrient availability, and protein transport can all influence this balance. It matters because persistent imbalance can interact with vascular, metabolic, and tissue-recovery biology.

RISK SCORE

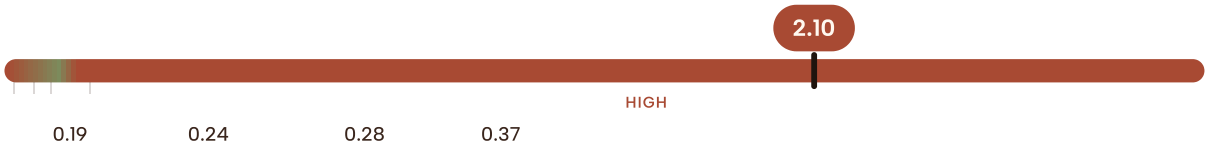
Current label
Discuss with clinician

What your results are showing

FERRITIN — 729 ng/mL

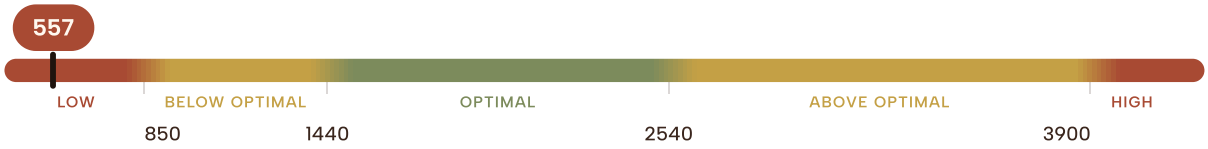
Your ferritin is paired with lower serum iron and high hs-CRP, creating a pattern that needs clinician interpretation. This has high decision value because it connects inflammatory, iron-handling, immune, and cardiovascular sections.

GLOBULIN — 2.1 g/dL (calc)



ABSOLUTE LYMPHOCYTES

557 cells/uL



ALBUMIN

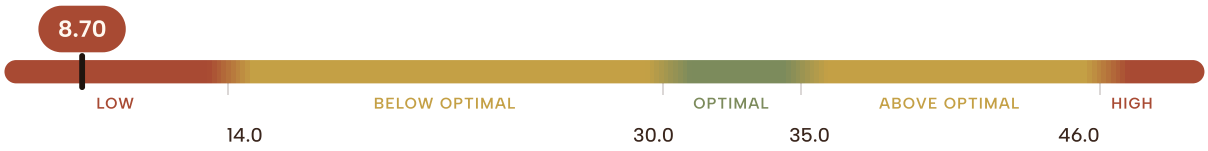
3.5 g/dL

LDL-CHOLESTEROL

111 mg/dL (calc)

LYMPHOCYTES

8.7 %



NEUTROPHILS

77.7 %

IRON, TOTAL

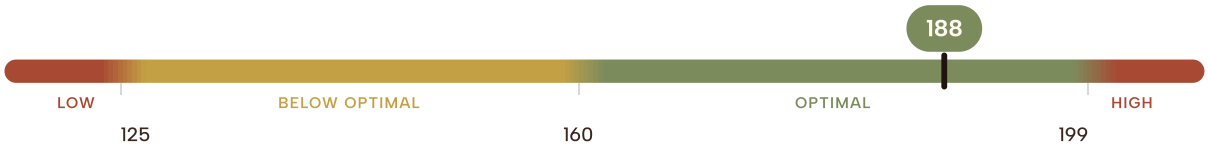
50 mcg/dL

BILIRUBIN, TOTAL

0.6 mg/dL

CHOLESTEROL, TOTAL

188 mg/dL



GGT

16 U/L

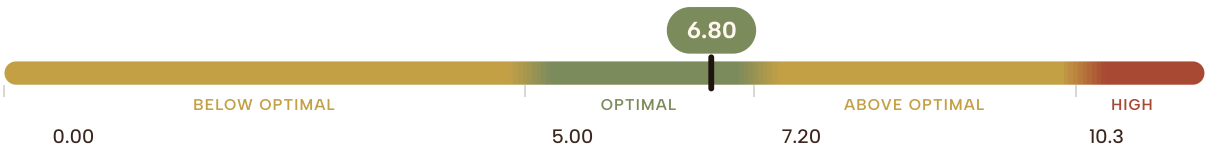
HDL CHOLESTEROL

63 mg/dL

Your HDL result helps anchor a mixed cardiovascular pattern. It is most informative alongside LDL cholesterol, apolipoprotein B, glucose, A1c, ferritin, and hs-CRP.

HOMOCYSTEINE

6.8 umol/L



PLATELET COUNT

232 Thousand/uL

URIC ACID 4.6 mg/dL

What this may mean

This February 10, 2026 pattern is less a direct measure of oxidative damage than a convergence of inflammatory, iron-handling, immune-cell, and circulating-protein signals. Ferritin was 729 ng/mL and hs-CRP was 18.5 mg/L, while serum iron was below optimal, albumin low, globulin high, lymphocytes low, and neutrophils high, a cluster that overlaps with the report's inflammation, cardiovascular, liver, GI, and immune narratives.

What this is not

This is not a oxidative damage, iron overload, infection, liver disease, immune disease, nutritional deficiency, or cardiovascular disease. Ferritin is both an iron-storage marker and an acute-response marker, so its elevation cannot by itself establish why it is high or whether iron stores are excessive.

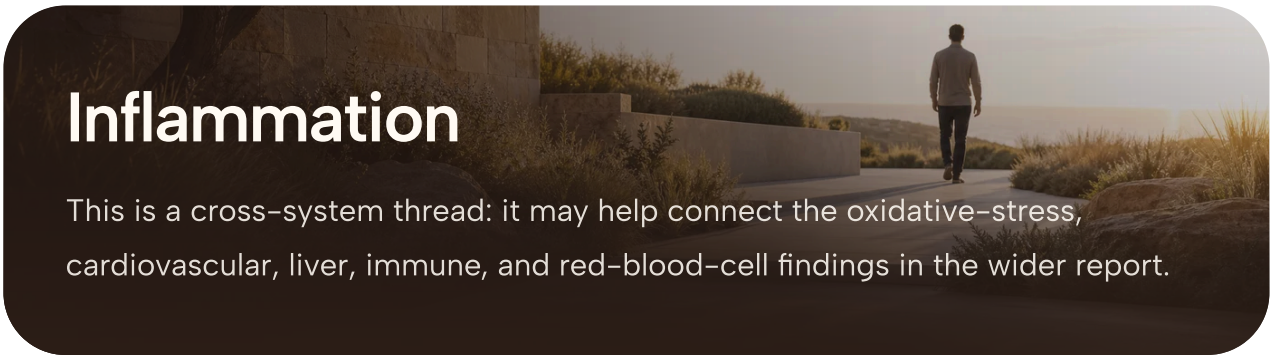
What to do next

Arrange clinician review promptly, ideally within the next 1 to 2 weeks, of the February 10, 2026 ferritin, hs-CRP, serum iron, albumin, globulin, and complete blood count pattern to determine whether further evaluation or repeat testing is appropriate

Until that review, avoid assuming that low serum iron means iron supplementation is appropriate. Record any relevant interval health changes before repeat testing, because they may help interpret whether this is a transient or persistent pattern

Choose one habit to focus on (sleep timing, stress recovery, and daily movement) and follow it consistently for the next 2 weeks.

Set a retest date and track FERRITIN plus one related marker from Oxidative Stress to confirm trend direction.



Inflammation

This is a cross-system thread: it may help connect the oxidative-stress, cardiovascular, liver, immune, and red-blood-cell findings in the wider report.

What is Inflammation?

Inflammation is the immune system's coordinated response to tissue stress, infection, injury, or other biological signals. Inflammatory proteins, iron handling, white blood cell distribution, and circulating proteins can shift together, affecting metabolic and vascular physiology when the pattern is sustained.

RISK SCORE

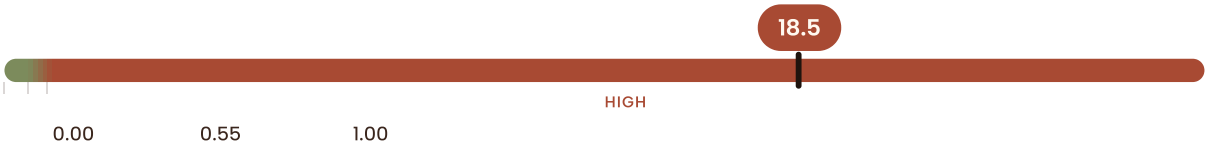
Current label
Discuss with clinician

What your results are showing

FERRITIN — 729 ng/mL

Your ferritin is paired with lower serum iron and high hs-CRP, creating a pattern that needs clinician interpretation. This has high decision value because it connects inflammatory, iron-handling, immune, and cardiovascular sections.

HS CRP — 18.5 mg/L



Your elevated hs-CRP changes the interpretation of ferritin and the cardiometabolic findings. Because no symptoms or recent-context details were reported, repeat and clinician assessment are especially important.

RDW

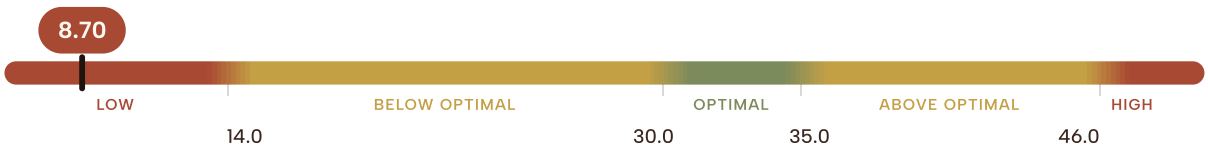
17 %

ALBUMIN

3.5 g/dL

LYMPHOCYTES

8.7 %



IRON, TOTAL

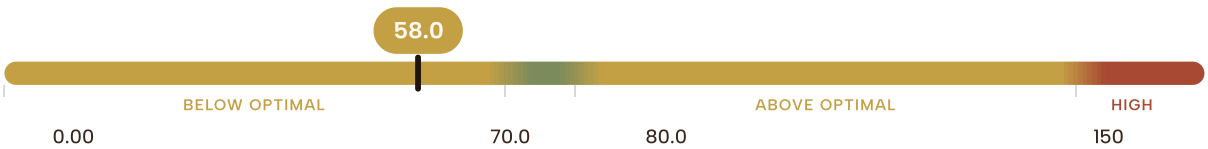
50 mcg/dL

SED RATE BY MODIFIED WESTERGREN

6 mm/h

TRIGLYCERIDES

58 mg/dL

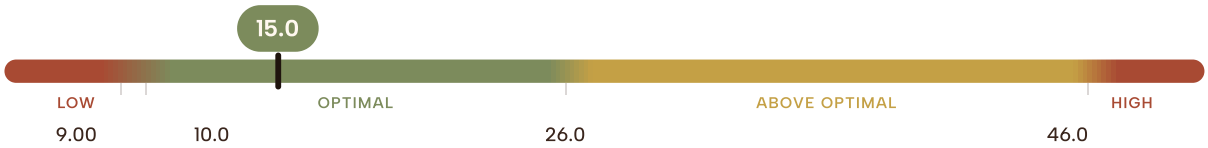


WHITE BLOOD CELL COUNT

6.4 Thousand/uL

ALT

15 U/L

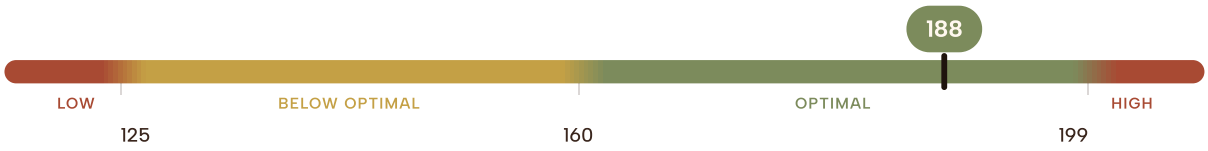


BASOPHILS

0.3 %

CHOLESTEROL, TOTAL

188 mg/dL



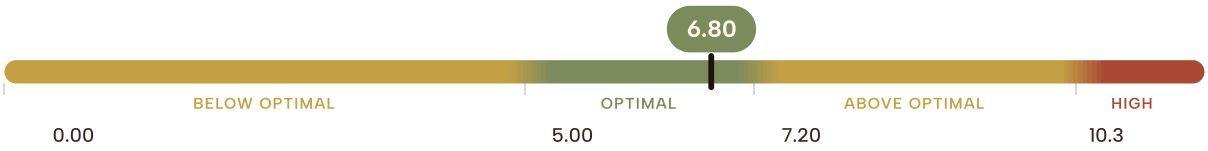
HDL CHOLESTEROL

63 mg/dL

Your HDL result helps anchor a mixed cardiovascular pattern. It is most informative alongside LDL cholesterol, apolipoprotein B, glucose, A1c, ferritin, and hs-CRP.

HOMOCYSTEINE

6.8 umol/L



URIC ACID 4.6 mg/dL

VITAMIN D,25-OH,TOTAL,IA 51 ng/mL

Your vitamin D result is a relative strength amid low calcium and albumin. It narrows the mineral discussion by showing that vitamin D status is not the main flagged signal in this report.

What this may mean

On February 10, 2026, hs-CRP of 18.5 mg/L and ferritin of 729 ng/mL form the central inflammatory signal. The pairing of high ferritin with below-optimal serum iron, plus the reported white-cell, lymphocyte, albumin, and globulin pattern, suggests that iron availability and protein balance should be interpreted in the context of an active inflammatory state rather than as isolated nutrition markers.

What this is not

This pattern does not identify the cause, duration, or location of inflammation, and it does not establish infection, iron overload, cardiovascular disease, or any other diagnosis. A single collection cannot distinguish a temporary response from a persistent process.

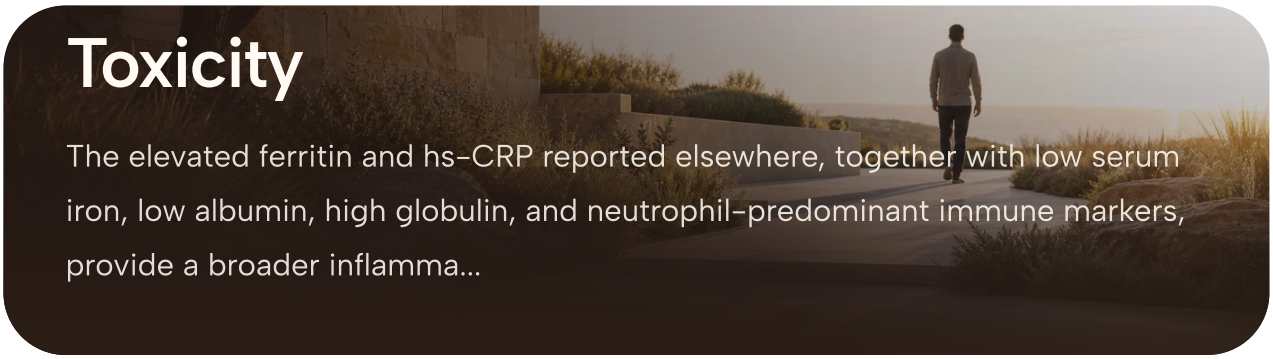
What to do next

Arrange a clinician review within the next few weeks, bringing the February 10 results and noting that no symptom, medication, supplement, or lifestyle context was captured in this record

With clinician guidance, obtain a focused repeat of the inflammatory, iron, blood-count, and protein pattern after the initial review, using the same laboratory conditions when feasible to determine whether hs-CRP and ferritin remain elevated

Choose one habit to focus on (sleep timing, stress recovery, and daily movement) and follow it consistently for the next 2 weeks.

Set a retest date and track HS CRP plus one related marker from Inflammation to confirm trend direction.



Toxicity

The elevated ferritin and hs-CRP reported elsewhere, together with low serum iron, low albumin, high globulin, and neutrophil-predominant immune markers, provide a broader inflamma...

What is Toxicity?

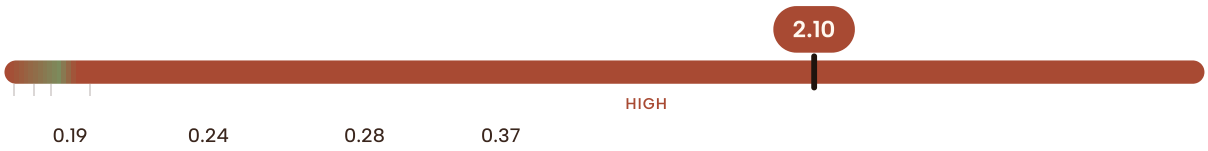
This is a supporting pattern that integrates markers involved in immune-cell distribution, circulating proteins, red blood cell indices, liver processing, kidney filtration, and metabolic byproducts. It is not a direct measurement of toxic exposure or body burden, but a way of asking whether these systems show a pattern that merits context.

RISK SCORE

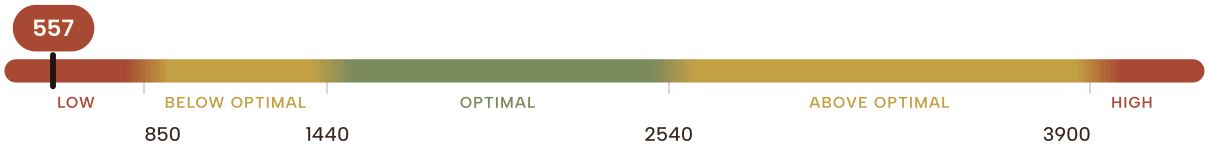
Current label
Discuss with clinician

What your results are showing

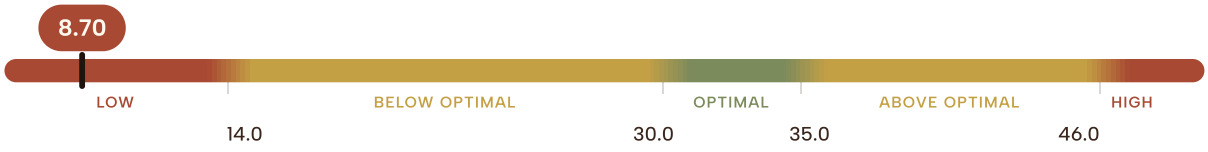
GLOBULIN — 2.1 g/dL (calc)



ABSOLUTE LYMPHOCYTES — 557 cells/uL

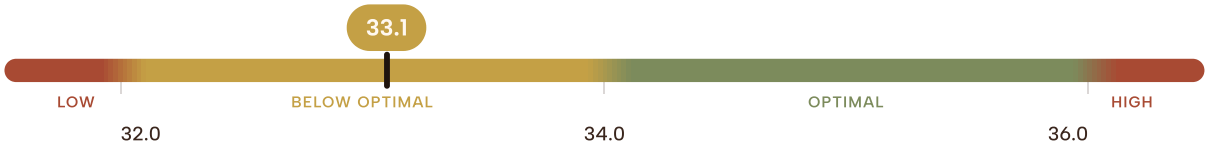


LYMPHOCYTES — 8.7 %



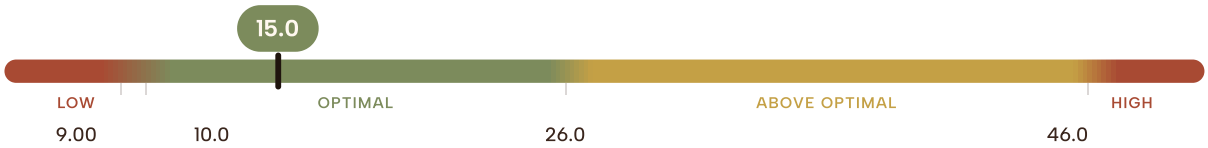
MCHC

33.1 g/dL



ALT

15 U/L



AST

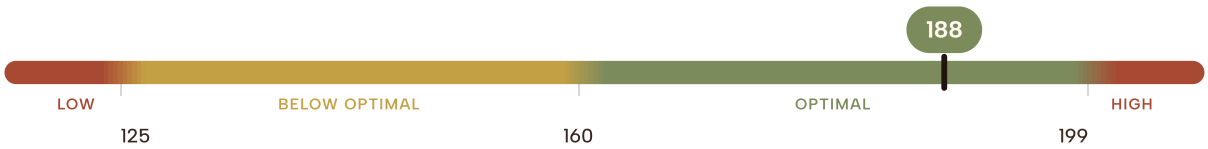
15 U/L

BILIRUBIN, TOTAL

0.6 mg/dL

CHOLESTEROL, TOTAL

188 mg/dL



CREATININE

0.96 mg/dL

GGT

16 U/L

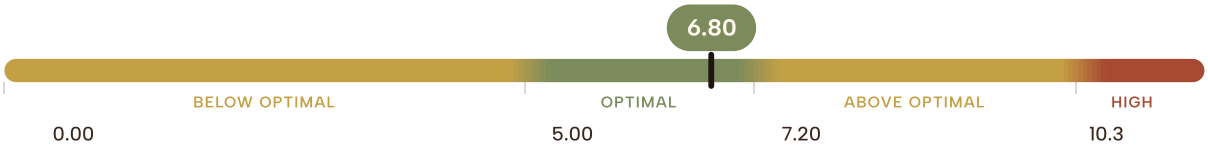
HDL CHOLESTEROL

63 mg/dL

Your HDL result helps anchor a mixed cardiovascular pattern. It is most informative alongside LDL cholesterol, apolipoprotein B, glucose, A1c, ferritin, and hs-CRP.

HOMOCYSTEINE

6.8 umol/L



MCH

28.8 pg

PLATELET COUNT

232 Thousand/uL

URIC ACID

4.6 mg/dL

What this may mean

On February 10, 2026, the low-risk toxicity pattern is shaped chiefly by elevated globulin, low lymphocyte percentage and absolute lymphocyte count, and below-optimal MCHC. It converges with the report's inflammation, oxidative-stress, immune, liver, and red-blood-cell threads, making the more useful question whether there is a shared source of immune activity, altered protein balance, and iron-related red-cell change.

What this is not

This is not proof of toxin exposure, poisoning, impaired detoxification, infection, liver disease, immune disease, or anemia. The label reflects an algorithmic supporting-system category, while the available laboratory pattern is nonspecific and requires clinical correlation.

What to do next

Schedule clinician review within the next 2 to 4 weeks to prioritize the markedly elevated ferritin and hs-CRP alongside the complete blood count, iron-related markers, albumin, globulin, and liver-related results

Avoid starting iron, DHEA, hormone, or other targeted supplementation specifically to correct this pattern before clinician review, because high ferritin with low serum iron needs integrated interpretation

Choose one habit to focus on (sleep timing, stress recovery, and daily movement) and follow it consistently for the next 2 weeks.

Set a retest date and track GLOBULIN plus one related marker from Toxicity to confirm trend direction.

pH Balance

Potassium and chloride are recurring signals across electrolyte, kidney, mineral, and adrenal-related sections, while albumin and calcium also connect this pattern to protein and b...

What is pH Balance?

pH balance reflects the body's tightly regulated acid-base environment, which depends on coordinated kidney, lung, electrolyte, and protein-buffering function. Stable acid-base regulation supports nerve and muscle signaling, circulation, and normal cellular energy production.

RISK SCORE

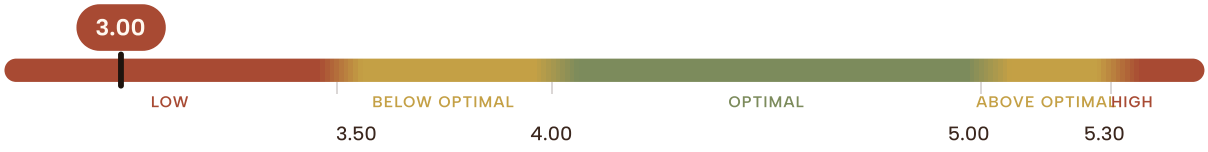
Current label
Monitor

What your results are showing

ALBUMIN — 3.5 g/dL

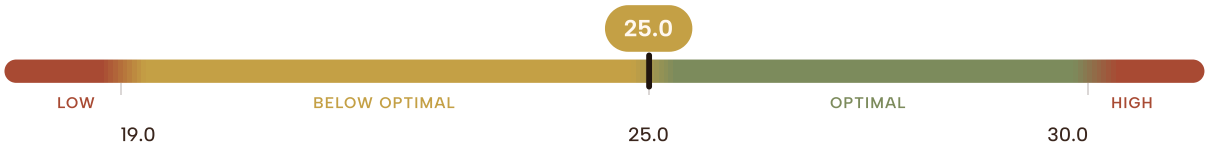
CALCIUM — 8.2 mg/dL

POTASSIUM — 3 mmol/L

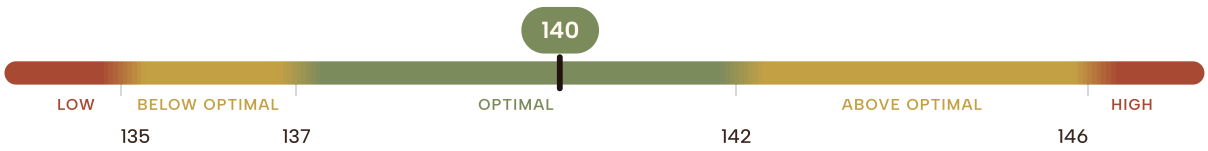


CHLORIDE 107 mmol/L

CARBON DIOXIDE 25 mmol/L



SODIUM 140 mmol/L



What this may mean

On the February 10, 2026 snapshot, low potassium, calcium, and albumin with above-optimal chloride create a mild, low-risk buffering and electrolyte pattern. It overlaps most clearly with the report's mineral, kidney, and adrenal-related follow-up threads, rather than establishing a separate acid-base disorder.

What this is not

This is not a acidosis, alkalosis, , or adrenal disease. It does not establish that a dietary, hydration, hormonal, or organ-level cause is present.

What to do next

Arrange clinician review soon to discuss the low potassium and the full electrolyte pattern from the February 10 collection, including whether repeat testing should occur before routine annual monitoring

Until that review, document any relevant changes in fluid intake, diet, gastrointestinal losses, training, or new medications or supplements if they occur, so repeat results can be interpreted with better context

Choose one habit to focus on (sleep timing, stress recovery, and daily movement) and follow it consistently for the next 2 weeks.

Set a retest date and track POTASSIUM plus one related marker from pH Balance to confirm trend direction.

Allergy

No symptoms, smoking or vaping exposure, heavy training, medication use, supplements, or allergy history were captured in the intake.

What is Allergy?

Allergy-related biomarkers help distinguish patterns more consistent with eosinophil- or basophil-associated immune activity from broader white-cell responses. This distinction matters because different immune-cell patterns can point clinicians toward different sources of inflammation or immune activation.

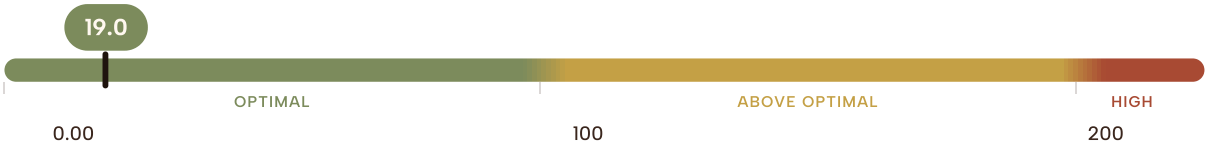
RISK SCORE

19

Current label
Strong

What your results are showing

ABSOLUTE BASOPHILS — 19 cells/uL



BASOPHILS — 0.3 %

EOSINOPHILS — 0 %

What this may mean

Allergy is comparatively steady within the broader report, without an eosinophil-driven pattern. The February 10, 2026 snapshot instead shows neutrophil and total white blood cell elevation with low absolute eosinophils, which fits more closely with the report's separate inflammatory and immune-cell thread than with a specific allergy conclusion.

What this is not

This pattern does not establish an allergy, infection, inflammatory disease, or absence of allergy. Low absolute eosinophils do not rule out allergic conditions, and elevated neutrophils are not allergy-specific.

What to do next

At the next clinician visit, review whether any illness, inflammation-related symptoms, or other relevant events were present near the February 10, 2026 blood draw, since none were captured in the intake

Arrange clinician-guided follow-up of the CBC with differential in conjunction with the broader inflammation review, rather than pursuing allergy-specific changes based on these markers alone

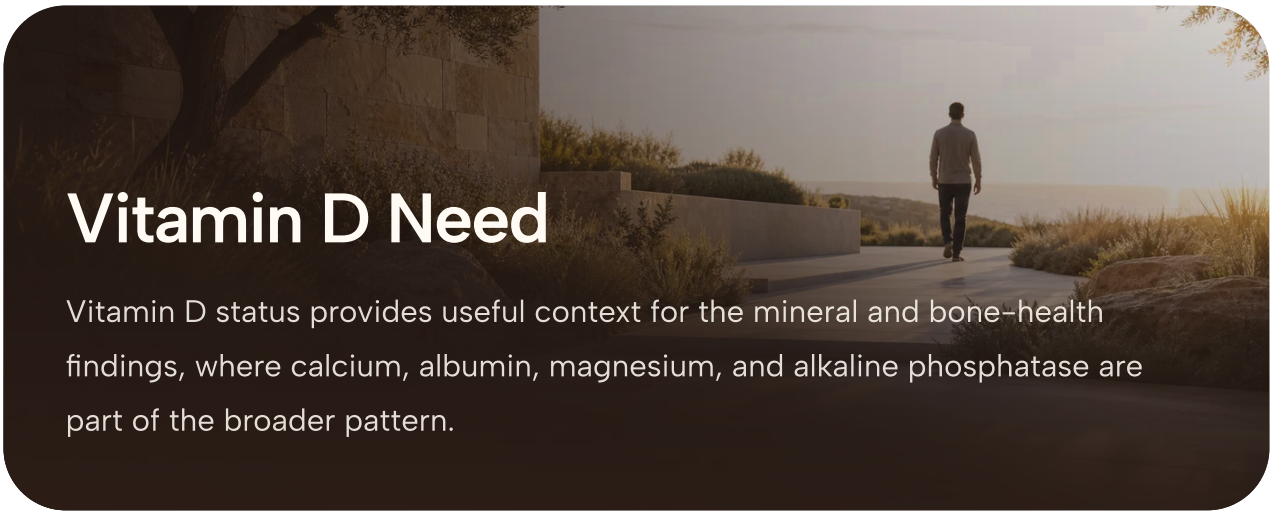
Choose one habit to focus on (sleep timing, stress recovery, and daily movement) and follow it consistently for the next 2 weeks.

Set a retest date and track ABSOLUTE EOSINOPHILS plus one related marker from Allergy to confirm trend direction.

NUTRIENT SYSTEMS · 17 SYSTEMS ASSESSED

Nutrient Health Systems

IN THIS SECTION



Vitamin D Need

Vitamin D status provides useful context for the mineral and bone-health findings, where calcium, albumin, magnesium, and alkaline phosphatase are part of the broader pattern.

What is Vitamin D?

Vitamin D reflects whether available vitamin D appears sufficient for the body's vitamin D dependent functions. Vitamin D supports calcium regulation, bone remodeling, immune signaling, and muscle function, so adequacy helps provide a stable foundation across several systems.

RISK SCORE

0

Current label
Strong

What your results are showing

VITAMIN D,25-OH,TOTAL,IA — 51 ng/mL

Your vitamin D result is a relative strength amid low calcium and albumin. It narrows the mineral discussion by showing that vitamin D status is not the main flagged signal in this report.

What this may mean

This is a steady background signal in the February 10, 2026 snapshot. The assessment indicates that measured 25-OH vitamin D is within its target range and does not show a current Vitamin D signal, allowing attention to remain on the more active hormone, inflammatory, mineral, and cardiometabolic patterns.

What this is not

This is not a measure of bone density, calcium intake, sun exposure, or a guarantee that vitamin D status will remain unchanged. It also does not resolve the separate calcium, albumin, magnesium, or alkaline phosphatase findings.

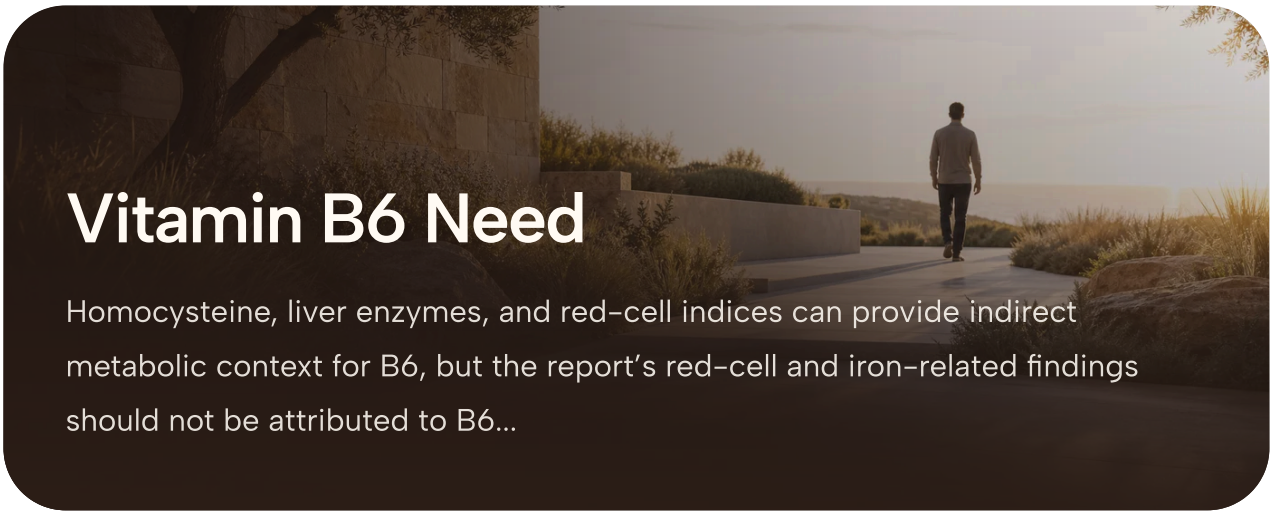
What to do next

At the next clinician review, treat vitamin D as a stable contextual marker while prioritizing the active electrolyte, protein, inflammatory, and hormone findings

Record any future 25-OH vitamin D result alongside calcium, albumin, magnesium, and alkaline phosphatase so direction can be assessed rather than relying on this one snapshot

Choose one habit to focus on (meal quality, protein balance, and hydration consistency) and follow it consistently for the next 2 weeks.

Set a retest date and track this marker plus one related marker from Vitamin D to confirm trend direction.



Vitamin B6 Need

Homocysteine, liver enzymes, and red-cell indices can provide indirect metabolic context for B6, but the report's red-cell and iron-related findings should not be attributed to B6...

What is Vitamin B6?

Vitamin B6 reflects whether the available biomarker pattern suggests increased need for vitamin B6, a cofactor used in amino-acid metabolism, neurotransmitter synthesis, and homocysteine processing. Adequate B6 supports normal metabolic and red blood cell related pathways, although routine blood markers assess this only indirectly.

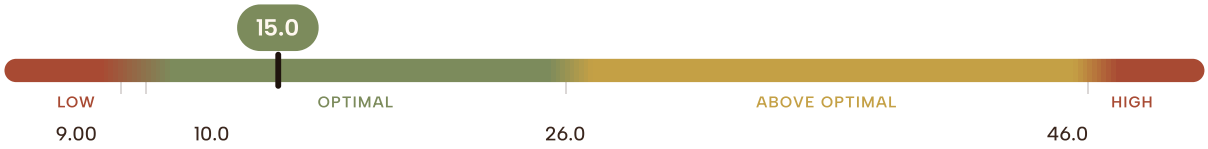
RISK SCORE

0

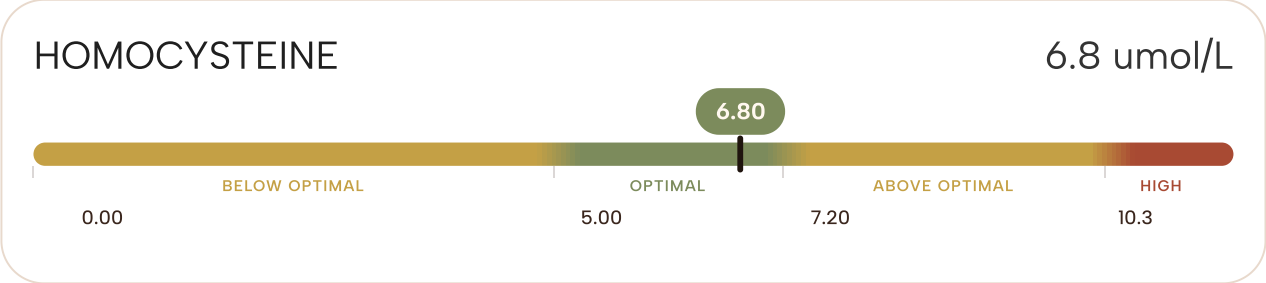
Current label
Strong

What your results are showing

ALT 15 U/L



AST 15 U/L



What this may mean

This February 10, 2026 snapshot does not show a strong signal for increased Vitamin B6. It is therefore a lower-priority nutrient thread relative to the report's more active inflammatory, iron-related, red-cell, thyroid, adrenal, and sex-hormone patterns.

What this is not

This is not a direct vitamin B6 sufficiency or deficiency. It is not evidence that B6 explains the reported red blood cell, liver, immune, or inflammatory findings.

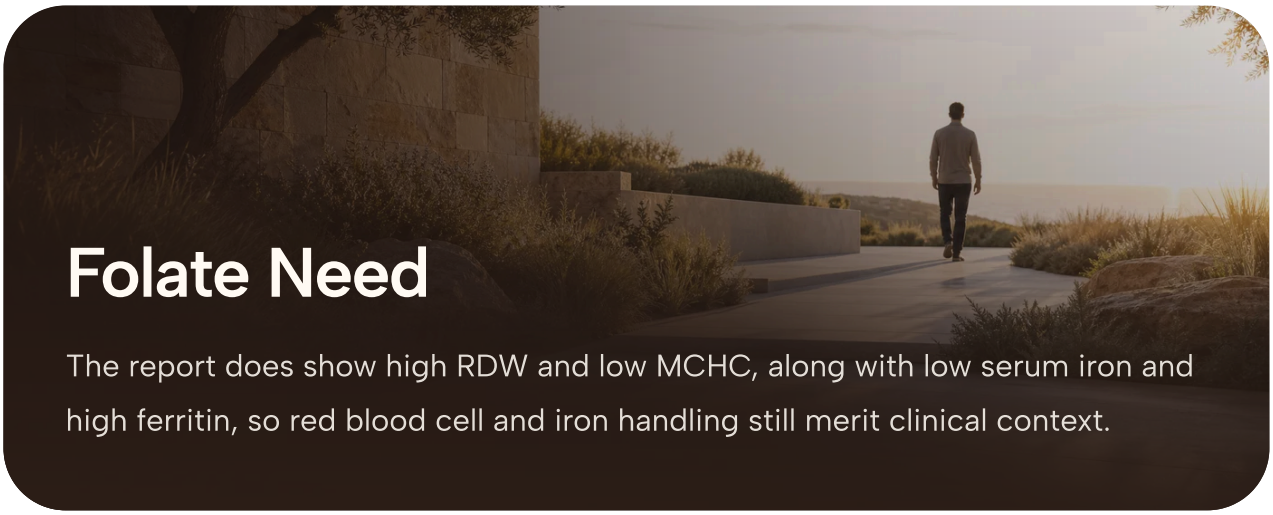
What to do next

At the next clinician visit, keep vitamin B6 as a background consideration rather than using it to explain the current iron, inflammatory, or red-cell findings

If future testing includes homocysteine, review it in parallel with the red-cell indices and liver markers already present in this report to assess whether the pattern remains stable

Choose one habit to focus on (meal quality, protein balance, and hydration consistency) and follow it consistently for the next 2 weeks.

Set a retest date and track this marker plus one related marker from Vitamin B6 to confirm trend direction.



Folate Need

The report does show high RDW and low MCHC, along with low serum iron and high ferritin, so red blood cell and iron handling still merit clinical context.

What is Folate?

Folate is a B vitamin required for one-carbon metabolism, DNA synthesis, cell division, and normal red blood cell development. Adequate folate also supports homocysteine processing. In plain terms, it helps the body build and renew cells efficiently, especially rapidly dividing blood cells.

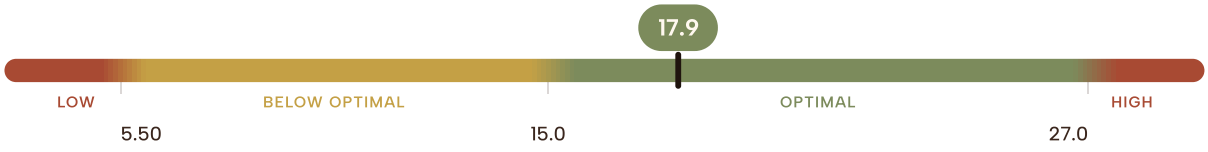
RISK SCORE

0

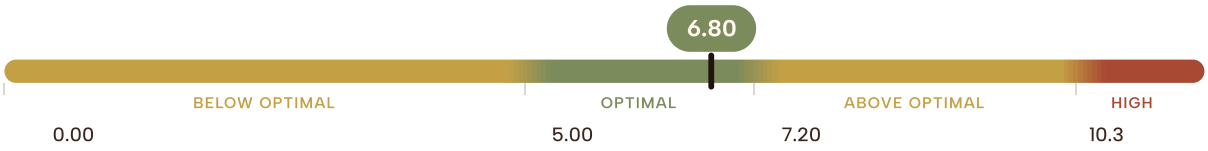
Current label
Strong

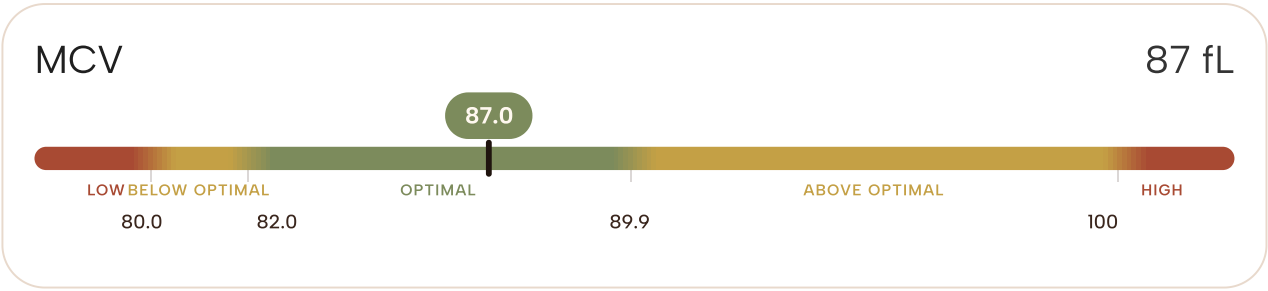
What your results are showing

FOLATE, SERUM 17.9 ng/mL



HOMOCYSTEINE 6.8 umol/L





What this may mean

This is a comparatively steady nutrient signal within a report that otherwise contains active inflammation, iron-availability, endocrine, and electrolyte follow-up threads. The available pattern does not identify folate insufficiency as a leading explanation for the broader red blood cell findings.

What this is not

This is not a direct measurement of dietary folate intake, tissue folate stores, or a folate adequacy. It also does not establish why RDW and MCHC are outside their optimal pattern.

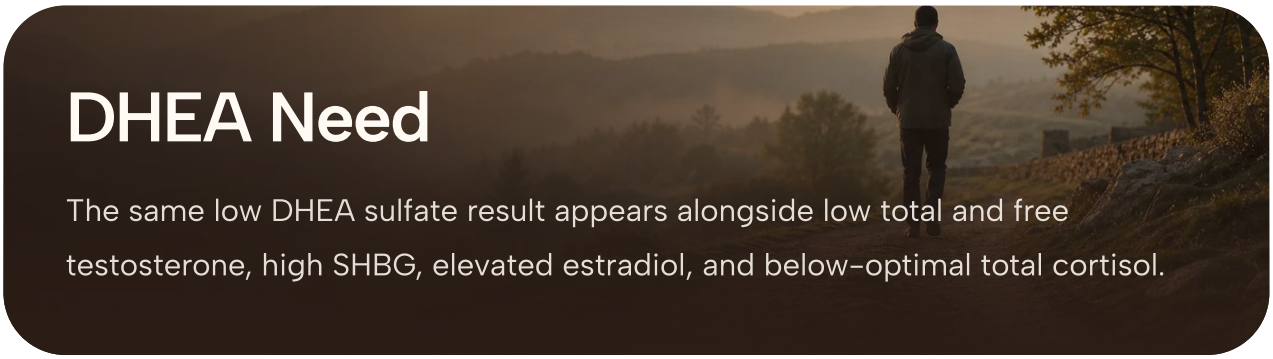
What to do next

At the next clinician review, place the folate pattern in the context of RDW, MCHC, serum iron, ferritin, and inflammation rather than interpreting it alone

At the next blood-count or iron follow-up, review MCV and RDW with any clinician-selected folate testing to determine whether this steady signal remains consistent

Choose one habit to focus on (meal quality, protein balance, and hydration consistency) and follow it consistently for the next 2 weeks.

Set a retest date and track this marker plus one related marker from Folate to confirm trend direction.



DHEA Need

The same low DHEA sulfate result appears alongside low total and free testosterone, high SHBG, elevated estradiol, and below-optimal total cortisol.

What is DHEA?

DHEA sulfate is a circulating storage form of DHEA, an adrenal-produced hormone that contributes precursor material for sex-hormone pathways. It is relatively stable compared with many hormones, so it can provide context on longer-term adrenal androgen output. This matters because adrenal and sex-hormone signaling are interconnected rather than separate systems.

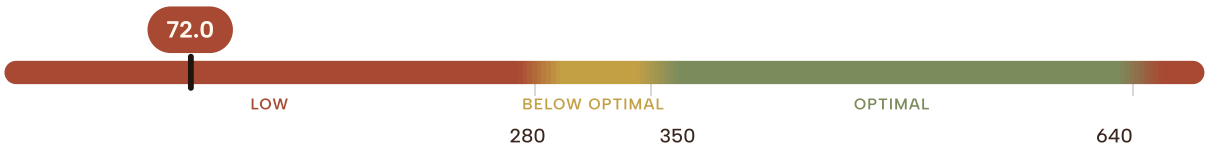
RISK SCORE

100

Current label
Discuss with clinician

What your results are showing

DHEA SULFATE 72 mcg/dL



What this may mean

On the February 10, 2026 collection, low DHEA sulfate is the single driver of this high-priority DHEA signal. It also sits upstream of the broader sex-hormone and adrenal patterns, so it is best interpreted as part of that connected network rather than as an isolated nutrient issue.

What this is not

This is not proof of adrenal disease, a hormone deficiency diagnosis, or a reason to self-treat with DHEA. The label reflects an algorithmic pattern based on one low DHEA sulfate result, not a clinical diagnosis.

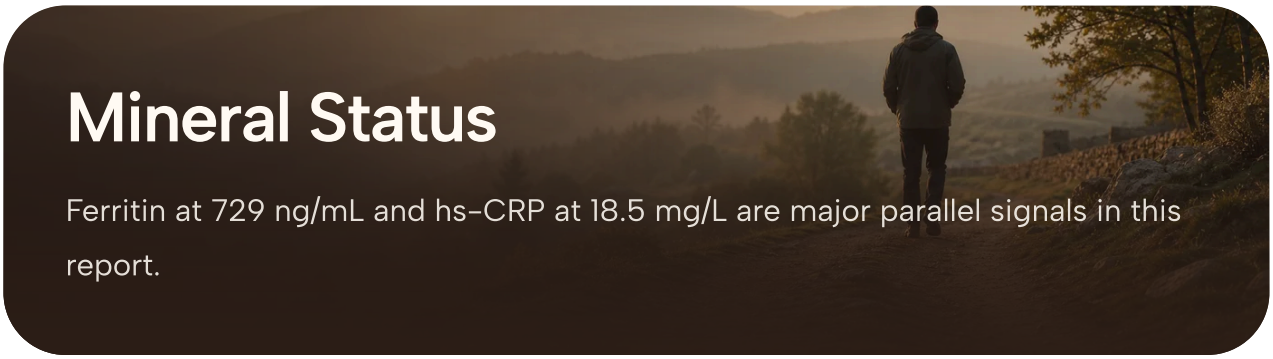
What to do next

Arrange a clinician review in the near term to interpret DHEA sulfate together with the complete sex-hormone, cortisol, and electrolyte results from February 10, 2026

Before that visit, document any relevant symptoms and confirm whether there were unrecorded medications, supplements, major training changes, illness, or other factors around the collection date that could help contextualize the result

Choose one habit to focus on (meal quality, protein balance, and hydration consistency) and follow it consistently for the next 2 weeks.

Set a retest date and track DHEA SULFATE plus one related marker from DHEA to confirm trend direction.



Mineral Status

Ferritin at 729 ng/mL and hs-CRP at 18.5 mg/L are major parallel signals in this report.

What is Mineral Status?

Mineral status reflects the availability and regulation of electrolytes and micronutrients that support cellular energy, nerve and muscle activity, oxygen transport, bone remodeling, and enzyme function. Mineral markers are best interpreted as a network because inflammation, protein balance, fluid regulation, and organ function can all alter their circulation or availability.

RISK SCORE

58

Current label
Optimize

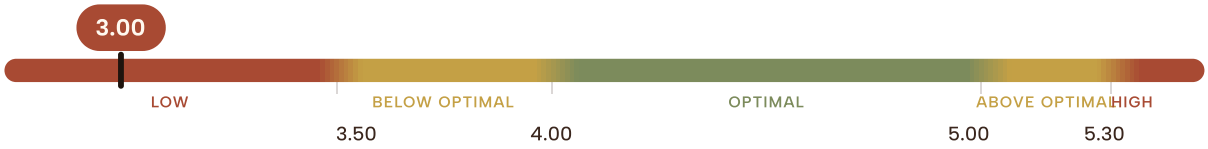
What your results are showing

FERRITIN — 729 ng/mL

Your ferritin is paired with lower serum iron and high hs-CRP, creating a pattern that needs clinician interpretation. This has high decision value because it connects inflammatory, iron-handling, immune, and cardiovascular sections.

CALCIUM — 8.2 mg/dL

POTASSIUM 3 mmol/L



ALKALINE PHOSPHATASE 109 U/L

IRON, TOTAL 50 mcg/dL

MAGNESIUM, RBC 4.9 mg/dL

What this may mean

The mineral pattern links low potassium, calcium, and serum iron with above-optimal alkaline phosphatase and markedly elevated ferritin, while red blood cell magnesium is also included as a driver. Rather than reading this as a simple intake issue, the report-wide pattern suggests that mineral availability should be interpreted alongside inflammation, circulating protein balance, and the liver, gastrointestinal, bone, and red-cell findings.

What this is not

This pattern does not diagnose a mineral deficiency, iron overload, malabsorption condition, bone disorder, or liver disease. It also does not show whether dietary intake, absorption, inflammation, or regulation is the main driver of any individual result.

What to do next

Schedule clinician review within the next few weeks centered on the ferritin, hs-CRP, serum iron, albumin, globulin, potassium, calcium, and alkaline phosphatase pattern, rather than addressing each mineral marker independently

For the next 1 to 2 weeks, compile the missing context most likely to change interpretation, including usual food intake, any supplements, hydration habits, recent illness, exercise load, and any gastrointestinal concerns, then use this information to guide a clinician-selected follow-up plan

Choose one habit to focus on (meal quality, protein balance, and hydration consistency) and follow it consistently for the next 2 weeks.

Set a retest date and track POTASSIUM plus one related marker from Mineral Status to confirm trend direction.

Electrolyte Status

Potassium and chloride are recurring signals across the adrenal and kidney sections, while calcium and red blood cell magnesium connect this pattern to bone and mineral status.

What is Electrolyte Status?

Electrolytes are charged minerals that regulate fluid distribution, nerve transmission, muscle contraction, acid-base balance, and cardiac electrical activity. Potassium, chloride, calcium, and magnesium work as an interacting network, so their balance matters more than any one value alone.

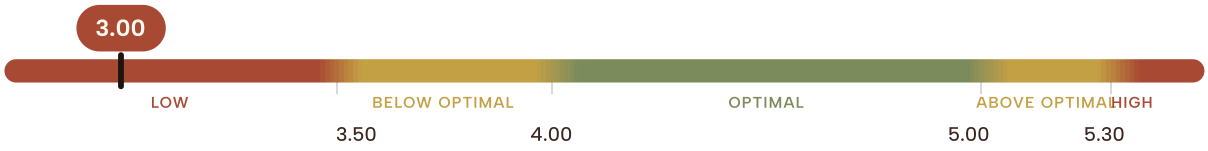
RISK SCORE

Current label
Optimize

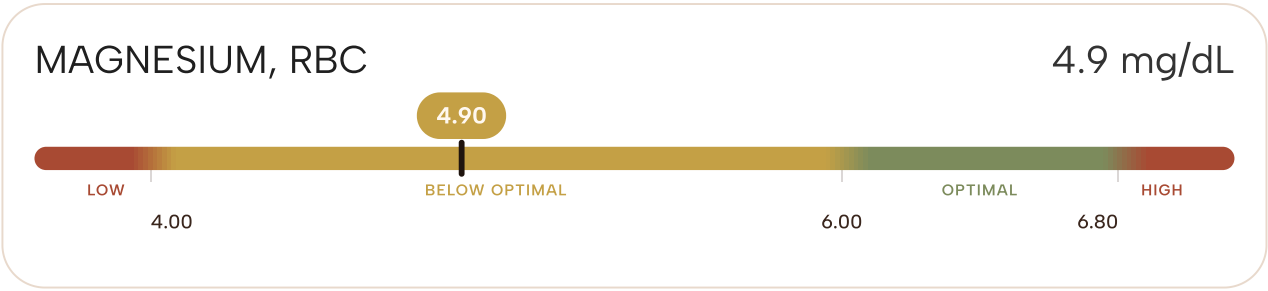
What your results are showing

CALCIUM — 8.2 mg/dL

POTASSIUM — 3 mmol/L



CHLORIDE — 107 mmol/L



What this may mean

The February 10, 2026 snapshot shows low potassium, above-optimal chloride, low calcium, and below-optimal red blood cell magnesium. This is a mild but cross-system mineral-regulation pattern that overlaps with the report's adrenal, kidney, pH-balance, and bone-health threads, rather than establishing a stand-alone electrolyte disorder.

What this is not

This is not proof of dehydration, inadequate dietary intake, adrenal disease, , or an acid-base disorder. It also does not establish that supplementation is appropriate without clinical review of the full electrolyte and kidney context.

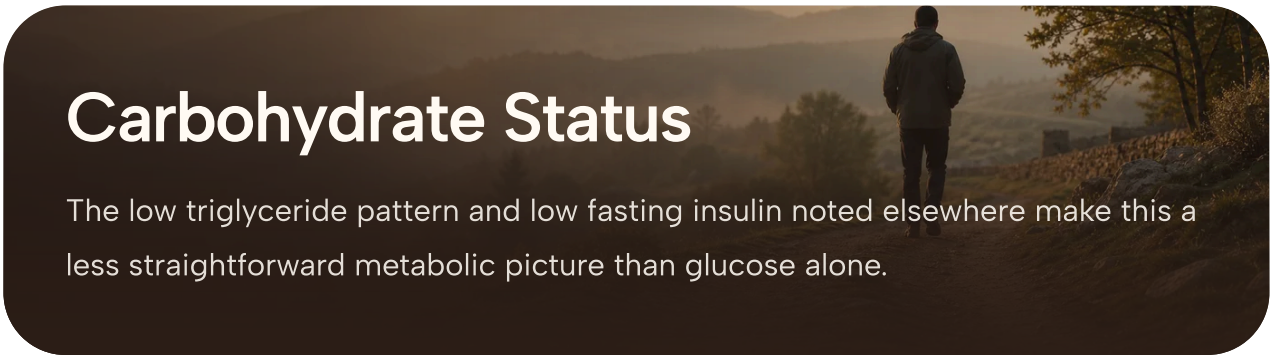
What to do next

Within the next 1 to 2 weeks, arrange clinician review of the low potassium and related electrolyte pattern, with the February 10 results available for context

Until that review, document usual food intake, fluid intake, and any non-prescription products or electrolyte drinks, if applicable, and avoid making targeted potassium or mineral changes without clinician guidance

Choose one habit to focus on (meal quality, protein balance, and hydration consistency) and follow it consistently for the next 2 weeks.

Set a retest date and track POTASSIUM plus one related marker from Electrolyte Status to confirm trend direction.



Carbohydrate Status

The low triglyceride pattern and low fasting insulin noted elsewhere make this a less straightforward metabolic picture than glucose alone.

What is Carbohydrate Status?

Carbohydrate Status reflects how circulating glucose and related lipid markers may be tracking energy handling over both the immediate and longer-term metabolic context. This matters because sustained disruption in glucose regulation can influence vascular, inflammatory, and recovery pathways.

RISK SCORE

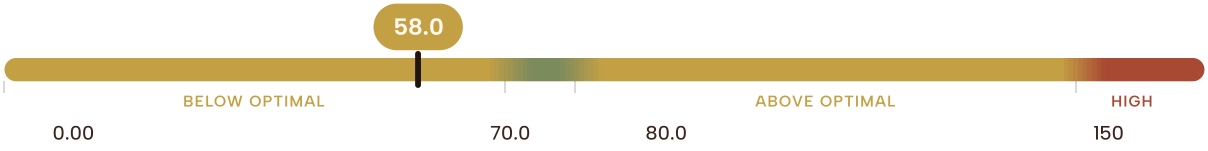
Current label
Monitor

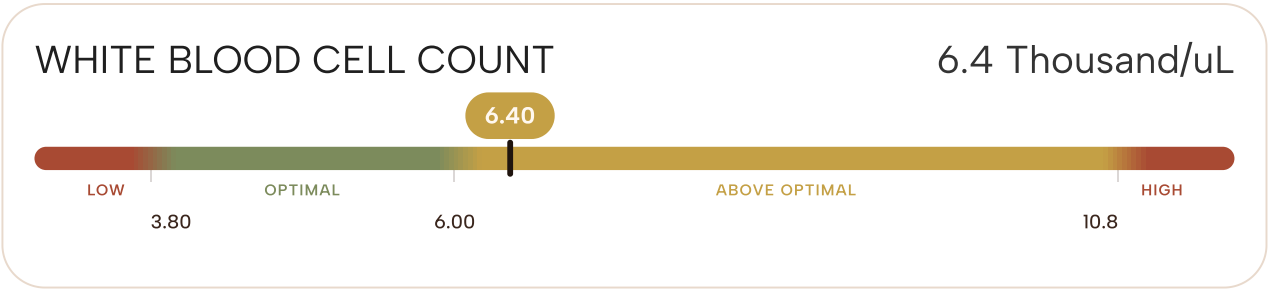
What your results are showing

GLUCOSE — 116 mg/dL

LDL-CHOLESTEROL — 111 mg/dL (calc)

TRIGLYCERIDES — 58 mg/dL





What this may mean

On February 10, 2026, the carbohydrate-specific system score was in the monitor range, but glucose was elevated at 116 and the wider report documents hemoglobin A1c of 5.8. In the broader map, this places carbohydrate handling alongside the cardiovascular and inflammation threads, rather than treating it as an isolated nutrition signal.

What this is not

This is not a , insulin resistance, or a specific dietary cause. One collection cannot establish persistence, and the available intake, activity, sleep, and symptom context is limited.

What to do next

Arrange a clinician review of the February 10 glucose and A1c results, together with hs-CRP, ferritin, lipids, thyroid findings, and the available fasting insulin result, within the next few weeks

For the next 2 to 4 weeks, record whether future glucose testing is performed fasting and note any relevant recent illness, unusual activity, meals, sleep disruption, or alcohol exposure to improve repeat-test interpretation

Choose one habit to focus on (meal quality, protein balance, and hydration consistency) and follow it consistently for the next 2 weeks.

Set a retest date and track GLUCOSE plus one related marker from Carbohydrate Status to confirm trend direction.

PART VI

Your plan for what to do next

These chapters turn your results into a concrete plan: the specific next steps to focus on, and which markers to retest and when.

Quick overview

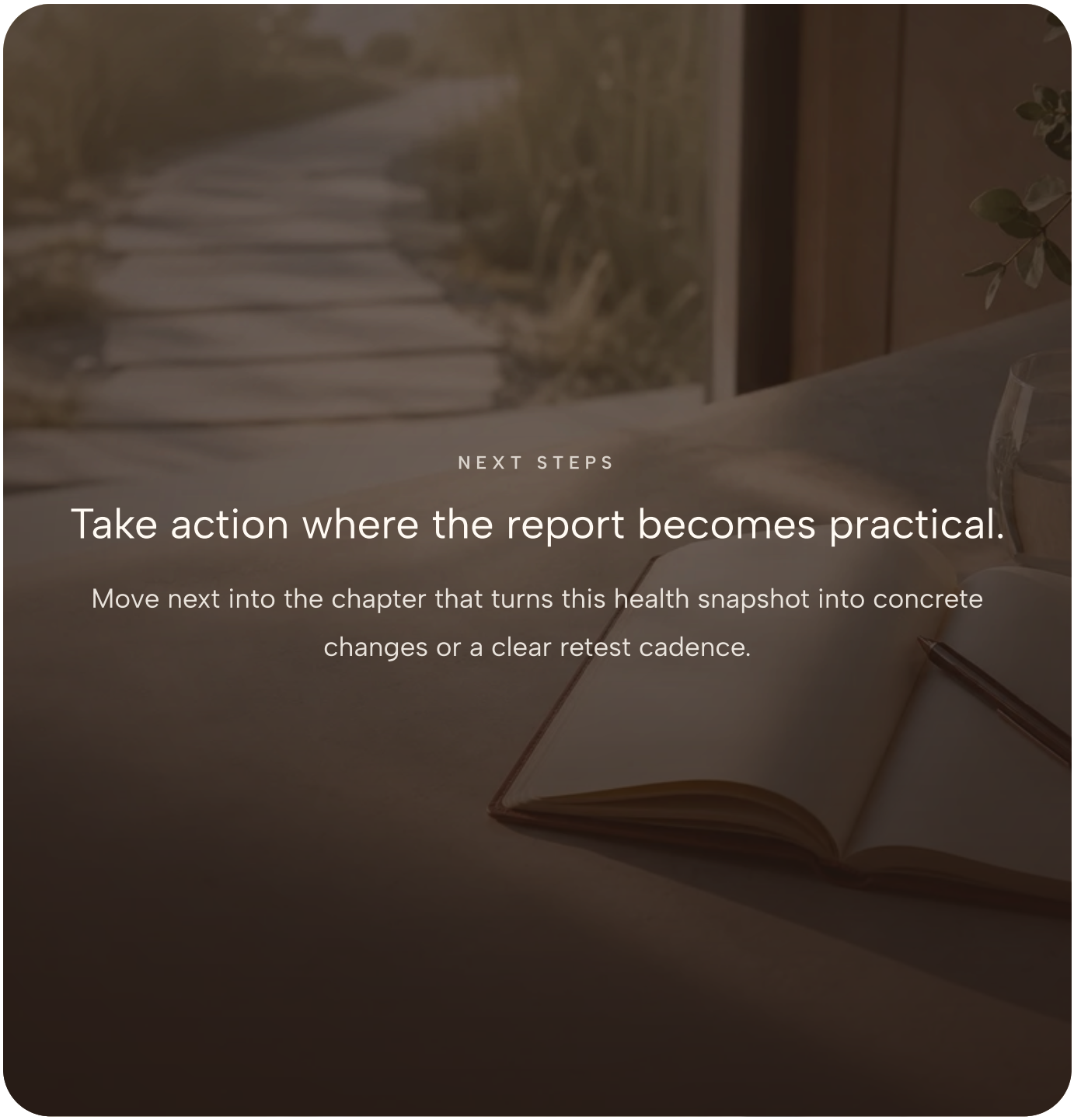
Use this quick overview to jump into the planning chapter you want to review first.

Your Action Plan

A focused chapter built from the canonical action plan, not a lightweight summary.

Your Retest Plan

A timing-focused chapter built from the canonical testing plan.



NEXT STEPS

Take action where the report becomes practical.

Move next into the chapter that turns this health snapshot into concrete changes or a clear retest cadence.

ACTION PLAN

Your action plan

Your complete action plan, organized by supplement support, nutrition, training, and recovery.

SUPPLEMENT SUPPORT

Vitamin D3 repletion (with clinician oversight)

Discuss a repletion protocol with your clinician (common evidence-based approaches include cholecalciferol [vitamin D3] 2,000–5,000 IU daily with food for 8–12 weeks; some protocols use higher short-term dosing when levels are extremely low, which should be clinician-guided). Pair with: magnesium glycinate 100–200 mg nightly if tolerated, and ensure adequate dietary calcium (do not add high-dose calcium supplements unless specifically advised). Recheck 25-OH vitamin D after 8–12 weeks and adjust to a maintenance dose commonly 1,000–2,000 IU/day. Safety: avoid high-dose vitamin D without monitoring if granulomatous disease, hypercalcemia, advanced , or are pregnant; review with clinician if you take thiazide diuretics or have kidney stones history.

WHY THIS IS RECOMMENDED

Your Vitamin D, 25-OH, Total is very low (Vitamin D, 25-Oh, Total (62292-8): 4 ng/mL). Optimizing vitamin D supports immune regulation, musculoskeletal function, and is commonly targeted when inflammation markers are elevated (hs-CRP, ESR).

HOW TO DO IT

- Take vitamin D with your largest meal (fat-containing) to improve absorption.
- If GI sensitivity, split the dose (morning + evening) and use an oil-based softgel.

SUPPLEMENT SUPPORT

Vitamin B12 repletion (prefer methylcobalamin or hydroxocobalamin)

Discuss starting oral/sublingual vitamin B12 1,000–2,000 mcg daily for 8–12 weeks, then reassess (or use a clinician-directed injection protocol if absorption is a concern). If you also have low folate or high homocysteine once measured, consider a balanced methylation approach (B12 + folate) with clinician guidance. Safety: B12 is generally safe; if Leber hereditary optic neuropathy, avoid B12 unless specifically directed. If acne/rosacea flares, reduce dose or switch form (hydroxo-).

WHY THIS IS RECOMMENDED

Vitamin B12 is low (Vitamin B12 (2132-9): 77 pg/mL). Even when other CBC indices are not clearly provided/consistent, B12 repletion is a high-yield, low-risk optimization step to support hematologic and neurologic function and can influence homocysteine once measured.

HOW TO DO IT

- Take B12 earlier in the day if it feels stimulating.
- If you follow a mostly plant-forward diet, a long-term low-dose maintenance (e.g., 250–500 mcg/day) is often needed after repletion.

SUPPLEMENT SUPPORT

Omega-3 (EPA+DHA) to support inflammatory balance (if not already using)

If you do not regularly eat fatty fish, consider a purified fish oil or algae-based omega-3 providing a combined 1–2 g/day EPA+DHA with meals for 8–12 weeks. If you are on anticoagulants/antiplatelets or have easy bruising, use the lower end and review with your clinician. Choose third-party tested products (IFOS/NSF).

WHY THIS IS RECOMMENDED

Inflammation markers appear high (Hs Crp (30522-7): 70 mg/L; Sed Rate By Modified Westergren (4537-7): 92 mm/h). Omega-3s can lower inflammatory markers in some populations and support cardiometabolic risk reduction even with a favorable ApoB.

HOW TO DO IT

- If reflux occurs, freeze capsules or switch to enteric-coated, or use liquid with food.
- Aim for at least 2 servings/week of fatty fish as a food-first alternative.

SUPPLEMENT SUPPORT

Magnesium glycinate (sleep + vitamin D support) — only if kidney function is confirmed normal

If your clinician confirms normal kidney function (eGFR available/normal), consider magnesium glycinate 100–300 mg elemental magnesium in the evening for 4–8 weeks. If stools loosen, reduce dose or switch to glycinate/taurate. Separate by 4 hours from thyroid medication or certain antibiotics. If significant , avoid magnesium supplements unless prescribed.

WHY THIS IS RECOMMENDED

Vitamin D repletion is planned (Vitamin D, 25-Oh, Total (62292-8): 4 ng/mL) and magnesium supports vitamin D metabolism and sleep quality; this may be helpful as part of an inflammation-reduction and recovery plan (Hs Crp (30522-7), Sed Rate By Modified Westergren (4537-7)).

HOW TO DO IT

- Start low (100 mg) for 3–4 nights, then titrate up as tolerated.
- If nighttime leg cramps, magnesium is often a practical first option to trial.

NUTRITION AND FOOD SHIFTS

Anti-inflammatory, nutrient-dense pattern (Mediterranean-style) with protein adequacy

Include: 6–10 servings/day of colorful plants (leafy greens, crucifers, berries), 25–35 g fiber/day, extra-virgin olive oil as primary fat, legumes 4–7x/week, nuts/seeds daily, and fish 2–3x/week (salmon, sardines, mackerel). Include adequate protein at each meal (aim ~25–40 g/meal from fish, poultry, eggs, tofu/tempeh, lentils, Greek yogurt/cottage cheese if tolerated). Avoid/limit: ultra-processed foods, sugar-sweetened beverages, frequent fried foods, processed meats, and refined grains. Replace: swap white bread/pasta → whole grains (oats, quinoa, brown rice) or legumes; swap desserts/snacks → fruit + nuts/Greek yogurt. If cultural food preferences, this pattern can be adapted by using your traditional staples while shifting cooking fats to olive oil, increasing vegetables, and prioritizing beans/lentils/fish.

WHY THIS IS RECOMMENDED

Very elevated inflammation markers (Hs Crp (30522-7), Sed Rate By Modified Westergren (4537-7)) often improve with a Mediterranean-style dietary pattern; this also supports cardiometabolic risk reduction even when ApoB/LDL are low (Apolipoprotein B (1884-6), Ldl-Cholesterol (13457-7)).

HOW TO DO IT

- Build plates: 1/2 non-starchy vegetables, 1/4 protein, 1/4 high-fiber starch or legumes + olive oil.
- Add one “bean-based meal” 3 days/week (lentil soup, chickpea curry, black bean bowl).

NUTRITION AND FOOD SHIFTS

Correct low B12 + support methylation with food (and confirm folate/iron status)

Include: animal-based B12 sources if you eat them (eggs, dairy, fish, lean meats) or fortified foods if plant-based (fortified plant milks, nutritional yeast with B12). Ensure protein with each meal. Avoid/limit: relying solely on unfortified plant foods for B12 if you are mostly plant-based. Replace: if breakfast is carbs-only, replace with: eggs + vegetables; Greek yogurt + berries + chia; tofu scramble + veggies. If reflux or gastritis symptoms or use acid-suppressing medications, review with clinician as these can reduce B12 absorption.

WHY THIS IS RECOMMENDED

Low Vitamin B12 (Vitamin B12 (2132-9): 77 pg/mL) benefits from both targeted supplementation and dietary support; additional labs (folate, iron studies, CBC indices) help clarify the full picture (Folate, Serum (2284-8), Iron, Total (2498-4), % Saturation (2502-3), Hemoglobin (718-7), MCV (787-2)).

HOW TO DO IT

- If vegetarian/vegan, plan a lifelong B12 strategy (fortified foods plus maintenance supplement).
- Pair iron-rich plant foods (lentils, spinach) with vitamin C foods (citrus, bell pepper) to improve non-heme iron absorption.

NUTRITION AND FOOD SHIFTS

Kidney/urinary support: hydration + oxalate-smart choices (food-first)

Include: water spaced through the day targeting pale-yellow urine; add citrus (lemon/lime) in water or foods; include calcium from foods with higher-oxalate meals (e.g., yogurt, kefir, calcium-set tofu) to bind oxalate in the gut. Avoid/limit: excessive high-oxalate foods if a stone history or crystals persist (spinach, beet greens, large amounts of almonds, rhubarb); avoid high-dose vitamin C supplements unless clinician-directed. Replace: spinach salads → mixed greens/arugula/romaine; almond flour snacks → oat/coconut-based alternatives; large black tea intake → herbal teas. If urinary symptoms, flank pain, or recurrent infections, review with clinician; crystals can be influenced by hydration, diet, and urinary factors.

WHY THIS IS RECOMMENDED

Calcium Oxalate Crystals (25148-8): 27 /[HPF] and Granular Cast (5793-5): 20 /[LPF] suggest a need to support urinary/kidney health habits while confirming kidney function labs (eGFR, creatinine units/validity).

HOW TO DO IT

- Aim for a consistent intake: large “catch-up” water at night can disrupt sleep and isn’t as effective as steady hydration.
- Have calcium-containing foods with the same meal as higher-oxalate foods (food pairing matters more than total daily calcium).

TRAINING AND MOVEMENT

Low-to-moderate aerobic base (inflammation-aware progression)

Frequency: 4–6 days/week. Duration: start 15–25 minutes/session and build to 30–45 minutes/session over 6–8 weeks. Intensity: mostly Zone 2 / "can talk in full sentences" (RPE 4–6/10). If you feel unusually fatigued or symptomatic, keep intensity easy and prioritize consistency. Progression: increase total weekly time by ~10% per week; add intensity only after 3–4 stable weeks. Options: brisk walking, cycling, elliptical, swimming, or low-impact dance.

WHY THIS IS RECOMMENDED

Regular moderate exercise is associated with lower systemic inflammation and improved immune regulation; it also supports insulin sensitivity (even though key glucose markers are missing) and cardiovascular risk reduction alongside favorable ApoB (Apolipoprotein B (1884-6)).

HOW TO DO IT

- Use a 'minimum dose' rule on busy days: 10 minutes easy movement still counts.
- If you're sore for >48 hours after sessions, reduce intensity/duration and progress more gradually.

TRAINING AND MOVEMENT

Strength training 2–3x/week (preserve lean mass + glucose control support)

Frequency: 2–3 non-consecutive days/week. Duration: 30–45 minutes. Intensity: start light-to-moderate (RPE 5–7/10) focusing on form. Plan: 6–8 movements covering squat/hinge/push/pull/carry/core. Example: sit-to-stand or goblet squat, hip hinge (Romanian deadlift with light weight), row, incline push-up, overhead press (light), farmer carry, dead bug or plank. Progression: when you can complete 2–3 sets of 8–12 reps comfortably, increase load by the smallest amount or add 1 set.

WHY THIS IS RECOMMENDED

Resistance training improves insulin sensitivity and supports musculoskeletal health, which is especially important while correcting low vitamin D (Vitamin D, 25-Oh, Total (62292-8): 4 ng/mL). It can also support overall inflammatory regulation when paired with adequate recovery (Hs Crp (30522-7), Sed Rate By Modified Westergren (4537-7)).

HOW TO DO IT

- If you're new to strength training, start with 1–2 sets for the first 2 weeks to avoid excessive soreness.
- Pair sessions with a protein-containing meal within 2 hours to support recovery.

SLEEP AND RECOVERY

Sleep schedule anchors + inflammation-friendly wind-down

Set two anchors for 14 days: (1) a consistent wake time within a 60-minute window daily; (2) 10–20 minutes of outdoor light within 1 hour of waking. Night routine: stop caffeine 8 hours before bed; dim bright overhead lights 2 hours before bed; do a 10-minute wind-down (choose 1: warm shower, light stretching, or 4-7-8 breathing). If you wake at night: keep lights low, avoid phone scrolling, and use a brief relaxation track. If you snore loudly, wake unrefreshed, or have witnessed breathing pauses, consider discussing a sleep evaluation with your clinician (optimization and safety).

WHY THIS IS RECOMMENDED

High inflammation markers (Hs Crp (30522-7), Sed Rate By Modified Westergren (4537-7)) can be influenced by sleep quantity/quality; better sleep also supports glucose regulation (pending missing glucose/insulin/A1c values) and recovery from exercise.

HOW TO DO IT

- Use a 'digital sunset': set phone to grayscale + app limits 1 hour before bed.
- If bedtime is inconsistent, start by moving bedtime 15 minutes earlier every 3–4 nights until stable.

RETEST PLAN

Your retest plan

This chapter shows what should be repeated, when, and why, using the actual testing-plan data rather than a synthetic timeline.

Immediate (Within 2 weeks) IMMEDIATE

Confirm low white-cell subtype pattern and establish a reliable baseline

CBC (includes Differential and Platelets) JUL 3, 2026 – JUL 17, 2026

Because your recent lymphocytes were 557 cells/uL and eosinophils were 0 cells/uL, a near-term confirmation helps separate a temporary fluctuation from a sustained pattern that needs follow-up. Discuss this result with a clinician promptly.

Watching Absolute Lymphocytes, Absolute Eosinophils, Absolute Monocytes, Neutrophils, RDW

October 2026 RETEST

Inflammation, metabolic risk, iron regulation, thyroid, and electrolytes

CBC (includes Differential and Platelets) OCT 3, 2026 - NOV 2, 2026

Following RDW and immune cell counts over time helps confirm your body has fully stabilized rather than simply having a short-term normal reading. Discuss this result with a clinician promptly if low eosinophils persist.

Watching RDW, Absolute Lymphocytes, Absolute Eosinophils, Neutrophils, Monocytes

Hemoglobin A1c with eAG OCT 3, 2026 - NOV 2, 2026

After an A1c of 5.8%, a 3-month recheck shows whether your average blood sugar is improving with your current plan.

Watching Hemoglobin A1c, eAG (mg/dL)

Ferritin OCT 3, 2026 - NOV 2, 2026

Ferritin came back at 729 ng/mL and was outside the standard lab reference range, so confirming the trend is important before waiting for the annual re-baseline.

Watching FERRITIN

hs-CRP OCT 3, 2026 - NOV 2, 2026

After a recent hs-CRP of 18.5 mg/L, confirming the trend helps determine whether inflammation is settling or remains a key priority.

Watching hs-CRP, HS CRP

Thyroid Panel with TSH OCT 3, 2026 - NOV 2, 2026

Because total T4 (3.3 mcg/dL) and free T4 index (1.2) were low, confirming the trend helps guide next-step thyroid support and whether further evaluation is needed.

Watching T4 (Thyroxine), Total, Free T4 Index (T7), TSH

Urinalysis, Complete

OCT 3, 2026 - NOV 2, 2026

Because blood sugar and blood proteins were off target, a urine check adds helpful context about urine glucose/protein and kidney handling.

Watching Leukocyte Esterase, Nitrite

January 2027

RETEST

Metabolic risk deepening + inflammation context + thyroid fine-tuning

Sed Rate by Modified Westergren

JAN 3, 2027 - FEB 2, 2027

Since inflammation has been a major theme, trending sedimentation rate helps corroborate progress even when day-to-day factors affect hs-CRP.

Watching Sed Rate by Modified Westergren

TSH

JAN 3, 2027 - FEB 2, 2027

Tsh came back at 4.32 mIU/L and was outside the target optimal range. Trending it helps connect the lab pattern to changes in symptoms, habits, and the action plan over time.

Watching TSH

July 2027

RETEST

Annual comprehensive reassessment and next-year goal setting

Max Full Body

JUL 3, 2027 - AUG 2, 2027

This gives you one complete yearly checkpoint instead of piecing together many separate tests. It helps show what improved, what stayed stable, and what may need attention in the next plan cycle.

APPENDIX

Full lab appendix

Every biomarker included in this report, sorted by priority for PDF review.

STATIC PDF APPENDIX — Showing 126 biomarkers

HOW TO READ THIS TABLE

STATUS

- Strong — In your optimal range
- Monitor — Just outside optimal — worth watching
- Optimize — Outside optimal — room to improve
- Priority — Needs attention
- Discuss with clinician — Review with your provider

PRIORITY

- Clinical
- High
- Medium
- Low
- None

CALCULATED VALUES

Ratios and indices (e.g. AST:ALT, Chol/HDL, HOMA-IR) are derived from your measured biomarkers and listed here alongside them. Values shown as "— unit" were reported below the lab's detection limit.

BIOMARKER	CATEGORY	RESULT	STATUS	PRIORITY
T3 UPTAKE	THYROID HEALTH	35 %	Strong	—
UREA NITROGEN (BUN)	KIDNEY HEALTH	12 mg/dL	Strong	—
CREATININE	KIDNEY HEALTH	0.96 mg/dL	Strong	—
EGFR	KIDNEY HEALTH	102 mL/min/1.73m2	Strong	—
SODIUM	KIDNEY HEALTH	140 mmol/L	Strong	—
CARBON DIOXIDE	KIDNEY HEALTH	25 mmol/L	Strong	—
ALBUMIN/GLOBULIN RATIO	LIVER & GALLBLADDER	1.667 ratio	Strong	—
BILIRUBIN, TOTAL	LIVER HEALTH	0.6 mg/dL	Strong	—
AST	LIVER HEALTH	15 U/L	Strong	—
ALT	LIVER HEALTH	15 U/L	Strong	—
VITAMIN D,25-OH,TOTAL,IA	NUTRIENTS, VITAMINS & MINERALS	51 ng/mL	Strong	—
URIC ACID	ENERGY & METABOLISM	4.6 mg/dL	Strong	—
RED BLOOD CELL COUNT	BLOOD HEALTH	4.93 Million/uL	Strong	—
HEMOGLOBIN	BLOOD HEALTH	14.2 g/dL	Strong	—
HEMATOCRIT	BLOOD HEALTH	42.9 %	Strong	—
MCV	BLOOD HEALTH	87 fL	Strong	—
MCH	BLOOD HEALTH	28.8 pg	Strong	—
PLATELET COUNT	BLOOD HEALTH	232 Thousand/uL	Strong	—
ABSOLUTE BASOPHILS	BLOOD HEALTH	19 cells/uL	Strong	—
EOSINOPHILS	BLOOD HEALTH	0 %	Strong	—
BASOPHILS	BLOOD HEALTH	0.3 %	Strong	—
CHOLESTEROL, VERY LOW DENSITY LIPOPROTEIN	HEART HEALTH	12 mg/dL	Strong	—
CHOLESTEROL, TOTAL	HEART HEALTH	188 mg/dL	Strong	—

BIOMARKER	CATEGORY	RESULT	STATUS	PRIORITY
HDL CHOLESTEROL	HEART HEALTH	63 mg/dL	Strong	—
HOMOCYSTEINE	INFLAMMATION & IMMUNITY	6.8 umol/L	Strong	—
APOLIPOPROTEIN A1	HEART HEALTH	157 mg/dL	Strong	—
GGT	LIVER HEALTH	16 U/L	Strong	—
LIPASE	LIVER HEALTH	17 U/L	Strong	—
IGF 1, LC/MS	HORMONAL HEALTH	206 ng/mL	Strong	—
FOLATE, SERUM	NUTRIENTS, VITAMINS & MINERALS	17.9 ng/mL	Strong	—
AST:ALT RATIO	LIVER & GALLBLADDER	1 ratio	Strong	—
DE RITIS RATIO	LIVER & GALLBLADDER	1 ratio	Strong	—
BILIRUBIN-TO-ALBUMIN RATIO (BAR)	LIVER & GALLBLADDER	0.171 ratio	Strong	—
BUN/CREATININE RATIO	KIDNEY	12.5 mg/mg	Strong	—
ANION GAP	KIDNEY	11 mmol/L	Strong	—
NEUTROPHIL-TO-LYMPHOCYTE & PLATELET RATIO (NLPR)	IMMUNE SYSTEM	20.713 ratio	Strong	—
CHOLESTEROL VLDL	LIPIDS	11.6 mg/dL	Strong	—
ATHEROGENIC INDEX (AIP)	LIPIDS	-0.036 ratio	Strong	—
LDL:HDL RATIO	LIPIDS	1.762 ratio	Strong	—
LDL-C/APOB RATIO	LIPIDS	1.233 ratio	Strong	—
NON-HDL/TOTAL CHOLESTEROL RATIO	LIPIDS	0.665 ratio	Strong	—
TOTAL CHOLESTEROL/HDL RATIO	LIPIDS	2.984 ratio	Strong	—
TRIGLYCERIDE:HDL RATIO	LIPIDS	0.921 ratio	Strong	—

BIOMARKER	CATEGORY	RESULT	STATUS	PRIORITY
A1C–GLUCOSE DISCORDANCE	METABOLIC	0.387 %	Strong	—
HOMA2-IR	METABOLIC	0.544 ratio	Strong	—
QUICKI	METABOLIC	0.427 ratio	Strong	—
IRON, TOTAL	NUTRIENTS, VITAMINS & MINERALS	50 mcg/dL	Optimize	Medium
% SATURATION	MINERALS	22.936 %	Optimize	Medium
TSH	THYROID HEALTH	4.32 mIU/L	Optimize	Medium
CHLORIDE	KIDNEY HEALTH	107 mmol/L	Optimize	Medium
GLOBULIN	LIVER & GALLBLADDER	2.1 g/L	Optimize	Medium
ALKALINE PHOSPHATASE	LIVER HEALTH	109 U/L	Optimize	Medium
EAG (MG/DL)	ENERGY & METABOLISM	120 mg/dL	Optimize	Medium
SED RATE BY MODIFIED WESTERGREN	INFLAMMATION & IMMUNITY	6 mm/h	Optimize	Medium
WHITE BLOOD CELL COUNT	BLOOD HEALTH	6.4 Thousand/uL	Optimize	Medium
MCHC	BLOOD HEALTH	33.1 g/dL	Optimize	Medium
MPV	BLOOD HEALTH	9.3 fL	Optimize	Medium
ABSOLUTE NEUTROPHILS	BLOOD HEALTH	4973 cells/uL	Optimize	Medium
ABSOLUTE MONOCYTES	BLOOD HEALTH	851 cells/uL	Optimize	Medium
TRIGLYCERIDES	HEART HEALTH	58 mg/dL	Optimize	Medium
CHOL/HDL-C RATIO	LIPIDS	2.984 ratio	Optimize	Medium
NON-HDL CHOLESTEROL	LIPIDS	125 mg/dL	Optimize	Medium
LIPOPROTEIN (A)	HEART HEALTH	22 nmol/L	Optimize	Medium
APOLIPOPROTEIN B	HEART HEALTH	90 mg/dL	Optimize	Medium
MAGNESIUM, RBC	NUTRIENTS, VITAMINS & MINERALS	4.9 mg/dL	Optimize	Medium

BIOMARKER	CATEGORY	RESULT	STATUS	PRIORITY
CORTISOL, TOTAL	HORMONAL HEALTH	9.8 mcg/dL	Optimize	Medium
INSULIN	ENERGY & METABOLISM	1.9 uIU/mL	Optimize	Medium
CALCIUM:ALBUMIN RATIO	MINERALS	2.343 ratio	Optimize	Medium
GGT/HDL RATIO	LIVER & GALLBLADDER	0.254 ratio	Optimize	Medium
FERRITIN/CRP RATIO	IMMUNE SYSTEM	39.405 ratio	Optimize	Medium
TYG INDEX	METABOLIC	8.121 ratio	Optimize	Medium
FREE T4 INDEX (T7)	HORMONES	1.155	Monitor	Low
EAG (MMOL/L)	ENERGY & METABOLISM	6.6 mmol/L	Monitor	Low
SPECIFIC GRAVITY	URINE	1.015	Monitor	Low
PH	URINE	6	Monitor	Low
LDL CHOLESTEROL	LIPIDS	113.4 mg/dL	Monitor	Low
Z SCORE (FEMALE)	HORMONAL HEALTH	0.8 SD	Monitor	Low
OCCULT BLOOD	URINE	—	Monitor	Low
LEUKOCYTE ESTERASE	URINE	—	Monitor	Low
WBC	URINE	— /HPF	Monitor	Low
RBC	URINE	— /HPF	Monitor	Low
SQUAMOUS EPITHELIAL CELLS	URINE	— /HPF	Monitor	Low
VITAMIN B12	NUTRIENTS, VITAMINS & MINERALS	— pg/mL	Monitor	Low
PSA, TOTAL	CANCER SCREENING	— ng/mL	Monitor	Low
FERRITIN-TO-ALBUMIN RATIO (FAR)	MINERALS	208.286 ratio	Monitor	Low
SODIUM:POTASSIUM RATIO	KIDNEY	46.667 ratio	Monitor	Low
CRP/ALBUMIN RATIO (CAR)	IMMUNE SYSTEM	5.286 ratio	Monitor	Low

BIOMARKER	CATEGORY	RESULT	STATUS	PRIORITY
LYMPHOCYTE-TO-MONOCYTE RATIO (LMR)	IMMUNE SYSTEM	0.655 ratio	Monitor	Low
MONOCYTE-TO-LYMPHOCYTE RATIO (MLR)	IMMUNE SYSTEM	1.528 ratio	Monitor	Low
NLR (NEUTROPHIL:LYMPHOCYTE)	IMMUNE SYSTEM	8.928 ratio	Monitor	Low
PLR (PLATELET:LYMPHOCYTE)	IMMUNE SYSTEM	416.517 ratio	Monitor	Low
SYSTEMIC IMMUNE-INFLAMMATION INDEX (SII)	IMMUNE SYSTEM	2071.339 ratio	Monitor	Low
SYSTEMIC INFLAMMATION RESPONSE INDEX (SIRI)	IMMUNE SYSTEM	7.598 ratio	Monitor	Low
% TESTOSTERONE BIOAVAILABLE	HORMONES	15.83 %	Monitor	Low
% TESTOSTERONE FREE	HORMONES	0.6 %	Monitor	Low
CORTISOL:DHEA-S RATIO	HORMONES	0.136 ratio	Monitor	Low
TESTOSTERONE BIOAVAILABLE	HORMONES	3.166 ng/dL	Monitor	Low
TESTOSTERONE/APOB RATIO	HORMONES	0.222 ratio	Monitor	Low
TESTOSTERONE/CRP RATIO	HORMONES	1.081 ratio	Monitor	Low
TESTOSTERONE/ESTRADIOL (T:E2)	HORMONES	0.385 ratio	Monitor	Low
HOMA2-%B	METABOLIC	12.906 %	Monitor	Low
HOMA2-%S	METABOLIC	183.757 %	Monitor	Low
IRON BINDING CAPACITY	NUTRIENTS, VITAMINS & MINERALS	218 mcg/dL	Priority	High
T4 (THYROXINE), TOTAL	THYROID HEALTH	3.3 mcg/dL	Priority	High
POTASSIUM	KIDNEY HEALTH	3 mmol/L	Priority	High
CALCIUM	KIDNEY HEALTH	8.2 mg/dL	Priority	High
PROTEIN, TOTAL	KIDNEY HEALTH	5.6 g/dL	Priority	High

BIOMARKER	CATEGORY	RESULT	STATUS	PRIORITY
ALBUMIN	LIVER HEALTH	3.5 g/dL	Priority	High
HEMOGLOBIN A1C	ENERGY & METABOLISM	5.8 %	Priority	High
ABSOLUTE LYMPHOCYTES	BLOOD HEALTH	557 cells/uL	Priority	High
ABSOLUTE EOSINOPHILS	BLOOD HEALTH	0 cells/uL	Priority	High
NEUTROPHILS	BLOOD HEALTH	77.7 %	Priority	High
LYMPHOCYTES	BLOOD HEALTH	8.7 %	Priority	High
MONOCYTES	BLOOD HEALTH	13.3 %	Priority	High
LD	LIVER HEALTH	108 U/L	Priority	High
AMYLASE	LIVER HEALTH	29 U/L	Priority	High
PROGESTERONE	HORMONAL HEALTH	1.4 ng/mL	Priority	High
ESTRADIOL	HORMONAL HEALTH	52 pg/mL	Priority	High
SEX HORMONE BINDING GLOBULIN	HORMONAL HEALTH	103 nmol/L	Priority	High
TESTOSTERONE, TOTAL, MS	HORMONAL HEALTH	20 ng/dL	Priority	High
TESTOSTERONE, FREE	HORMONAL HEALTH	1.2 pg/mL	Priority	High
FERRITIN	NUTRIENTS, VITAMINS & MINERALS	729 ng/mL	Discuss with clinician	Clinical
HS CRP	INFLAMMATION & IMMUNITY	18.5 mg/L	Discuss with clinician	Clinical
GLUCOSE	KIDNEY HEALTH	116 mg/dL	Discuss with clinician	Clinical
RDW	BLOOD HEALTH	17 %	Discuss with clinician	Clinical
DHEA SULFATE	HORMONAL HEALTH	72 mcg/dL	Discuss with clinician	Clinical