

Your Precision Peak Performance Report

Comprehensive Men's Health Analysis & Personalized Optimization Strategy

SAMPLE v4 · FOR ILLUSTRATION ONLY

PATIENT: John Doe | DATE OF BIRTH: June 14, 1982 | AGE: 43 | REPORT DATE: April 22, 2026 | CLINICIAN: Cody Lanteigne, MN, NP-PHC

Peak Performance Health Overview

Your clinical snapshot and roadmap at a glance

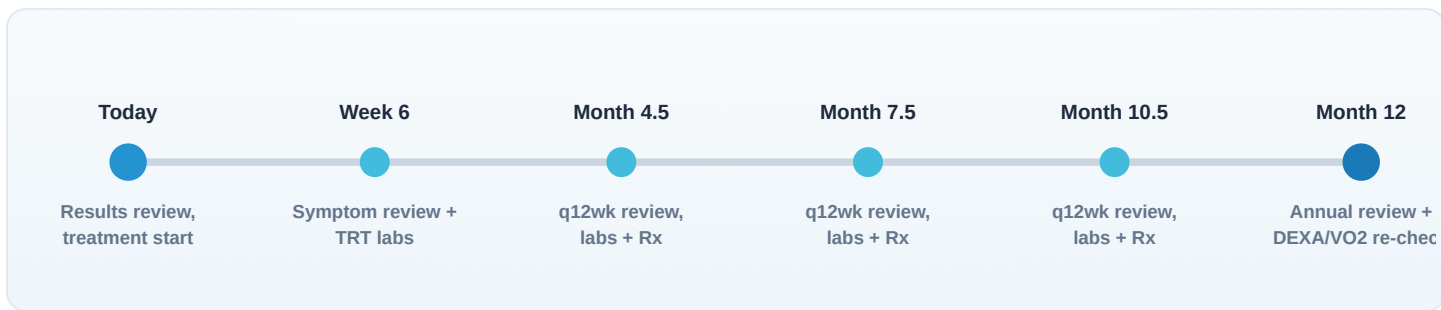
Clinical Snapshot

TOTAL TESTOSTERONE 10.4 nmol/L	FREE TESTOSTERONE 180 pmol/L	ESTRADIOL (E2) 33 pmol/L	PSA 2.2 µg/L	HEMATOCRIT 0.41 L/L
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Where You Stand

Your total testosterone (10.4 nmol/L) and free testosterone (180 pmol/L) both sit at the lower end of range, while LH and FSH are mid-normal and testicular exam is unremarkable. Paired with the symptoms you described (reduced energy, mental fog, slower recovery, weaker erections), the picture fits symptomatic hypogonadism with preserved pituitary signalling. PSA, hematocrit, DRE, and sleep-apnea screen all clear the usual gates for starting testosterone. Treatment centres on weekly testosterone cypionate, with F45 training, JM Nutrition, psychotherapy, and nicotine cessation layered alongside.

Treatment & Monitoring Timeline

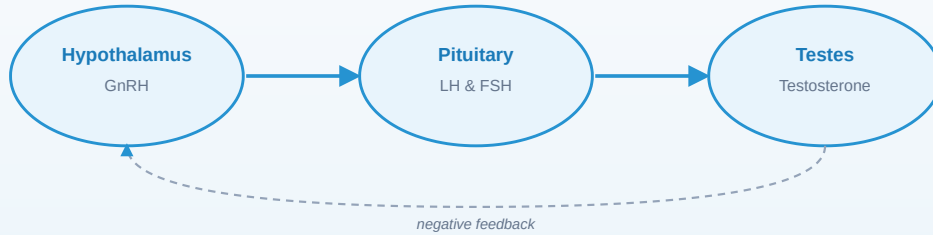


Hormone Deep-Dive

Your endocrine picture, explained in context

TEST	TREATMENT TARGET	CURRENT STATUS	CLINICAL INTERPRETATION
Total Testosterone nmol/L	18.0 - 28.0 (peak performance)	10.4 Low-Normal	Sits just above the Canadian lower reference limit but well below the peak-performance target. Population ranges include men not functioning optimally; the symptom picture is what tips this into treatable territory.
Free Testosterone pmol/L	200 - 600 (peak performance)	180 Low	Free T is the bioavailable fraction reaching tissues. Below range confirms the low-end total T reflects true androgen deficiency at the tissue level, not just a binding-protein quirk.
SHBG nmol/L	20 - 45 (optimal)	28 Normal	Mid-range SHBG means binding dynamics are unremarkable, so free T tracks total T in the expected way.
Estradiol (E2) pmol/L	60 - 150	33 Low-Normal	Low-end estradiol is internally consistent with your low-end testosterone (E2 is made from T). Expect this to rise as testosterone is restored; monitored at week 12.
LH IU/L	1.7 - 8.6	6.2 Normal	Healthy mid-range. Pituitary signal is intact, which rules out an obvious central cause.
FSH IU/L	1.5 - 12.4	5.8 Normal	Well within range. Combined with normal LH and a normal testicular exam, the signalling pathway and the gonads are anatomically intact.

The Hypothalamic-Pituitary-Gonadal (HPG) Axis



The hypothalamus signals the pituitary, which signals the testes to produce testosterone. Your signalling pathway is intact. The issue is functional: the system is running at a set-point that leaves tissue-level androgen activity below what you need to feel well. Exogenous testosterone restores that environment directly.

Screening Audits

Validated questionnaires to track mood, sexual, and urologic health

△ Elevated scores to track: ADAM positive, IIEF-5 in the 12-16 band, PHQ-9 at 12, GAD-7 at 8. STOP-BANG 1 is low risk. These scores are tracking tools, not standalone diagnoses; clinical judgement guides any formal diagnosis.

PHQ-9

12

PURPOSE

Depression symptom screener.

INTERPRETATION

Elevated score. Low energy, mental fog, and irritability often overlap with low testosterone and chronic stress, so the score is a tracking marker rather than a standalone diagnosis.

FOLLOW-UP

Repeat at six weeks. Psychotherapy referral in place.

GAD-7

8

PURPOSE

Generalized anxiety screener.

INTERPRETATION

Elevated score. Fits the chronic-stress picture tied to recent partner-track workload.

FOLLOW-UP

Re-assess at six weeks. CBT or counselling referral if no movement.

IIEF-5

14

PURPOSE

Erectile function screener.

INTERPRETATION

Below 22 range, consistent with the low-end testosterone picture you described.

FOLLOW-UP

Reassess at six weeks on TRT. PDE5 inhibitor available if hormonal restoration alone is insufficient.

ADAM

Positive

PURPOSE

Androgen Deficiency in Aging Males screen.

INTERPRETATION

Positive on Q1 (libido). Adds to the symptom picture alongside the lab values.

FOLLOW-UP

Re-screen at month 6. Expect resolution once testosterone is optimized.

STOP-BANG

1

PURPOSE

Sleep apnea risk screener.

INTERPRETATION

Low risk. Reassuring because untreated severe OSA is a relative contraindication to TRT.

FOLLOW-UP

No further workup. Re-screen annually or if sleep complaints emerge.

IPSS

9

PURPOSE

Urinary symptom screener.

INTERPRETATION

You denied storage, voiding, and post-micturition symptoms on review, and DRE was normal. The number sets a tracking baseline.

FOLLOW-UP

Track q12wk. Rise of >5 points or new symptoms triggers urology review.

Body Composition & Fitness

DEXA and VO2 max baselines for tracking year-one change

BODY FAT

22.5

% (DEXA)

LEAN MASS

56.2

kg total

VISCERAL FAT

112

cm² (upper end)

VO2 MAX

37

mL/kg/min (fair)

MEASURE	RESULT	INTERPRETATION
Body Fat %	22.5%	Upper end of the "average" band for age 43. Peak-performance target is 15-18%.
Lean Mass Index	18.8 kg/m ²	Healthy for age and frame. The lean-mass foundation is solid to build on with resistance training.
Bone Density (T-score)	+0.3 lumbar / +0.1 femoral neck	Normal. Provides a reference point for future monitoring.
VO2 Max	37 mL/kg/min	Average for age. Moving into the "good" band (>42) is one of the highest-yield longevity targets given that cardiorespiratory fitness is a strong predictor of all-cause mortality.

👍 Training Plan

F45 Training: 20% discount issued; referral complete. Target is resistance training 2-3x per week plus zone-2 cardio to build the aerobic base. **JM Nutrition:** referral sent; focus on protein adequacy (~1.6 g/kg/day) and consistent eating patterns. Re-measure DEXA and VO2 max at month 12 to quantify gains.

🔴 Cardiovascular & Metabolic Risk Reduction

The foundation of sustained performance and longevity

BLOOD PRESSURE

135/80

mmHg

BMI

24

kg/m²

RESTING HR

85

bpm

NECK CIRC.

42

cm

🔴 Lipid & Metabolic Panel

TEST	RESULT	REFERENCE	NOTES
LDL-C	3.2 mmol/L 🚨 Borderline	< 2.6 optimal	Above optimal for long-horizon cardiovascular risk. Diet and activity are first-line.
HDL-C	1.15 mmol/L 🚨 Low-Normal	> 1.30 optimal	Low-end HDL responds well to zone-2 cardio and consistent training.
Triglycerides	1.5 mmol/L ✅ Normal	< 1.7	Within range.
Non-HDL-C	3.8 mmol/L 🚨 Borderline	< 3.4 optimal	Tracks total atherogenic particle load; mirrors the LDL finding.
ApoB	1.02 g/L 🚨 Borderline	< 0.90 optimal	Most direct marker of atherogenic particles. Aligns with the lipid picture.
hs-CRP	1.8 mg/L	< 1.0 low risk	Average cardiovascular inflammation. Lifestyle levers (nicotine, stress, activity) move this most.
Fasting Glucose	5.2 mmol/L ✅ Normal	< 5.6	Within range.
HbA1c	5.4% ✅ Normal	< 5.7	Within range.
Fasting Insulin	8 mU/L	< 10 favourable	No current insulin resistance signal.
eGFR / Creatinine	98 / 86 µmol/L	eGFR > 90	Normal renal function.
ALT / AST	28 / 24 U/L	< 40	Liver enzymes within range, good baseline ahead of TRT.
Ferritin / B12 / Vit D	195 µg/L / 420 pmol/L / 68 nmol/L	Within range	Vitamin D at low end; supplementation reasonable.
TSH / Prolactin	1.8 mIU/L / 9 µg/L ✅ Normal	Within range	No thyroid or pituitary driver of symptoms.
STI Panel	All negative	—	HIV, HBV, HCV, syphilis, chlamydia, gonorrhea.

💡 Translation

Your cardiometabolic starting point is mostly favourable: BMI 24, glucose and A1c within range, renal and liver function normal, and no infectious findings. The signals to act on are the atherogenic lipid panel (LDL, non-HDL, ApoB all borderline) and the modifiable behavioural risks: **nicotine vaping** and **chronic stress (7/10 baseline, peaks 9/10)**. These levers move cardiovascular risk far more than any single lab value at this stage. Alcohol intake is low and not a driver.



Treatment & Monitoring Protocols

Your prescribed plan and ongoing support

Active Prescriptions

1 Testosterone Cypionate (Depo-Testosterone)

Dose & Route: 100 mg intramuscular once weekly. Self-administered, lateral thigh or ventrogluteal site.

Status: Off-label for symptom-based improvement in energy, cognition, libido, erectile function, and body composition. Consent signed, off-label status reviewed.

Rationale: Weekly cypionate gives stable serum levels without the peaks and troughs of bi-weekly dosing. 100 mg is conservative, aimed at moving total T toward 18-25 nmol/L without pushing E2 or hematocrit aggressively.

Expected benefits: First changes at 2-4 weeks (sleep, morning energy). Libido, erections, and cognitive clarity by weeks 6-12. Body composition shifts across months 3-6 with consistent training. Full effect by month 6.

2 Lifestyle Support

Psychotherapy: Recommended alongside TRT given the chronic-stress picture and recent partner-track workload. Skill-building on stress management pays off more than waiting for T to do the job alone.

Nicotine cessation: Single highest-yield cardiovascular intervention. Cessation pathways (NRT, varenicline, behavioural support) available on request.

Nutraceutical Menu (Discussed)

- Saw Palmetto [Prostate Support]
- Omega-3 [Cardio Protection]
- Magnesium [Sleep / Muscle]
- Creatine Monohydrate [Strength / Cognition]
- Vitamin D3 [Immune / Bone]
- Zinc [Hormonal Support]
- Ashwagandha [Stress Modulation]
- CoQ10 [Mitochondrial Function]

Expected Trajectory

TIMEFRAME	WHAT YOU CAN EXPECT
Weeks 2-6	Sleep quality and morning energy are usually the first domains to improve. Mood and motivation often follow.
Weeks 6-12	Libido, erectile quality, and cognitive clarity begin to normalize.
Months 3-6	Body composition shifts with consistent F45 training and nutrition support.
Months 6-12	Stabilization of hormonal and urologic metrics. DEXA and VO2 max re-checked at month 12.



Monitoring Thresholds

When we check, what we watch for, and what triggers action

BIOMARKER	WHEN CHECKED	THRESHOLD	ACTION
Hematocrit	Wk 6 · Mo 4.5 · Mo 7.5 · Mo 10.5 · Mo 12, then every 6 mo	> 0.52 L/L (caution) / > 0.54 L/L (hold)	Hydration review and dose reduction at 0.52. Pause treatment and consider therapeutic phlebotomy above 0.54.
PSA	Mo 4.5 · Mo 12, then annually	Rise > 1.4 µg/L in 12 months or absolute > 4.0 µg/L	Urology referral for DRE, repeat PSA, and risk-stratified imaging.
Estradiol (E2)	Wk 6 · Mo 4.5, then every 6 mo	> 150 pmol/L with symptoms	Dose adjustment or aromatase inhibitor trial where clinically indicated.
Blood Pressure	Every visit	> 140/90 mmHg sustained	Lifestyle optimization and review of antihypertensive therapy per Hypertension Canada guidelines.
IPSS	Mo 4.5 · Mo 12, then annually	Rise of > 5 points from today's score of 9	Urology referral for BPH evaluation. Review urinary symptom pattern.
PHQ-9	Wk 6 · Mo 4.5, then every 6 mo	Rise above 14 or any suicidal ideation	Mental health escalation and psychiatry referral. Reconsider TRT timing if mood is the primary driver.
Total Testosterone (on T)	Wk 6 (trough) · Mo 4.5, then every 6 mo	< 15 nmol/L or > 35 nmol/L at trough	Dose titration. Cross-check with symptom profile and hematocrit.



Safety

What supports starting TRT, what we watch, and when to call for help

FAVOURABLE SAFETY PROFILE

- ✓ Hematocrit 0.41 L/L (well below 0.54 cutoff)
- ✓ PSA 2.2 µg/L (below 4.0 threshold)
- ✓ DRE normal, no prostate nodule or induration
- ✓ Testicular exam normal, no masses or varicocele
- ✓ STOP-BANG 1 (low OSA risk)
- ✓ Family planning complete; fertility not desired
- ✓ BMI 24 and no active cardiovascular disease

WATCH-POINTS

- △ BP 135/80 (above optimal, tracked at every visit)
- △ Nicotine vaping (CV risk amplifier)
- △ Chronic stress (7/10 baseline, peaks 9/10)
- △ Borderline lipids (LDL, non-HDL, ApoB)
- △ Resting HR 85 bpm (upper end of normal)
- △ Waist measurement on file flagged for re-measurement

Key Safety Considerations

Erythrocytosis / clot risk: Testosterone increases red blood cell production. Hematocrit is tracked per the schedule in Section 7. Above 0.54 L/L, treatment is paused and therapeutic phlebotomy considered.

Fertility: Exogenous testosterone suppresses the HPG axis and reduces sperm production. This is typically reversible, and hCG is protective if needed. Family planning is complete here, so this is not a barrier.

Prostate: Testosterone does not cause prostate cancer, but can accelerate growth of an existing one (saturation model). Baseline DRE normal, PSA 2.2. The trajectory is what we track, not just the absolute value.

Cardiovascular: Current evidence supports cardiovascular safety of testosterone in appropriately selected men. Your blood-pressure reading, nicotine use, and resting HR are addressed in parallel.

Other side effects: acne or oily skin, hair loss if genetically predisposed, testicular atrophy (mitigated with hCG if desired), estrogen-related symptoms (monitored at week 12).

When To Seek Emergency Care (Call 911)

Chest pain · priapism (erection > 4 hours) · severe headache · sudden visual changes · leg swelling or pain · shortness of breath.

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Your Care& program includes access to your dedicated Nurse Practitioner specializing in men's health optimization.

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