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Medically Supervised Hormone and Testosterone Optimization in Colombia

SAMPLE REPORT - FICTIONAL PATIENT

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TRT Optima Comprehensive Hormone Evaluation

Patient: Daniel Herrera *(fictional patient)*
Age: 42 years
Evaluation Type: Initial Hormonal and Metabolic Review
Prepared by: TRT Optima
Important: All patient information, symptoms, laboratory values, and clinical circumstances presented in this sample report are fictional. This document demonstrates the type of evaluation TRT Optima provides and must not be used to diagnose or treat any real person.

Purpose of This Evaluation

This evaluation reviews the patient's reported symptoms, health history, and laboratory findings to identify hormonal and metabolic patterns that may warrant further medical investigation.

It is designed to accomplish two objectives:

1. Give the patient a clear understanding of what the laboratory results may mean and whether proceeding with a medical consultation would be appropriate.
2. Provide the treating physician with an organized clinical overview to support the consultation, diagnostic process, and discussion of possible treatment options.

This evaluation does not constitute a medical diagnosis or prescription. Any diagnosis or treatment must be determined by a licensed physician after reviewing the patient's complete medical history, confirming relevant laboratory findings, evaluating contraindications, and completing the appropriate medical consultation.

Patient Overview

Daniel is a 42-year-old male seeking evaluation for a progressive decline in energy, sexual function, physical performance, and overall sense of well-being.

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Over approximately the past two years, he reports:

- Persistent fatigue, particularly during the afternoon
- Reduced libido
- Less frequent morning erections
- Difficulty maintaining muscle despite exercising
- Increased abdominal fat
- Slower recovery after training
- Reduced motivation and mental clarity
- Irritability and inconsistent mood
- Nonrestorative sleep
- Difficulty losing weight

He exercises approximately three times per week but reports that his results no longer reflect his effort. He works primarily in an office environment, experiences moderate occupational stress, and sleeps approximately six hours per night.

Daniel is not currently using testosterone, anabolic steroids, enclomiphene, clomiphene, human chorionic gonadotropin, or other hormone-modifying medications.

He has not had a vasectomy and would prefer to preserve future fertility if treatment becomes necessary. This preference is clinically important because externally administered testosterone can suppress natural sperm production.

Relevant Health Information

Height: 178 cm
Weight: 91 kg
Estimated BMI: 28.7 kg/m²
Waist circumference: 101 cm
Blood pressure: 132/84 mmHg

Current medications: None reported
Known chronic conditions: None formally diagnosed
Smoking: No
Alcohol: Approximately 3–5 drinks per week
Family history: Type 2 diabetes and cardiovascular disease
Fertility considerations: Patient wishes to preserve future fertility
Previous hormone treatment: None

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The combination of increased waist circumference, family history of diabetes, limited sleep, and metabolic laboratory abnormalities increases the importance of evaluating Daniel's cardiovascular and metabolic health alongside his hormonal status.

Laboratory Results Summary

The following laboratory results are entirely fictional and were created exclusively for this sample report.

Test	Result	Reference Range	General Interpretation
Total testosterone	248 ng/dL	300–1,000 ng/dL	Low
Free testosterone	5.8 ng/dL	6.8–21.5 ng/dL	Low
SHBG	24 nmol/L	16–55 nmol/L	Normal, lower range
LH	2.1 mIU/mL	1.7–8.6 mIU/mL	Low-normal
FSH	2.8 mIU/mL	1.5–12.4 mIU/mL	Low-normal
Estradiol, sensitive	18 pg/mL	8–35 pg/mL	Within range
Prolactin	8.7 ng/mL	4.0–15.2 ng/mL	Normal
PSA	0.72 ng/mL	0.00–4.00 ng/mL	Reassuring baseline
Hemoglobin	15.2 g/dL	13.5–17.5 g/dL	Normal
Hematocrit	46.1%	41–53%	Normal
Fasting glucose	104 mg/dL	70–99 mg/dL	Elevated

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Hemoglobin A1c	5.8%	Below 5.7%	Prediabetes range
Fasting insulin	13.8 µIU/mL	2.6–24.9 µIU/mL	Within laboratory range but metabolically suboptimal
Total cholesterol	218 mg/dL	Below 200 mg/dL	Elevated
LDL cholesterol	142 mg/dL	Below 100 mg/dL	Elevated
HDL cholesterol	38 mg/dL	Above 40 mg/dL	Low
Triglycerides	186 mg/dL	Below 150 mg/dL	Elevated
ALT	43 U/L	7–56 U/L	Upper-normal
AST	29 U/L	10–40 U/L	Normal
TSH	2.21 µIU/mL	0.40–4.50 µIU/mL	Normal
Free T4	1.18 ng/dL	0.80–1.80 ng/dL	Normal
Vitamin D	24 ng/mL	30–100 ng/mL	Low
Vitamin B12	472 pg/mL	200–900 pg/mL	Adequate
Ferritin	118 ng/mL	30–400 ng/mL	Adequate

Executive Clinical Summary

Daniel presents with multiple symptoms commonly associated with androgen deficiency, including reduced libido, fewer morning erections, persistent fatigue, impaired recovery, difficulty maintaining muscle, increased abdominal fat, and reduced motivation.

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His total testosterone of 248 ng/dL and free testosterone of 5.8 ng/dL are both below the laboratory reference range. These findings provide a plausible hormonal explanation for at least some of his symptoms.

However, a definitive diagnosis of testosterone deficiency should not be based on symptoms or a single laboratory result alone. Current clinical guidance recommends confirming a low testosterone result with a second morning measurement and investigating its underlying cause before treatment is initiated. Endocrine Society guidance

Daniel's low-normal LH and FSH are also clinically relevant. In the presence of low testosterone, the absence of appropriately elevated gonadotropins may suggest a secondary or functional pattern of hypogonadism rather than clear primary testicular failure. Sleep deprivation, excess body fat, insulin resistance, certain medications, chronic stress, sleep apnea, and pituitary or hypothalamic conditions can all contribute to this pattern.

The results also identify a significant metabolic component. His hemoglobin A1c is within the prediabetes range, while elevated triglycerides, elevated LDL cholesterol, low HDL cholesterol, abdominal adiposity, and mildly elevated fasting glucose suggest impaired metabolic health and probable insulin resistance.

These issues should not be treated as separate from his hormonal health. Poor sleep, increased visceral fat, and insulin resistance can suppress normal testosterone production, while low testosterone may make maintaining muscle and improving body composition more difficult.

Overall, Daniel appears to be an appropriate candidate for a comprehensive medical consultation. The purpose of that consultation would be to confirm the hormonal pattern, investigate potentially reversible causes, evaluate fertility priorities and treatment safety, and determine whether lifestyle intervention alone or physician-directed hormonal treatment should be considered.

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