

PRE-PEPTIDE BLOODWORK

An Executive Guide to a Safer, Smarter Baseline

2026 EDITION

Comprehensive when possible.
Essential when practical.
Personalized to the therapy.

Prepared for adults around age 50 considering
clinician-supervised peptide or hormone-related therapy.

The 60-second executive summary

The goal is not to order every test available. It is to establish a high-quality baseline before therapy changes metabolism, hormones, blood counts, or organ-function markers.

Four decisions this bloodwork should support

1 Safety Is there a reason to delay, modify, or avoid therapy?	2 Selection Which intervention best fits the person and objective?
3 Dosing & monitoring What should be watched after treatment begins?	4 Outcomes Did health improve - beyond weight or appearance?

The practical recommendation

- Use the Executive Comprehensive Panel when access and budget allow.
- Use the Essential Panel when speed, cost, or local availability is limiting.
- Add therapy-specific tests based on the exact drug or peptide class.
- Repeat only the markers that can change or alter a clinical decision.

There is no universal “pre-peptide panel.” A GLP-1 medication, GH-axis agent, testosterone, and an investigational peptide do not share identical screening needs.

Medical note: This guide is educational and is not a prescription, diagnosis, or substitute for care from a licensed clinician. Testing and treatment should be individualized to symptoms, history, medications, examination, and the specific contemplated therapy.

Two levels of testing

ESSENTIAL PANEL	EXECUTIVE COMPREHENSIVE
Best for: a practical, widely available baseline Scope: major safety, metabolic, cardiovascular, endocrine, prostate, and kidney signals Use when: time, cost, or access is constrained	Best for: a high-resolution longevity and performance baseline Scope: adds advanced cardiovascular, kidney, hormone, nutrient, inflammation, and pancreatic markers Use when: multiple therapies are contemplated or precision matters

Start with the decision, not the menu

Before the blood draw, the clinician should know the therapy being considered, the desired outcome, medical history, current prescriptions and supplements, family history, prior abnormal results, and relevant symptoms. This prevents both undertesting and indiscriminate testing.

High-value non-blood baselines

- Body composition: DEXA, waist circumference, weight, and blood pressure
- Cardiovascular: resting ECG; coronary artery calcium (CAC) when age/risk and clinical decision-making support it
- Performance: VO2max or validated field test; grip strength
- Lifestyle: sleep, alcohol, nutrition, and training load

Essential Panel

The shorter list to request when the full panel is not available. These are grouped as orderable panels; each panel may report several component values.

AREA	REQUEST	WHY IT MATTERS
Blood & organs	CBC with differential; comprehensive metabolic panel (CMP); creatinine/eGFR	Anemia, infection, platelets, electrolytes, liver and kidney function
Glucose control	Fasting glucose; hemoglobin A1c; fasting insulin	Current glucose, longer-term trend, and insulin resistance context
Cardiovascular	Standard lipid panel; ApoB; Lp(a); hs-CRP	Atherosclerotic particle burden, inherited risk, and inflammation
Male hormones	Total testosterone; free testosterone; SHBG; sensitive estradiol; LH; FSH; prolactin	Distinguishes hormone level from its likely source and binding context
GH axis	IGF-1	Most useful stable baseline for GH-axis activity; random GH is usually not
Thyroid	TSH; free T4	Screens thyroid regulation and circulating thyroid hormone
Prostate	PSA total	Establishes a baseline, especially before androgen-related therapy
Iron & nutrients	Ferritin; iron/TIBC/% saturation; vitamin D; B12; folate	Detects common correctable deficiencies or overload patterns
Urine/kidney	Urinalysis; urine albumin/creatinine ratio (UACR)	Finds protein, blood, glucose, infection clues, and early kidney injury

If only a conventional minimum is feasible: CBC + CMP + fasting glucose + A1c + lipid panel + TSH + total/free testosterone + estradiol + IGF-1 + PSA + urinalysis. Add ApoB and Lp(a) whenever available.

Executive Comprehensive Panel

A high-resolution baseline for someone considering a broader longevity, metabolic, or performance program.

1. Hematology

Request: CBC with differential; RBC, hemoglobin, hematocrit, MCV, MCH, MCHC, RDW, platelets, MPV, WBC and differential

Executive interpretation: Especially important with testosterone/androgens because hematocrit may rise.

2. Kidney, liver & electrolytes

Request: CMP plus cystatin C/eGFR, magnesium, phosphorus, uric acid, GGT, direct bilirubin, LDH, urinalysis and UACR

Executive interpretation: Cystatin C is useful when high muscle mass makes creatinine harder to interpret.

3. Metabolic health

Request: Fasting glucose, A1c, fasting insulin, C-peptide; calculate HOMA-IR. Optional: fructosamine or glycated albumin

Executive interpretation: Establishes glucose/insulin status before metabolic or GH-axis interventions.

4. Advanced cardiovascular

Request: Total cholesterol, LDL-C, HDL-C, triglycerides, non-HDL-C, ApoB, Lp(a), ApoA1, ApoB/ApoA1 ratio, hs-CRP. Optional: LDL-P and particle size

Executive interpretation: ApoB and Lp(a) usually add more decision value than an elaborate particle-size panel.

5. Male hormone axis

Request: Total testosterone by LC/MS-MS when available, free testosterone, SHBG, albumin, sensitive estradiol by LC/MS-MS, LH, FSH, prolactin, DHEA-S. Optional: DHT, pregnenolone

Executive interpretation: Defines baseline production, binding, estrogen balance, and pituitary signals.

Executive Comprehensive Panel - continued

6. GH / IGF axis

Request: IGF-1 with Z-score when available; IGFBP-3. Optional: IGFBP-1

Executive interpretation: Random GH is usually low-value because secretion is pulsatile.

7. Thyroid

Request: TSH, free T4, free T3; TPO antibodies and thyroglobulin antibodies for a comprehensive baseline

Executive interpretation: Reverse T3 is selective, not a routine must-have.

8. Adrenal / stress axis

Request: Morning cortisol around 8 AM; DHEA-S. ACTH only when indicated

Executive interpretation: Timing and clinical context matter for cortisol interpretation.

9. Prostate / men's health

Request: PSA total, PSA free and percent-free PSA

Executive interpretation: Particularly relevant before testosterone or androgen treatment.

10. Iron & nutrition

Request: Ferritin, iron, TIBC, transferrin, saturation, B12, folate, 25-OH vitamin D; optional RBC magnesium, zinc, copper, ceruloplasmin, homocysteine

Executive interpretation: Identifies correctable factors affecting energy, blood formation, nerves, and performance.

11. Inflammation

Request: hs-CRP; ferritin. Optional ESR and fibrinogen. Specialized: IL-6 and TNF-alpha

Executive interpretation: Cytokine panels are advanced/research profiling, not a routine baseline.

12. Pancreas & metabolic liver

Request: Lipase and amylase when clinically indicated; GGT, AST, ALT and platelets; calculate FIB-4

Executive interpretation: Useful context for GLP-1/GIP selection and metabolic liver risk.

Match the panel to the therapy

The same lab list should not be applied blindly to every intervention.

Therapy Class	Priority Baseline	What it helps monitor
GLP-1 / GIP	Glucose, A1c, kidney/liver function; lipase/amylase when history or symptoms indicate; pregnancy testing when applicable	Metabolic response, tolerability, contraindications and dose planning
GH / secretagogues	IGF-1 (with Z-score), glucose/A1c; consider IGFBP-3, thyroid and lipids	IGF-1 response and glucose effects
Testosterone / androgens	CBC/hematocrit, PSA, total/free T, SHBG, LH/FSH, estradiol; lipids and liver markers	Erythrocytosis, prostate monitoring, hormone balance and cardiovascular risk
Repair / investigational peptides	CBC, CMP, kidney/liver function plus indication-specific testing	There may be no validated blood marker proving efficacy or safety
Multiple compounds	Use the Executive Comprehensive Panel and reconcile interactions with every drug/supplement	Stacking increases attribution and monitoring complexity

Important distinction

A baseline can reveal risk and create a point of comparison. It cannot make an unapproved or poorly studied compound “safe,” authenticate product purity, or substitute for clinical monitoring. Product testing and patient monitoring are separate questions.

Prepare for a cleaner baseline

Follow the ordering clinician's instructions first. Unless told otherwise, these steps can reduce avoidable noise in the results.

Timing

Use a morning appointment for testosterone and morning cortisol. Try to use the same time and laboratory for follow-up.

Fasting

Ask whether 8-12 hours fasting is desired. Water is usually encouraged unless restricted.

Training

Avoid unusually hard endurance or resistance exercise for 24-48 hours when feasible; strenuous exercise can move AST, CK, glucose and inflammatory markers.

Alcohol & illness

Avoid heavy alcohol beforehand and disclose infection, injury, poor sleep, dehydration, or recent travel.

Medications

Do not stop prescriptions. Bring a complete list of medicines, hormones, peptides and supplements, with dose and timing.

Biotin

High-dose biotin can interfere with some assays. Ask the clinician/lab whether it should be held.

Repeatability

Record draw time, fasting status, last workout, sleep, and last dose of relevant therapy.

One abnormal result is not a diagnosis

Unexpected findings often deserve confirmation and clinical interpretation before changing treatment. Trends, symptoms, assay method, hydration, and recent training all matter.

A sensible monitoring cadence

These are planning intervals, not universal rules. The prescriber should set the schedule.

WHEN	PURPOSE	FOCUS
Baseline	Before the first dose	Full selected panel; document vitals, body composition and medication list
Early check	About 4-6 weeks	Only markers likely to change early or needed for titration; therapy-specific
Primary review	About 3 months	Efficacy, tolerability and safety; compare with baseline
Ongoing	About 6 months	Repeat decision-relevant markers if treatment continues
Maintenance	Annually, or sooner if indicated	Broader health review; interval depends on therapy, dose and risk

Contact the clinician promptly for

- Severe or persistent abdominal pain, repeated vomiting, jaundice, chest pain, fainting, shortness of breath, new neurologic symptoms, or signs of an allergic reaction.
- A markedly abnormal result, a rapid change from baseline, or symptoms suggesting a treatment complication.

Urgent symptoms may require emergency care. This list is illustrative, not exhaustive.

Printable order checklist

Bring this page to the clinician. The checkboxes are discussion prompts, not a self-directed order.

CORE		
☐ CBC with differential	☐ CMP	☐ Creatinine/eGFR
☐ Urinalysis	☐ UACR	
METABOLIC		
☐ Fasting glucose	☐ A1c	☐ Fasting insulin
☐ C-peptide	☐ HOMA-IR (calculated)	
CARDIOVASCULAR		
☐ Lipid panel	☐ ApoB	☐ Lp(a)
☐ ApoA1	☐ hs-CRP	
MALE HORMONES		
☐ Total T	☐ Free T	☐ SHBG
☐ Sensitive estradiol	☐ LH	☐ FSH
☐ Prolactin	☐ DHEA-S	
GH / THYROID		
☐ IGF-1 (+ Z-score)	☐ IGFBP-3	☐ TSH
☐ Free T4	☐ Free T3	
PROSTATE / STRESS		
☐ PSA total	☐ PSA free / % free	☐ AM cortisol
NUTRITION / IRON		
☐ Ferritin	☐ Iron/TIBC/% saturation	☐ B12
☐ Folate	☐ 25-OH vitamin D	☐ Homocysteine
ADVANCED / SELECTIVE		
☐ Cystatin C	☐ Magnesium	☐ Phosphorus
☐ Uric acid	☐ GGT	☐ Zinc
☐ Copper	☐ Lipase	☐ Amylase
☐ TPOAb	☐ TgAb	

Sources & clinical guardrails

This guide synthesizes a broad health/performance baseline with therapy-specific safety considerations. Key clinical references:

- American Diabetes Association. Standards of Care in Diabetes - 2026: Comprehensive Medical Evaluation and Assessment of Comorbidities. diabetesjournals.org
 - ACC/AHA. 2026 Guideline on the Management of Dyslipidemia; risk refinement with Lp(a), ApoB, hs-CRP and CAC where appropriate. professional.heart.org
 - Endocrine Society. Testosterone Therapy in Men With Hypogonadism: Clinical Practice Guideline; baseline hematocrit and prostate-risk assessment. endocrine.org
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How to use this guide

1. Select Essential or Executive Comprehensive with the prescribing clinician.
2. Add tests relevant to the exact proposed therapy.
3. Record baseline symptoms, vitals, body composition, training and medications.
4. Agree in advance on follow-up timing and thresholds that would change treatment.

Educational use only. This document does not endorse any peptide, compounded product, or investigational compound. Availability, approval status, contraindications, and monitoring requirements vary by treatment and jurisdiction. Results should be interpreted by a qualified clinician.

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