

**Test: Health Check Comprehensive (Male)**  
**Identification Data: JOHN SAMPLE (000000000X)**  
**Analysis Number: X00000000**  
**Date: 01/04/2026**



## Evidence-Based Science for Early Detection, Cancer Prevention and Longevity

## **TERMS AND CONDITIONS**

THIS TEST IS NOT INTENDED TO SUBSTITUTE OR REPLACE MEDICAL VISITS; ON THE CONTRARY, IT AIMS TO ENHANCE AND ENRICH THEM, PROVIDING PREVENTIVE AND COMPLEMENTARY INFORMATION THAT HELPS BOTH INDIVIDUALS AND HEALTHCARE PROFESSIONALS MAKE BETTER DECISIONS.

THE TRADITIONAL HEALTHCARE MODEL, CHARACTERISTIC OF MEDICINE 2.0, HAS HISTORICALLY BEEN FOCUSED ON DISEASE: IT CONCENTRATES ON DIAGNOSING AND TREATING ONCE SYMPTOMS APPEAR. ALTHOUGH THIS APPROACH HAS ENABLED MAJOR THERAPEUTIC ADVANCES, IT PRESENTS IMPORTANT LIMITATIONS: IT OFTEN ARRIVES TOO LATE, IS MORE REACTIVE THAN PREVENTIVE, AND FREQUENTLY DOES NOT TAKE INTO ACCOUNT THE INDIVIDUALITY OF EACH PERSON. IN CONTRAST, ALL OUR TESTS ARE BASED ON THE PRINCIPLES OF MEDICINE 3.0, A FAR MORE ADVANCED MODEL. MEDICINE 3.0 IS FOUNDED ON THE 4 P's —PREDICTION, PREVENTION, PERSONALIZATION, AND PATIENT PARTICIPATION—. THIS MEANS ANTICIPATING RISKS BEFORE THEY TURN INTO DISEASES, INTERVENING EARLY WITH STRATEGIES GROUNDED IN SCIENTIFIC EVIDENCE, AND TAILORING RECOMMENDATIONS TO EACH INDIVIDUAL. MOREOVER, IT EMPOWERS PEOPLE TO TAKE AN ACTIVE ROLE IN MANAGING THEIR OWN HEALTH.

OUR TESTS EVALUATE BIOMARKERS AND CLINICAL PATTERNS ASSOCIATED WITH MORE THAN 300 DISEASES AND HEALTH CONDITIONS, INCLUDING SOME THAT MAY BE PRESENT BEFORE SYMPTOMS OR SIGNS APPEAR. THE RESULTS MAY PROVIDE VALUABLE CLUES THAT SUPPORT EARLY DETECTION, TIMELY REFERRAL AND A MORE COMPLETE MEDICAL EVALUATION. HOWEVER, THESE FINDINGS DO NOT CONSTITUTE A DIAGNOSIS ON THEIR OWN. ADDITIONALLY, NOT ALL POSSIBLE DISEASES CAN ALWAYS BE IDENTIFIED.

THIS TEST CAN CAUSE OVERDIAGNOSIS, THAT IS, DIAGNOSIS OF A MEDICAL CONDITION THAT COULD NOT CAUSE ANY SYMPTOMS, OR WHICH, WITH CURRENT MEDICAL KNOWLEDGE, IS NOT RELATED TO THE APPEARANCE OF A FUTURE PATHOLOGY. LIKEWISE, THERE MAY ALSO BE ANOMALIES WHICH COULD BE SOLVED SPONTANEOUSLY. ON THE OTHER HAND, IF YOU FEEL —BOTH PERSISTENT OR INTERMITTENT—, DISCOMFORT, IMPAIRMENT OR PAIN, PLEASE GO TO THE EMERGENCY ROOM AS IT COULD BE DUE TO AN ACUTE DISORDER AS WELL AS TO A PSYCHOSOMATIC CAUSE.

THIS REPORT CONTAINS A SERIES OF INTERPRETATIVE COMMENTS BASED ON THE BEST AVAILABLE SCIENTIFIC EVIDENCE, AS WELL AS THE LATEST MEDICAL AND CLINICAL ADVANCES, WITH THE AIM OF PROVIDING AN UPDATED AND EVIDENCE-BASED OVERVIEW OF YOUR HEALTH STATUS. BY CONTINUING TO READ THIS REPORT, YOU ACKNOWLEDGE YOUR AGREEMENT WITH THE TERMS AND CONDITIONS SET FORTH HEREIN, AS WELL AS WITH ALL WARNINGS AND LIMITATIONS OF LIABILITY CONTAINED THEREIN, AND YOU EXPRESSLY RELEASE THE COMPANY FROM ANY AND ALL RESPONSIBILITY.

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## Legend

|  |                                                                                                              |
|--|--------------------------------------------------------------------------------------------------------------|
|  | A: this section contains no findings that should be reviewed by a healthcare professional.                   |
|  | B: this section contains some minor findings that do not require review by a health professional.            |
|  | C: this section contains some mild-moderate findings that should be reviewed by a healthcare professional.   |
|  | D: this section contains some moderate-severe findings that should be reviewed by a healthcare professional. |
|  | E: this section contains some severe findings that should be reviewed by a healthcare professional.          |

## Report with Interpretative Commenting

### Patient Information



#### Identification Data

Patient ID: ES-000000000X  
 Patient Name: JOHN  
 Patient Surname: SAMPLE  
 Blood Collection Date: 01/04/2026  
 Urine Collection Date: 01/04/2026

#### Personal Data

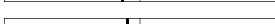
Gender at Birth: Male  
 Date of Birth (day/month/year): 11/05/1971  
 Age (years): 54

### Clinical Data

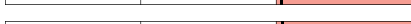
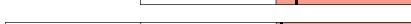
#### RHR & Blood Pressure

|                            | Value    | Min    | Max    | Visual Score                                                                        |
|----------------------------|----------|--------|--------|-------------------------------------------------------------------------------------|
| Heart Rate (BPM):          | 64       | 50.00  | 83.00  |  |
| Systolic Pressure (mmHg):  | 129.00 ↑ | 100.00 | 120.00 |  |
| Diastolic Pressure (mmHg): | 84.00 ↑  | 60.00  | 80.00  |  |

#### Anthropometric Data

|                           | Value   | Min   | Max    | Visual Score                                                                          |
|---------------------------|---------|-------|--------|---------------------------------------------------------------------------------------|
| Height (cm):              | 173.00  |       |        |                                                                                       |
| Weight (kg):              | 83.50 ↑ | 55.37 | 74.82  |  |
| Neck Circumference (cm):  | 39.00   |       | 43.18  |  |
| Waist Circumference (cm): | 96.00   |       | 102.00 |  |
| Hip Circumference (cm):   | 98.00   |       |        |                                                                                       |
| Body Fat (%):             | 24.44 ↑ | 16.40 | 21.40  |  |
| Body Fat Mass (kg):       | 20.41 ↑ | 13.69 | 17.87  |  |

#### Anthropometric Indices

|                                       | Value   | Min   | Max   | Visual Score                                                                          |
|---------------------------------------|---------|-------|-------|---------------------------------------------------------------------------------------|
| Body Mass Index (kg/m <sup>2</sup> ): | 27.90 ↑ | 18.50 | 25.00 |  |
| Waist-to-Hip Ratio:                   | 0.98 ↑  | 0.78  | 0.90  |  |
| Waist-to-Height Ratio:                | 0.55 ↑  | 0.40  | 0.50  |  |
| Hypertriglyceridemic Waist:           | No      |       |       |                                                                                       |
| Lipid Accumulation Product:           | 53.63 ↑ |       | 37.75 |  |
| Body Adiposity Index:                 | 25.07 ↑ | 11.00 | 23.00 |  |
| Visceral Adiposity Index:             | 1.47    |       | 1.93  |  |
| Body Shape Index:                     | 0.08 ↑  |       | 0.07  |  |
| Conicity Index:                       | 1.27 ↑  |       | 1.25  |  |

#### Lifestyle

|                           | Value           |
|---------------------------|-----------------|
| Red Meat:                 | 3-5 times/week  |
| Fruits/Vegetables:        | 1 serving/day   |
| Physical Activity:        | Moderate        |
| Smoking:                  | Past            |
| Alcohol per Day (drinks): | Between 3 and 5 |

## Laboratory Results (with Advanced Coefficients, Indices and/or Ratios)



| Hemogram                              | Value  | Min    | Max    | Visual Score           |
|---------------------------------------|--------|--------|--------|------------------------|
| RBC Count (x10 <sup>12</sup> /L):     | 5.00   | 4.20   | 5.80   | <div><div></div></div> |
| Hgb (g/dL):                           | 16.40  | 13.00  | 17.50  | <div><div></div></div> |
| HCT (%):                              | 48.50  | 40.00  | 55.00  | <div><div></div></div> |
| HCT-to-Hgb Ratio:                     | 2.96   |        | 3.20   | <div><div></div></div> |
| ESR (mm):                             | 2.00   | 0.60   | 18.00  | <div><div></div></div> |
| Red Blood Cell Indices                | Value  | Min    | Max    | Visual Score           |
| MCV (fL):                             | 97.00  | 80.00  | 101.00 | <div><div></div></div> |
| MCH (pg):                             | 32.80  | 25.00  | 35.00  | <div><div></div></div> |
| MCHC (g/dL):                          | 33.81  | 28.00  | 37.00  | <div><div></div></div> |
| RDW (%):                              | 13.60  |        | 22.00  | <div><div></div></div> |
| Leukocyte Count                       | Value  | Min    | Max    | Visual Score           |
| Leukocytes (x10 <sup>9</sup> /L):     | 5.59   | 4.20   | 11.50  | <div><div></div></div> |
| Neutrophils (x10 <sup>9</sup> /L):    | 3.05   | 1.89   | 8.58   | <div><div></div></div> |
| Lymphocytes (x10 <sup>9</sup> /L):    | 1.81   | 0.84   | 5.18   | <div><div></div></div> |
| Monocytes (x10 <sup>9</sup> /L):      | 0.51   | 0.04   | 0.95   | <div><div></div></div> |
| Eosinophils (x10 <sup>9</sup> /L):    | 0.18   |        | 0.58   | <div><div></div></div> |
| Basophils (x10 <sup>9</sup> /L):      | 0.04   |        | 0.18   | <div><div></div></div> |
| Leukocyte Formula                     | Value  | Min    | Max    | Visual Score           |
| Neutrophils (%):                      | 54.50  | 45.00  | 75.00  | <div><div></div></div> |
| Lymphocytes (%):                      | 32.40  | 20.00  | 45.00  | <div><div></div></div> |
| Monocytes (%):                        | 9.10   | 0.20   | 10.00  | <div><div></div></div> |
| Eosinophils (%):                      | 3.20   |        | 5.00   | <div><div></div></div> |
| Basophils (%):                        | 0.80   |        | 1.50   | <div><div></div></div> |
| Platelets                             | Value  | Min    | Max    | Visual Score           |
| Platelet Count (x10 <sup>9</sup> /L): | 215.00 | 130.00 | 450.00 | <div><div></div></div> |
| MPV (fL):                             | 9.00   | 6.00   | 11.00  | <div><div></div></div> |
| Coagulation                           | Value  | Min    | Max    | Visual Score           |
| PT (%):                               | 100.00 | 70.00  | 100.00 | <div><div></div></div> |
| aPTT (s):                             | 32.60  | 28.00  | 41.00  | <div><div></div></div> |
| Antibodies                            | Value  | Min    | Max    | Visual Score           |
| Anti-CCP Antibodies (U/mL):           | 0.49   |        | 3.00   | <div><div></div></div> |
| H. pylori IgG Ab (U/mL):              | 0.49   |        | 1.10   | <div><div></div></div> |
| Rheumatoid Factor (UI/mL):            | 5.00   |        | 14.00  | <div><div></div></div> |

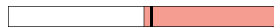
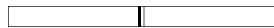
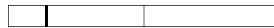
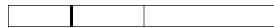
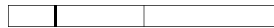
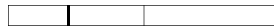
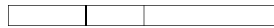
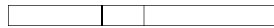
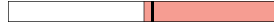
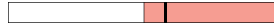
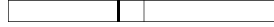
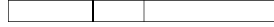
## Laboratory Results (with Advanced Coefficients, Indices and/or Ratios)



| Electrolytes                 | Value    | Min    | Max    | Visual Score           |
|------------------------------|----------|--------|--------|------------------------|
| Calcium (mg/L):              | 98.60    | 83.00  | 106.00 | <div><div></div></div> |
| Chloride (mmol/L):           | 105.00   | 102.00 | 111.00 | <div><div></div></div> |
| Magnesium (mg/dL):           | 2.11     | 1.60   | 2.60   | <div><div></div></div> |
| Phosphorus (mg/dL):          | 2.34 ↓   | 2.40   | 5.10   | <div><div></div></div> |
| Potassium (mmol/L):          | 4.41     | 3.50   | 5.10   | <div><div></div></div> |
| Sodium (mmol/L):             | 140.70   | 136.00 | 145.00 | <div><div></div></div> |
| Corrected Electrolytes       | Value    | Min    | Max    | Visual Score           |
| Corrected Calcium (mg/L):    | 91.96    | 83.00  | 106.00 | <div><div></div></div> |
| Corrected Chloride (mmol/L): | 104.67   | 102.00 | 111.00 | <div><div></div></div> |
| Corrected Magnesium (mg/dL): | 2.07     | 1.60   | 2.60   | <div><div></div></div> |
| Corrected Sodium (mmol/L):   | 140.94   | 136.00 | 145.00 | <div><div></div></div> |
| Electrolytic Ratios          | Value    | Min    | Max    | Visual Score           |
| Ca-to-Mg Ratio:              | 4.44     | 2.41   | 5.00   | <div><div></div></div> |
| Ca-to-P Ratio:               | 3.93 ↑   |        | 3.50   | <div><div></div></div> |
| Na-to-K Ratio:               | 31.96    | 30.00  | 50.00  | <div><div></div></div> |
| Proteins                     | Value    | Min    | Max    | Visual Score           |
| Albumin (g/L):               | 48.30 ↑  | 32.00  | 48.00  | <div><div></div></div> |
| Apolipoprotein A1 (mg/dL):   | 146.00   | 79.00  | 169.00 | <div><div></div></div> |
| Apolipoprotein B (mg/dL):    | 107.00   | 46.00  | 174.00 | <div><div></div></div> |
| ApoB/ApoA1 Ratio:            | 0.73     |        | 0.90   | <div><div></div></div> |
| hs-CRP (mg/L):               | 0.99     |        | 5.00   | <div><div></div></div> |
| Ferritin (ng/mL):            | 325.00 ↑ | 22.00  | 322.00 | <div><div></div></div> |
| Globulin (g/L):              | 26.70    | 20.00  | 35.00  | <div><div></div></div> |
| Lipoprotein(a) (mg/dL):      | 86.00 ↑  |        | 29.00  | <div><div></div></div> |
| Total Protein (g/L):         | 75.00    | 57.00  | 82.00  | <div><div></div></div> |
| Hepatic Enzymes              | Value    | Min    | Max    | Visual Score           |
| ALP (IU/L):                  | 48.00    | 40.00  | 129.00 | <div><div></div></div> |
| AST (IU/L):                  | 34.00    |        | 34.00  | <div><div></div></div> |
| ALT (IU/L):                  | 45.00    |        | 49.00  | <div><div></div></div> |
| GGT (IU/L):                  | 59.00 ↑  |        | 55.00  | <div><div></div></div> |
| LDH (IU/L):                  | 146.00   | 120.00 | 246.00 | <div><div></div></div> |
| Hepatic Enzymes Ratios       | Value    | Min    | Max    | Visual Score           |
| AST-to-ALT Ratio:            | 0.76     | 0.70   | 1.40   | <div><div></div></div> |
| Pancreatic Enzymes           | Value    | Min    | Max    | Visual Score           |
| Amylase (IU/L):              | 61.00    | 30.00  | 118.00 | <div><div></div></div> |
| Pancreatic Amylase (IU/L):   | 24.00    | 13.00  | 53.00  | <div><div></div></div> |
| Lipase (IU/L):               | 44.00    | 12.00  | 53.00  | <div><div></div></div> |

## Laboratory Results (with Advanced Coefficients, Indices and/or Ratios)



| MAFLD/NAFLD Indices                 | Value    | Min   | Max    | Visual Score                                                                          |
|-------------------------------------|----------|-------|--------|---------------------------------------------------------------------------------------|
| Fatty Liver Index (FLI):            | 74.27 ↑  |       | 60.00  |    |
| Hepatic Steatosis Index (HSI):      | 38.49 ↑  |       | 36.00  |    |
| K-NALFD Score:                      | 2.11 ↑   |       | 0.88   |    |
| NAFLD Liver Fat Score (LFS):        | -1.31    |       | -0.64  |    |
| NAFLD Logit Score (NLS):            | 1.00 ↑   |       | 0.45   |    |
| NAFLD Ridge Score (NRS):            | -1.24    |       | 0.44   |    |
| NAFLD/NASH Indices                  | Value    | Min   | Max    | Visual Score                                                                          |
| acNASH:                             | 4.05     |       | 7.73   |    |
| FAT Score:                          | 2.00     |       | 3.00   |    |
| GHOLAM Score:                       | 9.26 ↑   |       | 8.22   |    |
| HAIR Score:                         | 2.00     |       | 2.00   |    |
| NASH/Fibrosis Indices               | Value    | Min   | Max    | Visual Score                                                                          |
| AST-to-Platelet Ratio Index (APRI): | 0.47     |       | 1.50   |    |
| BAAT Score:                         | 2.00     |       | 4.00   |    |
| BARD Score:                         | 0.76     |       | 2.00   |   |
| FIB 4 Score:                        | 1.27     |       | 2.67   |  |
| Fibrometer:                         | 21.84    |       | 36.00  |  |
| Forns Fibrosis Index (FFI):         | 5.00     |       | 6.90   |  |
| NAFLD Fibrosis Score (NFS):         | -1.16    |       | 0.68   |  |
| SAFE Score:                         | 8.34     |       | 20.00  |  |
| Sterols & Fatty Acids               | Value    | Min   | Max    | Visual Score                                                                          |
| Total Cholesterol (mg/dL):          | 220.00 ↑ |       | 200.00 |  |
| HDL-c (mg/dL):                      | 52.00    | 40.00 |        |  |
| Non-HDL-c (mg/dL):                  | 168.00 ↑ |       | 150.00 |  |
| LDL-c (mg/dL):                      | 136.55 ↑ |       | 130.00 |  |
| Lp(a) Corrected LDL-c (mg/dL):      | 110.75   |       | 130.00 |  |
| VLDL-c (mg/dL):                     | 31.45    | 15.00 | 70.00  |  |
| Triglycerides (mg/dL):              | 173.00 ↑ |       | 150.00 |  |
| Atherogenic Indices                 | Value    | Min   | Max    | Visual Score                                                                          |
| Atherogenic Coefficient (AC):       | 3.23     |       | 3.50   |  |
| Atherogenic Index of Plasma (AIP):  | 0.16 ↑   |       | 0.11   |  |
| Castelli Risk Index I:              | 4.23     |       | 5.00   |  |
| Castelli Risk Index I + TB:         | 1.48     |       | 2.25   |  |
| Castelli Risk Index II:             | 2.63 ↑   |       | 2.50   |  |
| Castelli Risk Index II + TB:        | 0.92     |       | 2.25   |  |
| Triglycerides/HDL-c Index (THI):    | 3.33     |       | 3.50   |  |
| Muscle and Cardiac Enzymes          | Value    | Min   | Max    | Visual Score                                                                          |
| Creatine Kinase (IU/L):             | 128.00   | 46.00 | 171.00 |  |

## Laboratory Results (with Advanced Coefficients, Indices and/or Ratios)



| Muscular System Indexes       | Value    | Min    | Max    | Visual Score           |
|-------------------------------|----------|--------|--------|------------------------|
| CK-to-AST Ratio:              | 3.76 ↓   | 15.00  | 20.00  | <div><div></div></div> |
| Hormones                      | Value    | Min    | Max    | Visual Score           |
| 17-Beta Estradiol (pg/mL):    | 33.20    |        | 39.80  | <div><div></div></div> |
| Insulin (μU/mL):              | 6.22     | 3.00   | 25.00  | <div><div></div></div> |
| PTHi (pg/mL):                 | 67.00    | 18.40  | 80.10  | <div><div></div></div> |
| SHBG (ng/mL):                 | 1.96     | 1.86   | 9.73   | <div><div></div></div> |
| Total Testosterone (ng/mL):   | 3.31     | 1.88   | 6.84   | <div><div></div></div> |
| TSH (mIU/L):                  | 3.19     | 0.55   | 4.78   | <div><div></div></div> |
| T4 Free (ng/dL):              | 1.69     | 0.89   | 1.76   | <div><div></div></div> |
| Androgen and Estrogen Ratios  | Value    | Min    | Max    | Visual Score           |
| E2-to-SHBG Ratio:             | 162.65 ↑ | 50.00  | 150.00 | <div><div></div></div> |
| E2-to-TT Ratio:               | 10.03    | 5.00   | 12.00  | <div><div></div></div> |
| Androgenic Ratios             | Value    | Min    | Max    | Visual Score           |
| Free Androgen Index (FAI):    | 56.22    | 18.00  | 82.00  | <div><div></div></div> |
| Endocrine Indices             | Value    | Min    | Max    | Visual Score           |
| Metabolic Syndrome (ATP-III): | 2.00     |        | 3.00   | <div><div></div></div> |
| TyG Index:                    | 9.16 ↑   |        | 8.80   | <div><div></div></div> |
| HOMA-IR:                      | 1.69     |        | 2.64   | <div><div></div></div> |
| HOMA-Beta (%):                | 47.64 ↓  | 67.70  |        | <div><div></div></div> |
| HOMA-S (%):                   | 59.17    | 37.80  |        | <div><div></div></div> |
| QUICKI:                       | 0.35     | 0.30   |        | <div><div></div></div> |
| Thyroid Ratios                | Value    | Min    | Max    | Visual Score           |
| T4 Free-to-TSH Ratio:         | 0.53     | 0.50   | 2.50   | <div><div></div></div> |
| Vitamins                      | Value    | Min    | Max    | Visual Score           |
| Vitamin B12 (pg/mL):          | 616.00   | 211.00 | 911.00 | <div><div></div></div> |
| Vitamin D 25-OH (ng/mL):      | 12.21 ↓  | 30.00  | 100.00 | <div><div></div></div> |
| Tumor Markers                 | Value    | Min    | Max    | Visual Score           |
| AFP (ng/mL):                  | 2.00     |        | 10.00  | <div><div></div></div> |
| CA 19.9 (U/mL):               | 7.10     | 3.00   | 37.00  | <div><div></div></div> |
| CEA (ng/mL):                  | 0.50     |        | 5.00   | <div><div></div></div> |
| PSA Total (ng/mL):            | 0.50     |        | 3.50   | <div><div></div></div> |
| PSA Free (ng/mL):             | 0.17     |        |        |                        |
| Tumor Marker Ratios           | Value    | Min    | Max    | Visual Score           |
| CA 19.9-to-CEA Ratio:         | 14.20    |        | 29.77  | <div><div></div></div> |
| fPSA-to-tPSA Ratio (%fPSA):   | 0.35     | 0.20   |        | <div><div></div></div> |



## Laboratory Results (with Advanced Coefficients, Indices and/or Ratios)



| Other Serum Analytes               | Value      | Min     | Max     | Visual Score           |
|------------------------------------|------------|---------|---------|------------------------|
| Creatinine (mg/dL):                | 0.95       | 0.70    | 1.30    | <div><div></div></div> |
| Creatinine Clearance (mL/min):     | 104.99     | 40.00   | 150.00  | <div><div></div></div> |
| eGFR (mL/min/1.73m <sup>2</sup> ): | 95.12      | 90.00   |         | <div><div></div></div> |
| Glucose (mg/dL):                   | 110.00 ↑   | 74.00   | 106.00  | <div><div></div></div> |
| HbA1c (%):                         | 4.90       | 4.30    | 6.10    | <div><div></div></div> |
| Serum Iron (µg/dL):                | 110.00     | 65.00   | 175.00  | <div><div></div></div> |
| Total Bilirubin (mg/dL):           | 0.97       | 0.30    | 1.20    | <div><div></div></div> |
| Direct Bilirubin (mg/dL):          | 0.44 ↑     |         | 0.31    | <div><div></div></div> |
| Indirect Bilirubin (mg/dL):        | 0.53       | 0.30    | 0.85    | <div><div></div></div> |
| Direct-to-Total Bilirubin Ratio:   | 0.45       |         | 0.70    | <div><div></div></div> |
| Urea (mg/dL):                      | 35.00      | 19.00   | 49.00   | <div><div></div></div> |
| BUN (mg/dL):                       | 16.33      | 10.00   | 25.00   | <div><div></div></div> |
| BUN-to-Creatinine Ratio:           | 17.19      | 12.00   | 20.00   | <div><div></div></div> |
| Uric Acid (mg/dL):                 | 6.40       | 3.70    | 9.20    | <div><div></div></div> |
| Other Urine Analytes               | Value      | Min     | Max     | Visual Score           |
| Urine Albumin (g/L):               | 0.06       |         | 0.15    | <div><div></div></div> |
| Urine Creatinine (g/L):            | 2.03 ↑     | 0.60    | 1.80    | <div><div></div></div> |
| Urine ACR (mg/g):                  | 29.06      |         | 30.00   | <div><div></div></div> |
| Urinalysis                         | Value      | Min     | Max     | Visual Score           |
| Urine Density (g/L):               | 1030.00    | 1010.00 | 1030.00 | <div><div></div></div> |
| Urine pH:                          | 5.00       | 4.50    | 8.50    | <div><div></div></div> |
| WBC in Urine:                      | Negative   |         |         |                        |
| Nitrites in Urine:                 | Negative   |         |         |                        |
| Protein in Urine:                  | Negative   |         |         |                        |
| Glucose in Urine:                  | Negative   |         |         |                        |
| Ketones in Urine:                  | Trace (1+) |         |         |                        |
| Urobilinogen in Urine:             | Negative   |         |         |                        |
| Urobilin in Urine:                 | Negative   |         |         |                        |
| RBC in Urine:                      | Negative   |         |         |                        |

## Technical Interferences

| Serum             | Value | Urine             | Value |
|-------------------|-------|-------------------|-------|
| Hemolyzed Sample: | No    | Abnormal Density: | No    |
| Icteric Sample:   | No    |                   |       |
| Lipemic Sample:   | No    |                   |       |

## Legend

|             |                                                                                                        |
|-------------|--------------------------------------------------------------------------------------------------------|
| <div></div> | Values are within the reference range limits.                                                          |
| <div></div> | Values are outside the reference range limits.                                                         |
| <div></div> | Values are outside the reference range limits, concretely more than 4 times the normality upper limit. |

## Technical Validation of Laboratory Results



Laboratory: Laboratorio Echevarne, S.A.

## Coefficients, Indices and Ratios Descriptions

In addition to the results provided by Laboratorio Echevarne, Blueberry Diagnostics has added to this report several innovative coefficients, indices and ratios —calculated and validated by the company itself—, to help your healthcare providers to get a more accurate diagnosis since, they can provide a holistic view of the state of your health by integrating multiple factors that can allow clinicians to have more comprehensive data, potentially leading to better-informed decisions.



Besides, they also can improve the sensitivity and specificity of predictions —by reducing false positives and false negatives—. Moreover, they can also help differentiate between diseases with similar clinical presentations —reducing the probability of misinterpretation or excessive dependence on a single parameter—. Furthermore they can guide treatment decisions to improve patient outcomes.

NOTE: No coefficient, indice or ratio should be used in isolation, since they are specifically designed to provide additional insight when an abnormality is detected. For example, the AST-to-ALT ratio has no clinical value if no liver disease is present —regardless of whether the result is altered—. However, if liver injury exists, the AST-to-ALT ratio can help to differentiate whether the damage is of alcoholic or viral origin, non-alcoholic fatty liver disease (NAFLD), or mild hepatocellular injury. In this way, it is possible that not all coefficients, indices or ratios will be mentioned in the reports, even if their values are altered.

You will find a complete description by scanning the QR code of this section.

## Cardiovascular-Kidney-Metabolic (CKM) Syndrome Score



### Results

According to your blood pressure levels, your weight, and the relationship between your cardiovascular and renal health, you could have stage 2 Cardiovascular-Kidney-Metabolic (CKM) syndrome—which is staged from 0 to 4—. This means that interconnected metabolic and blood pressure factors are present, suggesting active monitoring to protect your heart and kidneys over the long term.

### Cardiovascular-Kidney-Metabolic (CKM) Syndrome Score



### Cardiovascular-Kidney-Metabolic (CKM) Syndrome Description

The Cardiovascular-Kidney-Metabolic (CKM) syndrome is a clinical framework that recognizes the deep, overlapping connection between your heart, kidneys, and metabolic systems, which manage things like weight, blood sugar, and cholesterol. Now recognized as the new global epidemic, this syndrome affects approximately 90 percent of adults in the United States and between 85 percent and 88 percent of the population worldwide. In the past, conditions such as obesity, type 2 diabetes, chronic kidney disease, and cardiovascular conditions were viewed and treated as completely separate illnesses. Today, medical science understands them as a single, unified health spectrum, acknowledging that because these vital systems are constantly interacting, a shift or imbalance in one area can silently trigger a chain reaction that affects the others.

This syndrome typically develops gradually and silently over many years without causing any noticeable physical symptoms, often beginning in early stages with subtle indicators like abdominal weight gain, prediabetes, or mild blood pressure elevation. Over time, this continuous imbalance creates a persistent pro-inflammatory environment that places stress on blood vessels and vital organs, while also creating cellular conditions that increase the risk of developing cancer. Advanced preventive screenings are designed to intercept these risks early by identifying this silent cross-talk, capturing subclinical inflammation and minor changes in kidney filtration or metabolic function long before any single organ or system reaches a critical threshold.

Instead of looking at isolated laboratory numbers that only offer fragmented pieces of information, a comprehensive CKM assessment integrates your cardiovascular, renal, and metabolic markers into a single, unified health profile. This approach translates complex biomarker data into clear, actionable intelligence, giving you and the healthcare team a priceless window of opportunity. Ultimately, understanding your personal CKM profile empowers you to take proactive control of the health journey through early, targeted lifestyle and nutritional adjustments, effectively protecting vital organs and supporting long-term vitality.

## Health Score



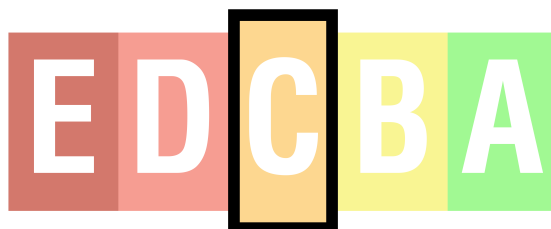
### Results

According to the laboratory results analyzed in this test, together with the personal and clinical information provided, your Health Score falls within category C.

This overall score is determined when at least one critical bodily system or function is evaluated at level C, or when there is a combination of several non-critical bodily systems at level C, D or E. Please refer to the summary in the Table of Contents to identify which specific category or categories are triggering this score. This indicates findings that require further assessment by a healthcare professional.

This score does not constitute a diagnosis on its own or determine the clinical severity of a specific disease.

### Health Score



### Health Score Description

Health Score is a qualitative indicator of health status that presents its result through a graphical representation based on a gradient of 5 colors corresponding to 5 quantitative levels (from left to right: E, D, C, B, and A), with level E being the worst and level A the best of all.

The final Health Score result is obtained from a mathematical algorithm developed by Blueberry Diagnostics that processes personal, clinical, and laboratory data into a global score. In this way, the bodily systems and functions classified as critical include: Iron Function; Cardiovascular System; Glucose Metabolism; Pancreatic Endocrine System; Hepatobiliary Function; and Renal Function (as well as Prostate Function in men in those tests that include it). The remaining sections are classified as non-critical (although specific scores such as a D or an E, resulting from potentially severe findings, carry greater weight in the final calculation).

Please refer to the summary in the Table of Contents to identify which specific category or categories are triggering this score. These findings require further assessment by a healthcare professional, but do not constitute a diagnosis on their own or determine clinical severity.

The basic premise of Health Score is that only what can be measured, can be managed and, consequently, improved through acting: Detect, Act, Live Longer.

## Longevity Score



### Results

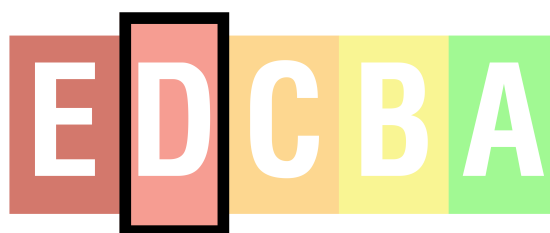
According to the laboratory tests analyzed in this assessment, your biological age estimated by the PhenoAge model—a biological aging public algorithm that estimates the functional age of your body based on nine standard blood biomarkers—is 50.3 years, compared to your chronological age of 54 years, and suggest biological aging in accordance with their chronological age, within the expected parameters.

On the other hand, your Oxidative Stress Score falls within a highly elevated category of the model. The biomarkers evaluated demonstrate a severe imbalance, indicating present and active cellular damage. The analyzed markers suggest that the antioxidant defense mechanisms of the body are critically compromised, failing to prevent oxidative degradation of vital cellular structures, including cell membranes and DNA. This physiological profile is correlated with a significant acceleration in biological aging parameters and an increased susceptibility to chronic pathologies, consistent with a severely reduced capacity for cellular recovery and repair.

Besides, your Longevity Score falls within a critical category of the model and suggests a significant reduction in physiological resilience within the parameters evaluated. The analyzed markers indicate active systemic wear that compromises functional reserves, reflecting an accelerated biological aging profile. The data show that the cellular repair mechanisms of the body are compromised, leading to progressive wear across major physiological systems. This state carries an elevated risk of functional impairment and correlates with markers of pathological aging, substantially weakening overall physiological resilience.

Finally, your Resilience Score is 38.33 percent, which falls within a critical category of the model and indicates a significant compromise in systemic resilience, where cellular repair mechanisms are insufficient to offset accumulated biological wear. At this level, an elevated Oxidative Stress Score indicates that the markers evaluated in the Longevity Score are severely compromised due to a reduction in the functional resistance of physiological systems and organs. This score suggests an elevated risk of functional decline when facing external stressors, reflecting a depletion of the physiological reserves required to maintain long-term homeostatic stability.

### Longevity Score



### Longevity Score Description

Unlike the Health Score—which represents a snapshot of your current health status—and the Oxidative Stress Score—which evaluates the balance between free radical production and the efficacy of the antioxidant systems of the body—the Longevity Score is a qualitative indicator of the state of your longevity—healthy life expectancy—that also shows its result through a graphical representation based on a gradient of 5 colors corresponding to 5 quantitative levels (from left to right, E, D, C, B and A), being the level E the worst and level A the best of all.

This score represents a metric of your biological resilience by detecting your damage burden. In this way, the Longevity Score identifies longevity thieves —mainly markers of metabolic stress and silent inflammation—, and award points according several rules, resulting in a total value. It is important to note that this result may diverge from the findings in other sections of this report, as they pursue distinct objectives and use reference values that differ from those used to detect current pathologies.

Besides, the true power of this score lies in its ability to assess the longevity shield. Unlike other scores, this one actively rewards strengths by reducing risk when, for example, vitamin D or magnesium levels, among others, are excellent —these analytes act as biological buffers that protect telomeres (the ends of DNA) and keep the immune system alert yet calm—. Having a high protective reserve means that, even in the face of external stressors, the body possesses the necessary infrastructure to neutralize them.

In summary, the Longevity Score can help you know exactly where to invest effort: whether in optimizing metabolism, calming inflammation, or strengthening natural defenses.

## Conclusions

The laboratory results reveal a level of oxidative stress that is closely linked to your cardiovascular health, liver function, and inflammatory response, manifesting proportionally to these variables. It could suggest that systemic inflammation is mediating direct damage to the heart and liver, resulting in a level of cellular stress.

On the other hand, the main factors that impact your longevity —reducing your Longevity Score— are related to your cardiometabolic, hepatic and inflammatory systems.

We suggest General Practitioner (GP) or, if possible, Longevity Practitioner consultation to help you reduce your oxidative stress that impacts in your Longevity Score. This could be achieved through a comprehensive strategy that may include personalized lifestyle interventions (functional nutrition and precision exercise), advanced pharmacology and geroprotective supplementation, and the metabolic and hormonal optimization necessary to preserve your long-term biological resilience.

## Summarized Results



### Iron Transport Function

Main hemogram related values are inside the reference range and do not suggest any red line or iron transport function disorder.

### Iron Storage Function

Although serum iron is within the reference range, slightly or moderately elevated ferritin levels may suggest a secondary underlying inflammatory condition related to overweight, non-alcoholic fatty liver disease (NAFLD), or metabolic syndrome (MetS).

### Immune Cells System

Main leukocytes related values are inside the reference range and do not suggest any immune system disorder.

### Platelet Function

Both Platelet Count and Mean Platelet Volume (MPV) levels are inside the reference range and do not suggest any platelet function disorder.

### Coagulation Function

Main coagulation and hemogram related values are inside the reference range and do not suggest any coagulation function disorder.

### Cardiometabolic System

According to the Adult Treatment Panel III (ATP-III) —defined by the National Cholesterol Education Program (NCEP)—, there is a low risk of Metabolic Syndrome (MS).

The anthropometric indicators —Body Mass Index (BMI) and Waist-Hip Ratio (WHR)—, the blood pressure —both systolic pressure as diastolic pressure—, the atherogenic indices —Triglycerides/Cholesterol HDL Index, Atherogenic Index of Plasma (AIP), Castelli Risk Index I (CRI-I), Castelli Risk Index II (CRI-II) and Atherogenic Coefficient (AC)—, suggest a moderate Cardiovascular Risk (CVR).

Otherwise, according to Framingham Risk Score (FRS) —a model based on a longitudinal study of more than 15,000 patients across several generations of residents from the city of Framingham (Massachusetts, US), spanning over 75 years to understand the progression of cardiovascular disease—, there is a moderate 10-year risk of developing a Coronary Heart Disease (CHD). Specifically, there is a risk of 10.60 percent for Myocardial Infarction (MI), Angina Pectoris (AP), Heart Failure (HF), and Cardiac Death (CD). Please note, the optimal Framingham Risk Score for a person like you, that is, same gender and same age, but without any of risk factors linked to CHD —smoker, hypertension (HT), high TC, low HDL-c, as well as high Glucose—, is 2.02 percent.

Moreover, the ApoB/ApoA1 Ratio does not increase the risk obtained by the Framingham Risk Score (FRS).

Regarding the Cardiovascular Risk (CVR) —a clinical tool based on accumulated epidemiological evidence obtained from your gender, age, Systolic Blood Pressure (SBP), Total Cholesterol (TC), High-Density Lipoprotein Cholesterol (HDL-c) and smoking habits—, suggest that you have a Vascular Age (VA) of 57 years (while your chronological age is 54 years), meaning you have the same risk as a 57 years old healthy man (instead of the one that would correspond to a healthy man of your age).

Additionally, your Endothelial Score —a multidimensional index that evaluates arterial wall integrity by

combining metabolic, inflammatory, and viscosity biomarkers with lifestyle factors to predict the risk of early vascular dysfunction—, suggests a low risk of endothelial damage. While your profile is generally stable, there are minor metabolic or anthropometric indicators that, if left unaddressed, could lead to early vascular aging in the long term.

Finally, Lipoprotein(a) is above the reference range and may act as a clinically relevant modifier of cardiovascular risk, particularly when other risk factors or a family history of premature cardiovascular disease is present.

Lipoprotein(a) has a strong genetic component, and its levels generally remain relatively stable throughout life. Unlike other lipid parameters, it is usually only minimally affected by lifestyle changes. Its clinical relevance should therefore be assessed together with the overall cardiovascular risk, family history and complete lipid profile of the patient.

## Glucose Metabolism

Glucose is outside the reference range and suggest hyperglycemia, possible prediabetes.

According to guidelines from leading health organizations, such as the American Diabetes Association (ADA), a prediabetes diagnosis is established when abnormal results are obtained in two separate tests.

In this regard, experts state that if a patient presents fasting glucose levels between 100 and 125 mg/dL in two different measurements —usually separated by an interval of one to two weeks—, the patient is confirmed to have prediabetes.

However, according to Diabetes Risk Calculator (DRC), there is a high 7.5-year risk of developing Type 2 Diabetes Mellitus (DM2). Specifically, there is a risk of 38.11 percent if at least one parent or sibling has Diabetes Mellitus (DM). However, if this is not the case, there is a risk of 27.57 percent.

## Pancreatic Endocrine Function

Although HOMA-IR is low, insulin levels suggest a a possible hypersensitivity to insulin, or the beginning of Beta-secretion claudication —it does not translate into a high hyperglycemia because Insulin Sensitivity (IS) is still quite good—.

## Thyroid Hypothalamic Pituitary Axis Function

Both Thyroid Stimulating Hormone (TSH) and T4 Free (T4F) are inside the reference range and do not suggest any thyroid function disorder.

## Parathyroid Function

Both calcium and parathyroid hormone (PTHi) are inside the reference range and do not suggest any parathyroid function disorder.

## Vitamin D Function

Vitamin D is below the reference range and suggest vitamin D insufficiency (possibly due to not enough vitamin D is obtained from the diet or there is not enough sun exposure).

It is important to note that vitamin D is a fat-soluble vitamin, so it is advisable to eat foods rich in vitamin D (such as salmon, tuna, sardines, mackerel, egg yolk, beef liver or whole dairy products, among others), along with healthy fats (such as avocado, olive oil, nuts or seeds, among others), to improve its absorption.

## Vitamin B12 Function



Vitamin B12 is inside the reference range and does not suggest any vitamin B12 insufficiency.

## Gastrointestinal Tract

Negative Helicobacter pylori IgG Antibody do not suggest any digestive tract disorder related to a H. pylori infection.

## Liver and Biliary Function

GGT is outside the reference range and could suggest an undetermined—but mild—, liver function disorder, probably related to alcohol intake.

Besides, according to Fatty Liver Index (FLI), Liver Fat Score (LFS), Hepatic Steatosis Index (HSI), K-NAFLD Score, NAFLD Logit Score and NAFLD Ridge Score, there is a high risk for Metabolic Dysfunction-Associated Fatty Liver Disease (MAFLD) and/or Non-Alcoholic Fatty Liver Disease (NAFLD).

Moreover, the NAFLD/NASH Indices evaluated do not identify an increased risk of Non-Alcoholic Steatohepatitis (NASH).

Furthermore, the NASH/Fibrosis Indices evaluated do not identify an increased risk of Non-Alcoholic Steatohepatitis (NASH) with fibrosis.

On the other hand, according Chronic Liver Disease (CLivD) Score, the estimated risk of developing Chronic Liver Disease (CLD) within the next 15 years is mild (2 percent). However, this may not be the case in the future—this percentage can be increased—, if you do not control your weight, since a high-calorie diet (fast food type foods or diets rich in refined carbohydrates—especially fructose, saturated fats and sugary drinks—), along with little physical activity leads to overweight and obesity, which are among the main risk factors of Metabolic Dysfunction-Associated Fatty Liver Disease (MAFLD) and/or Non-Alcoholic Fatty Liver Disease (NAFLD), which can lead to NASH and fibrosis.

## Pancreatic Exocrine Function

Main pancreatic enzymes are inside the reference range and do not suggest any pancreatic exocrine function disorder.

## Muscular System

Both Creatine kinase (CK) and LDH levels are inside the reference range and do not suggest any muscle damage.

CK is the most specific and sensitive indicator of acute muscle injury, while LDH rises more consistently, reflecting metabolic damage. Besides, LDH rises later than CK and remains detectable in the blood for a longer period.

## Renal Function

Both estimated Glomerular Filtration Rate (eGFR) as well as Albumin-to-Creatinine Ratio (ACR) do not suggest any renal function disorder (grade G1/A1).

Note: Estimated Glomerular Filtration Rate (eGFR) has been calculated using the CKD-EPI 2021 equation based on creatinine. Creatinine is a metabolic waste product generated by normal muscle breakdown and excreted by the kidneys. While it remains the standard first-line biomarker for assessing renal filtration, its serum levels are inherently tied to physical constitution. Consequently, factors such as high muscle mass, recent intensive training, or creatine supplementation can artificially lower the eGFR score, whereas low muscle mass or sarcopenia may overestimate kidney function.

Moreover, according to the Kidney Failure Risk Equation (KFRE), there is a very low 2-years risk of developing Renal Failure (RF). Specifically, there is a risk of 0.00 percent. Furthermore, the 5-years risk is 0.01.

### Hydroelectrolytic Metabolism

Some serum electrolytes are slightly outside the reference range and could suggest a very slight hydroelectrolytic metabolism disorder.

### Uric Acid Metabolism

Uric acid is inside the reference range and does not suggest neither hyperuricemia nor hypouricemia.

### Prostate Function

Main prostate specific antigens are inside the reference range and do not suggest any prostate function disorder.

Clinical Note: Although Total PSA and Free PSA levels may fall within reference ranges (even below 1 ng/mL) —which is an excellent indicator of prostate health that largely rules out the presence of malignancy—, as men age, particularly after 50, the prostate naturally tends to enlarge. In this way, since the prostate surrounds the urethra —the tube that carries urine out of the body—, this benign growth can mechanically compress the urinary tract. Therefore, if you notice difficulty starting to urinate, a weak urine stream, a flow that stops and starts several times, or a feeling of incomplete bladder emptying, it is highly likely that you are developing early-stage Benign Prostatic Hyperplasia (BPH), as these obstructive symptoms are classic signs of BPH. Because it is a structural issue, BPH can cause significant daily discomfort without elevating blood markers. Consequently, it is advisable to consult your General Practitioner (GP) for a physical evaluation or an ultrasound to measure the actual volume of your prostate.

### Inflammatory Response

Although main inflammatory-related analytes are inside the reference range and do not suggest any Chronic Inflammatory Disease (CID), some Acute-Phase Reactants (APR) —such as Erythrocyte Sedimentation Rate (ESR), C-Reactive Protein (CRP) or Ferritin—, are outside the reference range and could suggest a Chronic Inflammatory State (CIS), as well as a potential seronegative Rheumatoid Arthritis (RA), mainly if symptoms related to joint involvement are present.

### Sex Hormones Balance

The combined results obtained from E2-to-SHBG Ratio, E2-to-TT Ratio and Free Androgen Index (FAI), could suggest a mild risk for sex hormones imbalance, specifically, a mild increased —but balanced—, aromatization —the body converts an excessive amount of testosterone into estrogen (estradiol), but manages to maintain testosterone levels within normal ranges at the cost of very high androgen production—.

### Conclusions

We suggest consulting the doctor who ordered this test (or your general practitioner if you requested the test yourself).



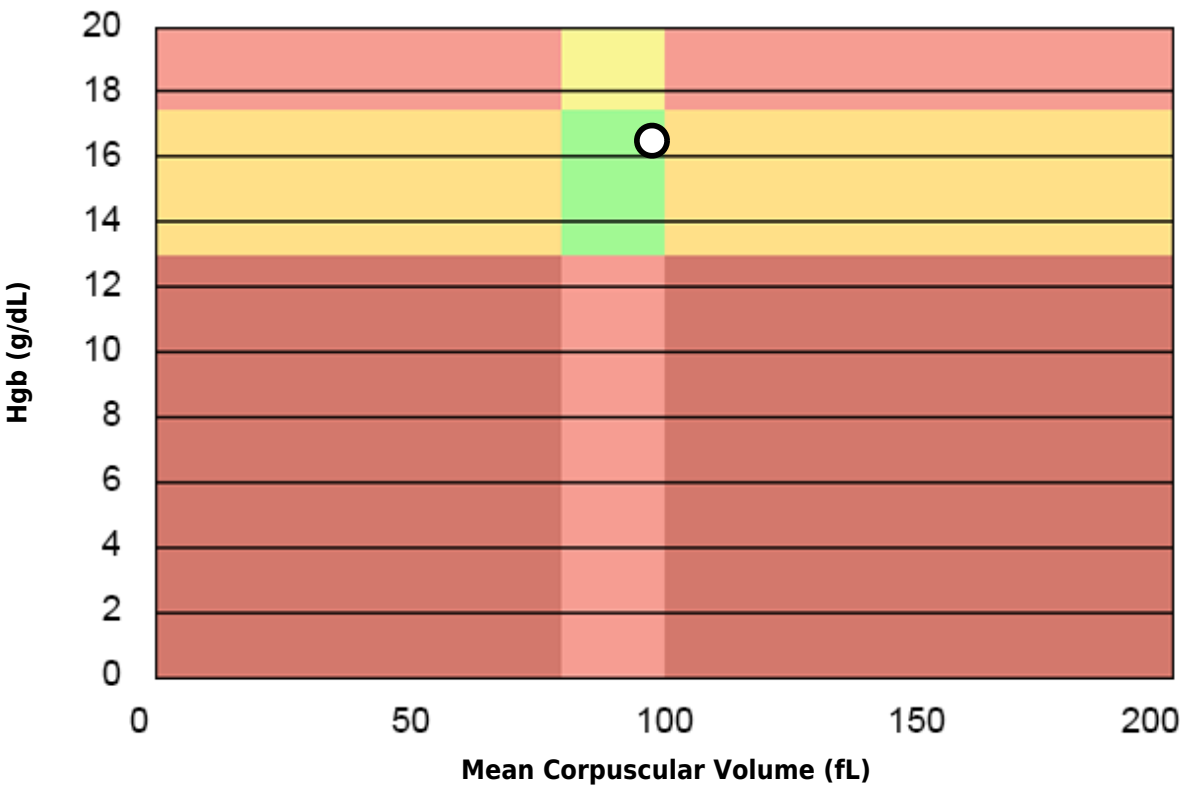
Iron Transport Function



Results

Main hemogram related values are inside the reference range and do not suggest any red line or iron transport function disorder.

Graphical Representation of the Results



Graph Description

The graphic for hematology (Red Line) shows a black dot corresponding your Mean Corpuscular Volume (MCV) —plotted on the X-axis— and hemoglobin —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border).

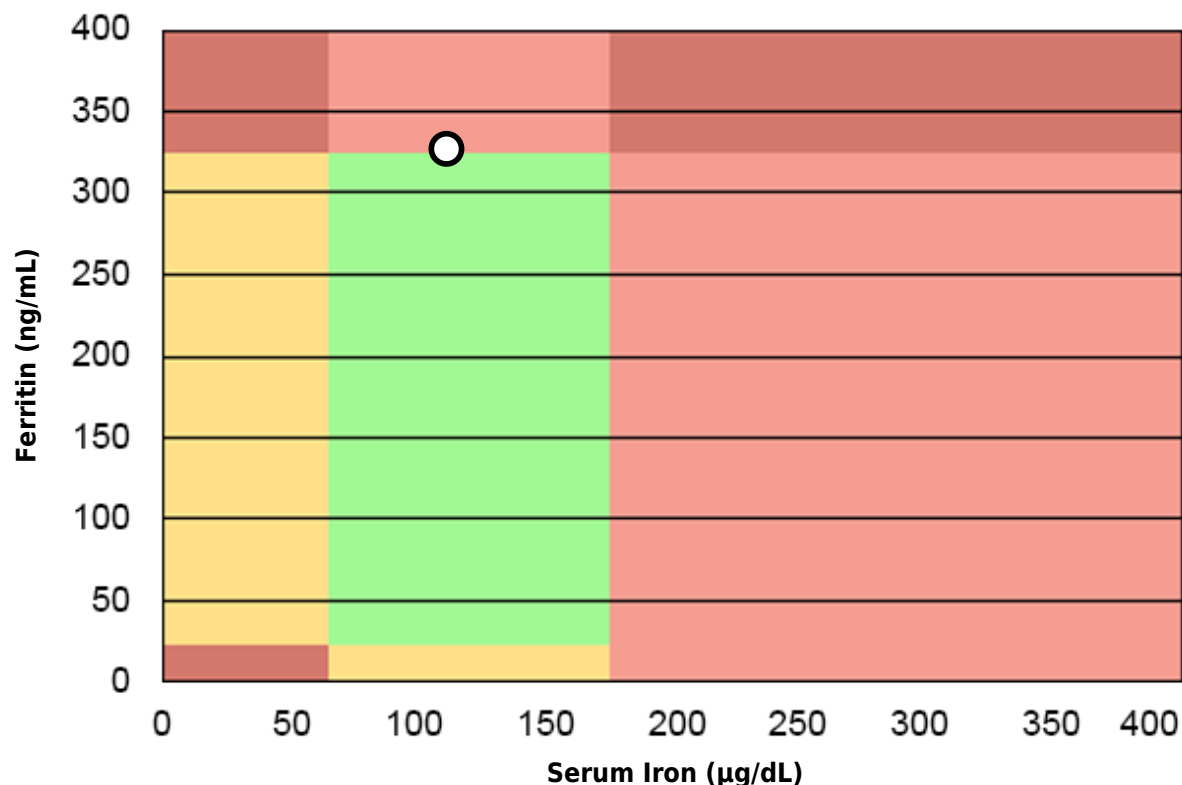
## Iron Storage Function



### Results

Although serum iron is within the reference range, slightly or moderately elevated ferritin levels may suggest a secondary underlying inflammatory condition related to overweight, non-alcoholic fatty liver disease (NAFLD), or metabolic syndrome (MetS).

### Graphical Representation of the Results



### Graph Description

The graphic for iron storage function shows a black dot corresponding your serum iron —plotted on the X-axis— and ferritin —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border).

### Conclusions

We suggest consulting the doctor who ordered this test (or your general practitioner if you requested the test yourself).

### Suggestions

In order to make the most of the doctor appointment, remember to make a list of all your symptoms, key medical information, family history and medications, vitamins or supplements you take.

## Immune Cells System

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### Results

Main leukocytes related values are inside the reference range and do not suggest any immune system disorder.

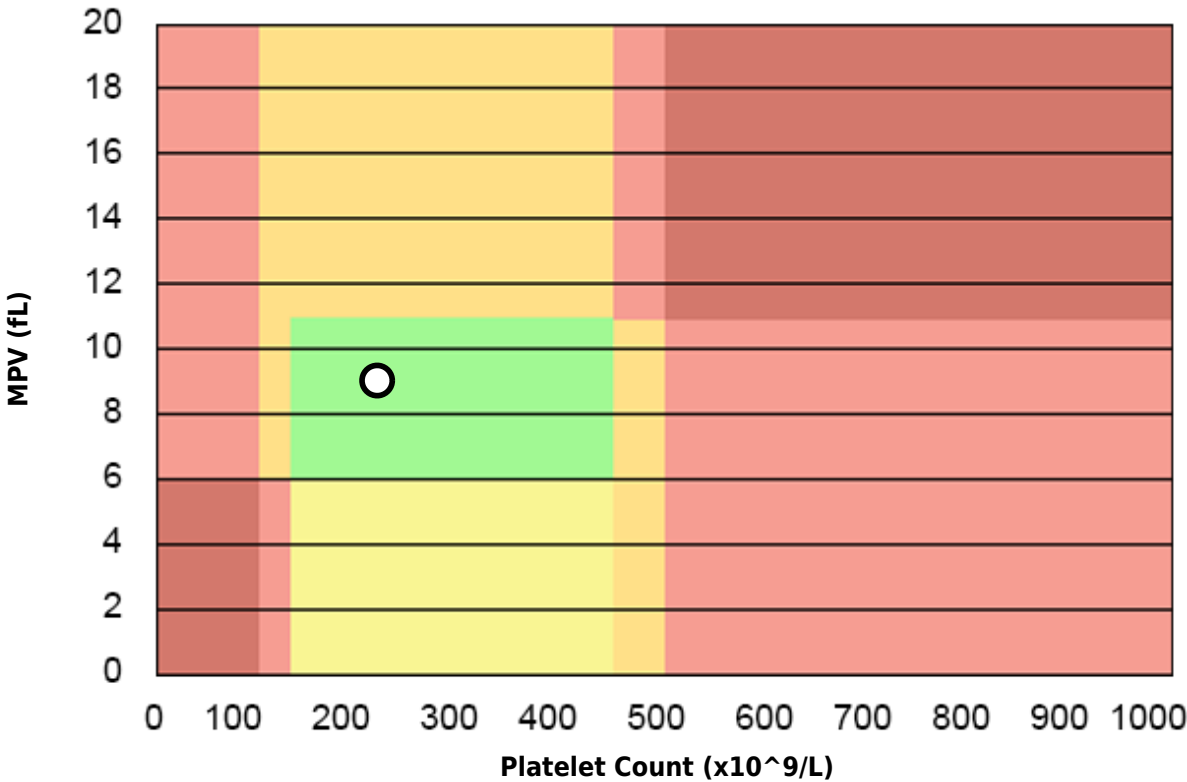
Platelet Function



Results

Both Platelet Count and Mean Platelet Volume (MPV) levels are inside the reference range and do not suggest any platelet function disorder.

Graphical Representation of the Results



Graph Description

The graphic for platelet function shows a black dot corresponding your platelet count —plotted on the X-axis— and Mean Platelet Volume (MPV) —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border).

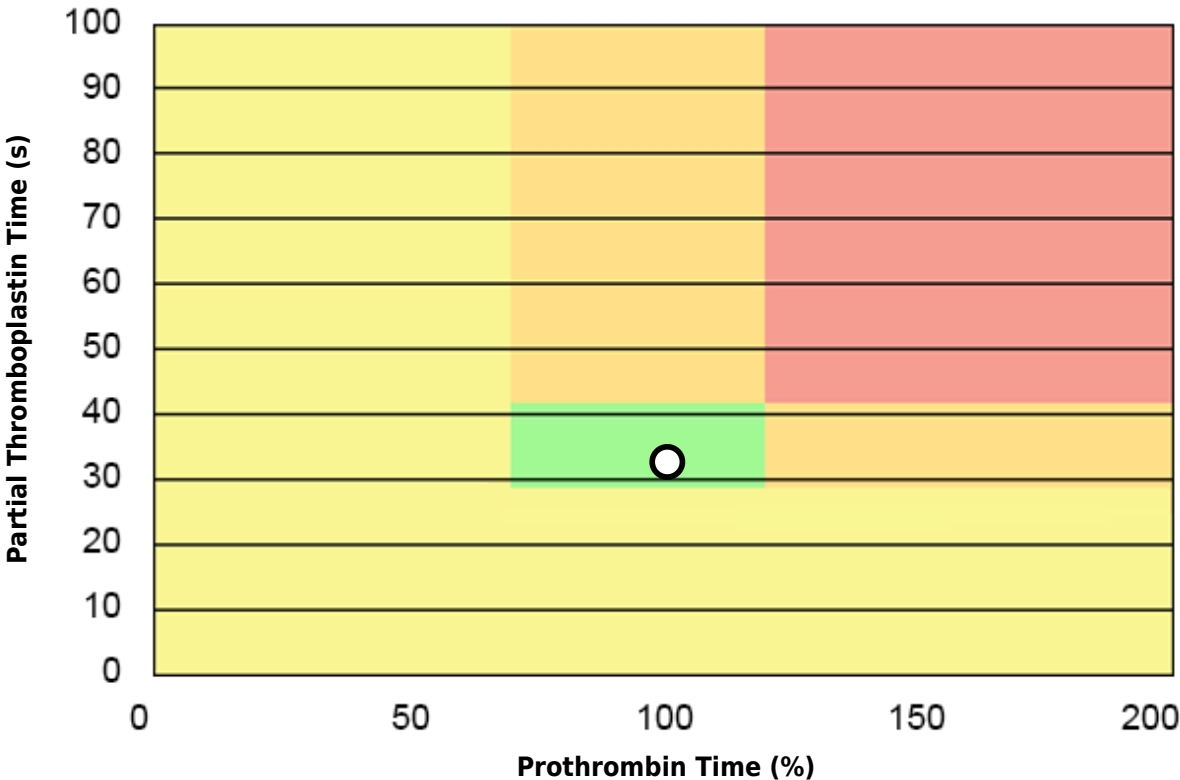
Coagulation Function



Results

Main coagulation and hemogram related values are inside the reference range and do not suggest any coagulation function disorder.

Graphical Representation of the Results



Graph Description

The graphic for coagulation function shows a black dot corresponding your Prothrombin Time (PT) —plotted on the X-axis— and Partial Thromboplastin Time (PTT) —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border).

**Cardiometabolic System****Results**

According to the Adult Treatment Panel III (ATP-III) —defined by the National Cholesterol Education Program (NCEP)—, there is a low risk of Metabolic Syndrome (MS).

The anthropometric indicators —Body Mass Index (BMI) and Waist-Hip Ratio (WHR)—, the blood pressure —both systolic pressure as diastolic pressure—, the atherogenic indices —Triglycerides/Cholesterol HDL Index, Atherogenic Index of Plasma (AIP), Castelli Risk Index I (CRI-I), Castelli Risk Index II (CRI-II) and Atherogenic Coefficient (AC)—, suggest a moderate Cardiovascular Risk (CVR).

Otherwise, according to Framingham Risk Score (FRS) —a model based on a longitudinal study of more than 15,000 patients across several generations of residents from the city of Framingham (Massachusetts, US), spanning over 75 years to understand the progression of cardiovascular disease—, there is a moderate 10-year risk of developing a Coronary Heart Disease (CHD). Specifically, there is a risk of 10.60 percent for Myocardial Infarction (MI), Angina Pectoris (AP), Heart Failure (HF), and Cardiac Death (CD). Please note, the optimal Framingham Risk Score for a person like you, that is, same gender and same age, but without any of risk factors linked to CHD —smoker, hypertension (HT), high TC, low HDL-c, as well as high Glucose—, is 2.02 percent.

Moreover, the ApoB/ApoA1 Ratio does not increase the risk obtained by the Framingham Risk Score (FRS).

Regarding the Cardiovascular Risk (CVR) —a clinical tool based on accumulated epidemiological evidence obtained from your gender, age, Systolic Blood Pressure (SBP), Total Cholesterol (TC), High-Density Lipoprotein Cholesterol (HDL-c) and smoking habits—, suggest that you have a Vascular Age (VA) of 57 years (while your chronological age is 54 years), meaning you have the same risk as a 57 years old healthy man (instead of the one that would correspond to a healthy man of your age).

Additionally, your Endothelial Score —a multidimensional index that evaluates arterial wall integrity by combining metabolic, inflammatory, and viscosity biomarkers with lifestyle factors to predict the risk of early vascular dysfunction—, suggests a low risk of endothelial damage. While your profile is generally stable, there are minor metabolic or anthropometric indicators that, if left unaddressed, could lead to early vascular aging in the long term.

Finally, Lipoprotein(a) is above the reference range and may act as a clinically relevant modifier of cardiovascular risk, particularly when other risk factors or a family history of premature cardiovascular disease is present.

Lipoprotein(a) has a strong genetic component, and its levels generally remain relatively stable throughout life. Unlike other lipid parameters, it is usually only minimally affected by lifestyle changes. Its clinical relevance should therefore be assessed together with the overall cardiovascular risk, family history and complete lipid profile of the patient.

**Conclusions**

We suggest consulting the doctor who ordered this test (or your general practitioner if you requested the test yourself), in order to control your blood pressure, as well as to get advice on good eating and healthy lifestyle habits, as the best prevention against cardiovascular disorders.

**Suggestions**

In order to make the most of the doctor appointment, remember to make a list of all your symptoms,





key medical information, family history and medications, vitamins or supplements you take.

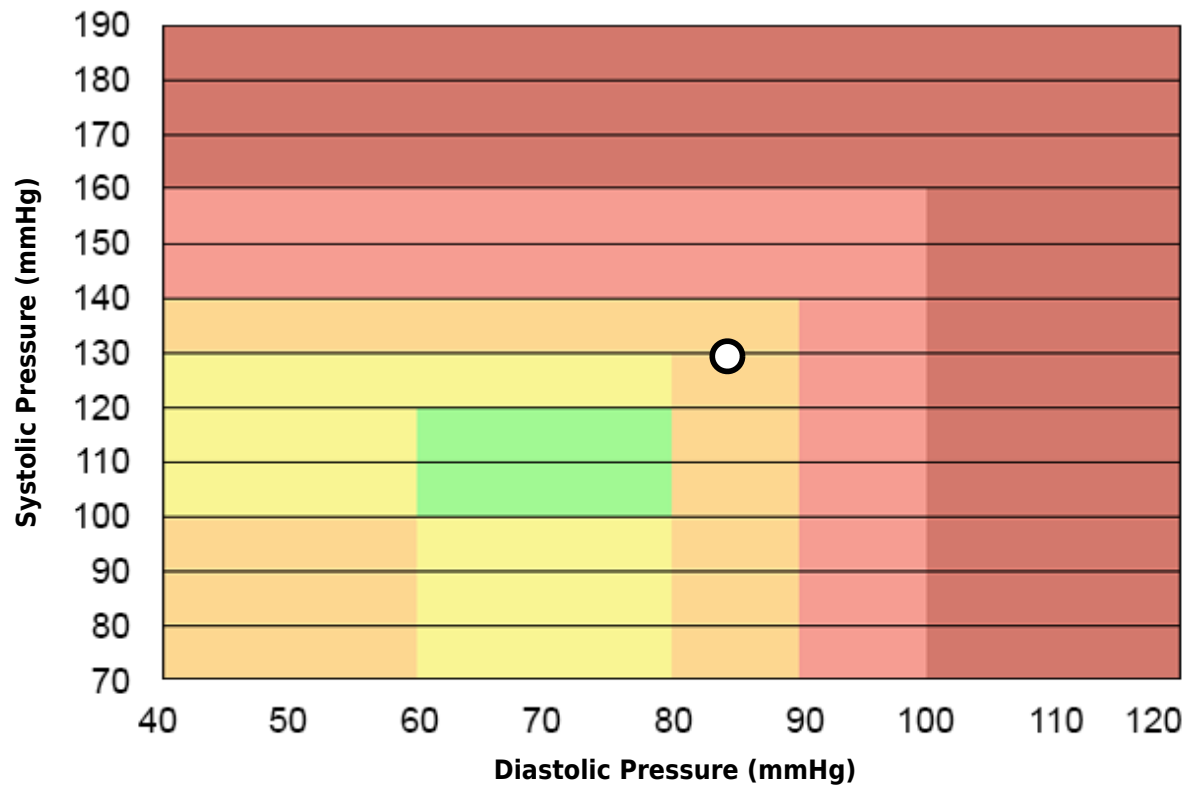
Blood Pressure



Results

Both systolic and diastolic values suggest elevated blood pressure.

Graphical Representation of the Results



Graph Description

The graphic for blood pressure shows a black dot corresponding your diastolic pressure —plotted on the X-axis— and systolic pressure —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border).

Conclusions

We suggest consulting the doctor who ordered this test (or your general practitioner if you requested the test yourself).

Suggestions

In order to make the most of the doctor appointment, remember to make a list of all your symptoms, key medical information, family history and medications, vitamins or supplements you take.

## Anthropometric Indicators



### Results

Some anthropometric indicators are outside the reference range and could suggest a mild-moderate metabolic disorder (specifically, overweight with mild increased abdominal fat).

In this way, according to the Hodgdon & Beckett Formula related to Body Fat (BF) percentage, you have 24.44 percent of BF, when ideally —according to the Jackson-Pollack method for evaluating body fat percentage carried out in the late 1970s— you should be 18.90 percent. This means that, according to your weight (83.50 kg), you have 20.41 kg of fat mass and 63.09 kg of lean mass, so you should lose 4.63 kg of body fat.

### Conclusions

We suggest consulting the doctor who ordered this test (or your general practitioner if you requested the test yourself), in order to get advice on good eating and healthy lifestyle habits, as the best prevention against several disorders related to overweight with mild increased abdominal fat.

### Suggestions

In order to make the most of the doctor appointment, remember to make a list of all your symptoms, key medical information, family history and medications, vitamins or supplements you take.

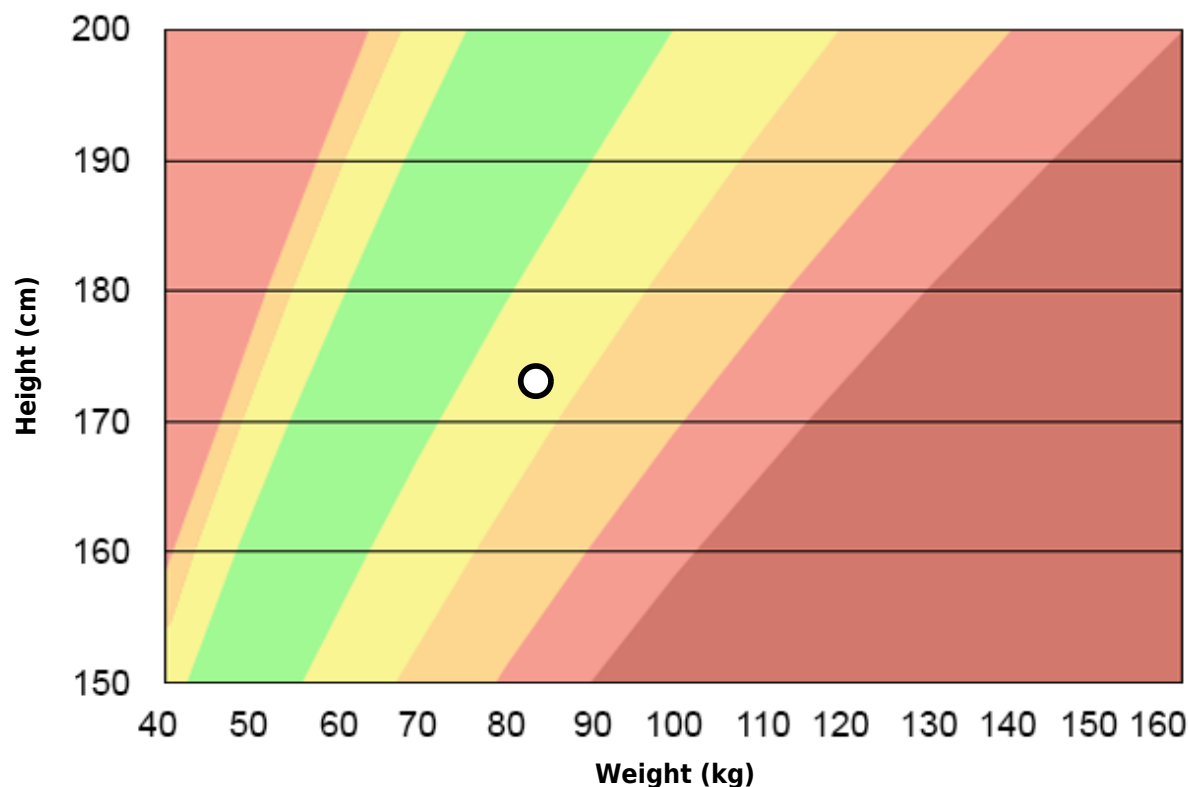
## Body Mass Index (BMI)



### Results

According to height and weight, the Body Mass Index (BMI) obtained means overweight (pre-obesity).

### Graphical Representation of the Results



### Graph Description

The graphic for Body Mass Index (BMI) shows a black dot corresponding your weight —plotted on the X-axis— and height —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border). BMI has been calculated according to the 2013 AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults (A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society/BMI classification/World Health Organization) formula.

NOTE: BMI DOES NOT CONSIDER INDIVIDUAL FACTORS, SUCH AS BONE OR MUSCLE MASS, SO IT MAY INACCURATELY CATEGORIZE PEOPLE WITH HIGH MUSCLE MASS, ATHLETES, OR ELDERLY PEOPLE AS OVERWEIGHT OR UNDERWEIGHT. FOR THIS REASON, THE WAIST-TO-HIP RATIO (WHR) AND WAIST-TO-HEIGHT RATIO (WTHR) INDICES WERE SUBSEQUENTLY DEVELOPED —WHICH ARE ON THE FOLLOWING PAGES—, TO PROVIDE MORE PRECISE TOOLS FOR THESE CASES.

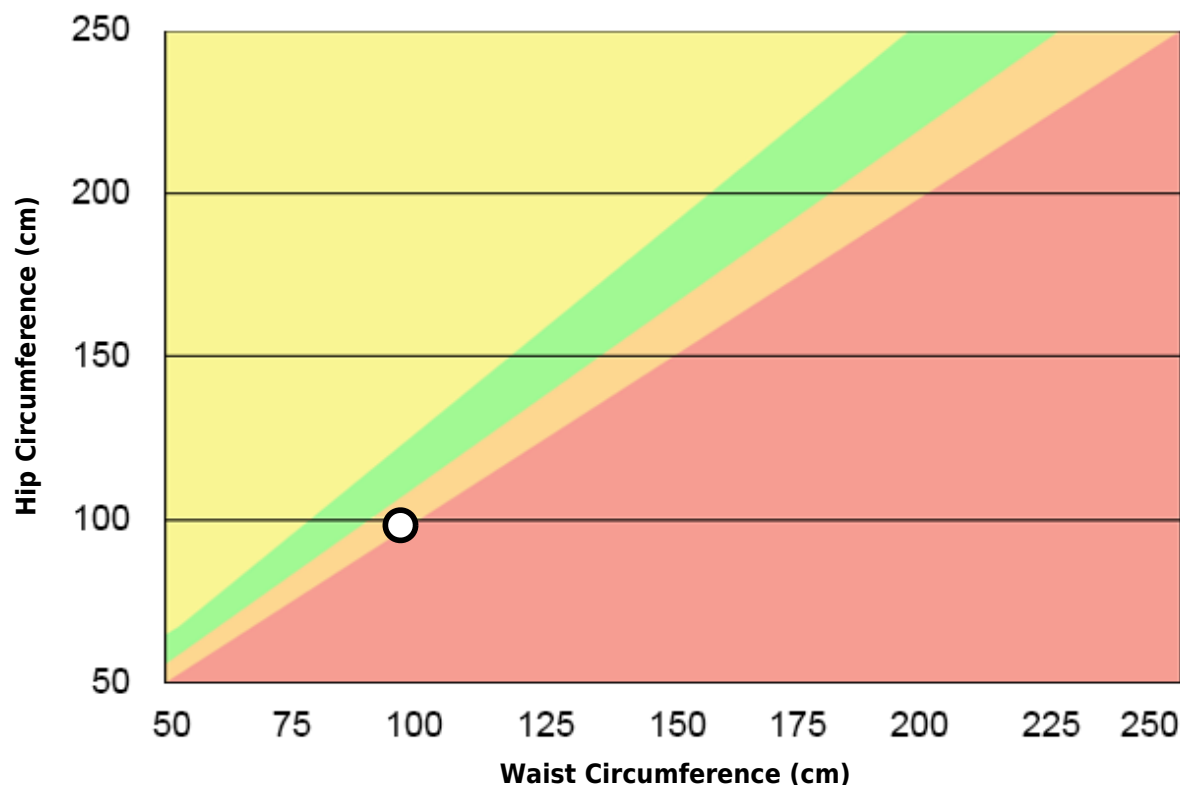
## Waist-to-Hip Ratio (WHR)



### Results

According to waist and hip circumferences, the Waist-Hip Ratio (WHR) obtained means mild increased abdominal fat.

### Graphical Representation of the Results



### Graph Description

The graphic for Waist-Hip Ratio (WHR) shows a black dot corresponding your waist —plotted on the X-axis— and hip —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border). WHR has been calculated according to the World Health Organization (WHO) formula —that states that abdominal obesity is defined as a WHR above 0.90 for males and above 0.85 for females—.



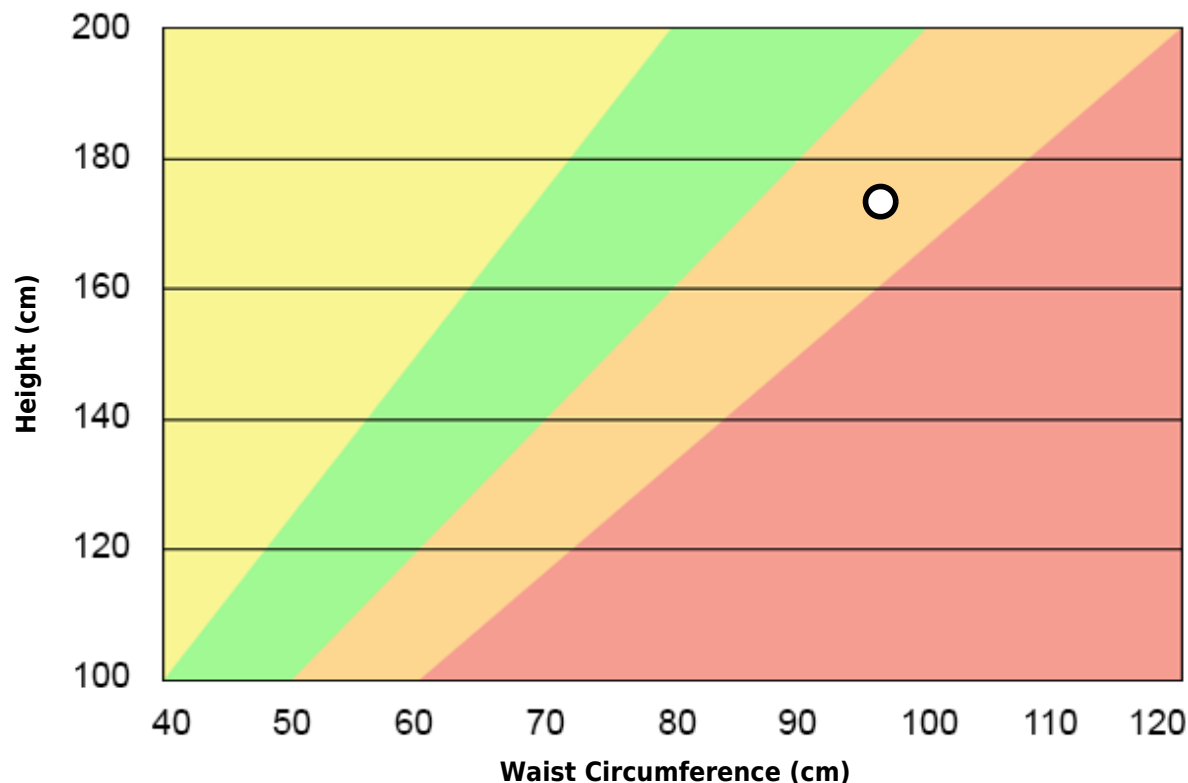
Waist-to-Height Ratio (WtHR)



Results

According to waist and height, the Waist-to-Height Ratio (WtHR) obtained means mild increased abdominal fat.

Graphical Representation of the Results



Graph Description

The graphic for Waist-to-Height Ratio (WtHR) shows a black dot corresponding your waist —plotted on the X-axis— and height —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border). WtHR has been calculated according to the 'Ashwell® Shape Chart based on waist-to-height ratio', developed by Margaret Ashwell in the 1990s, as a tool to assess an individual's risk of developing health problems related to obesity, particularly those linked to abdominal fat.

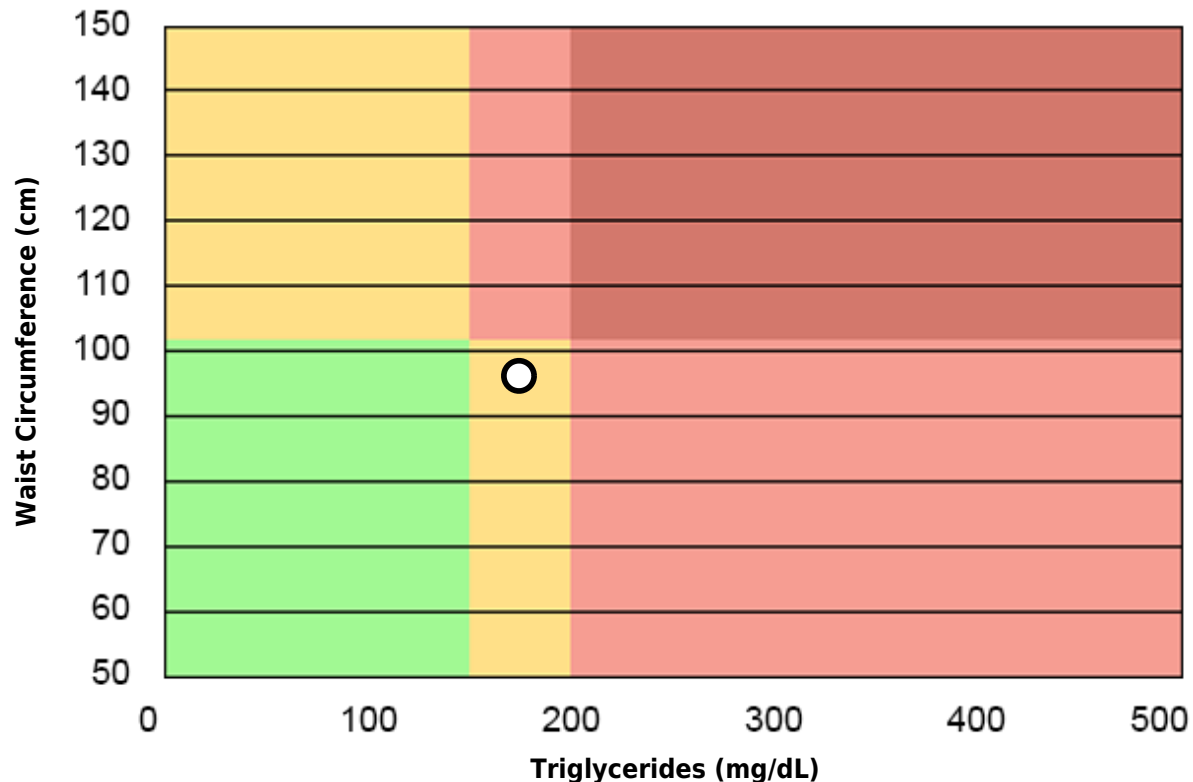
Hypertriglyceridemic Waist (HW)



Results

According to waist circumference and Triglycerides (TG) levels, there is Normal Waist with Elevated Triglycerides (NWET).

Graphical Representation of the Results



Graph Description

The graphic for Hypertriglyceridemic Waist (HW) shows a black dot corresponding your Triglycerides (TG) —plotted on the X-axis— and waist —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border). HW has been calculated according to the EPIC-Norfolk study —a population-based study involving 25.668 men and women aged 45-79 years in Norfolk, United Kingdom—.

## Atherogenic Indices



### Results

Some atherogenic indices are outside the reference range and could suggest a mild-moderate atherogenic disorder. Please review next pages for more details.





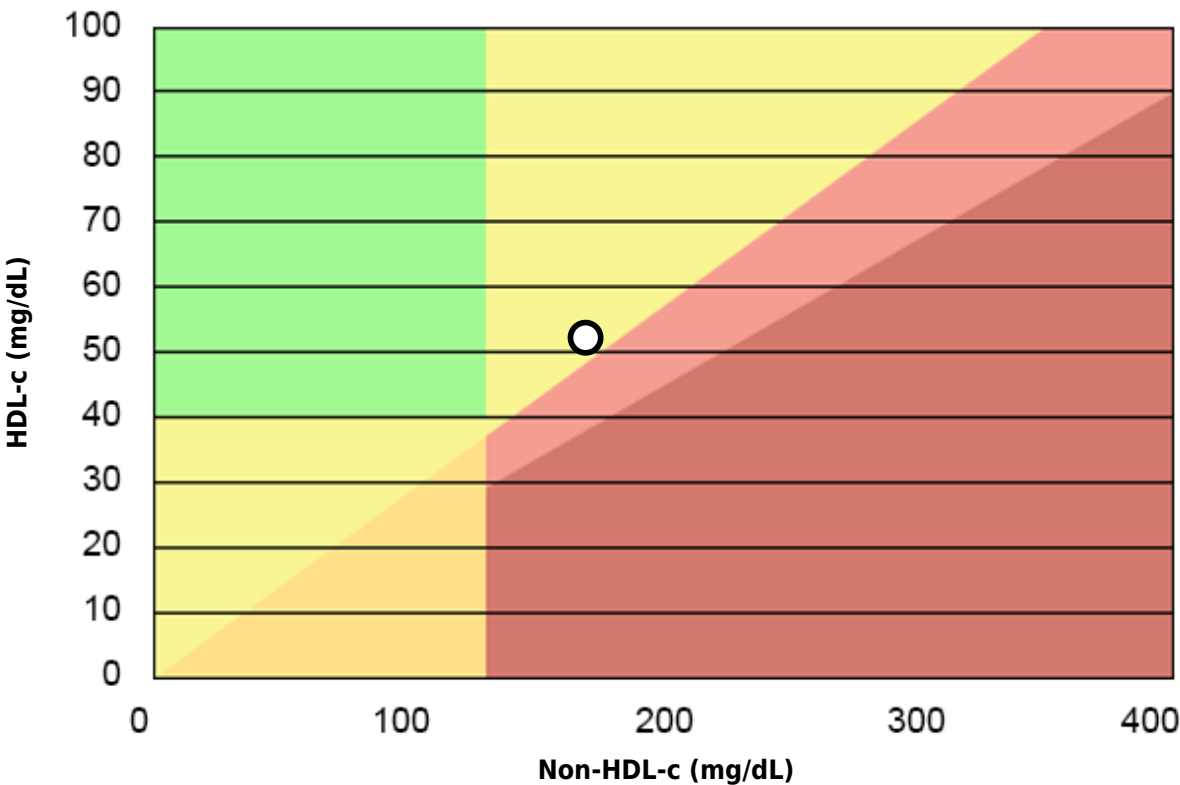
Atherogenic Indices (AC)



Results

According to Atherogenic Coefficient (AC), the estimated atherogenic risk is low.

Graphical Representation of the Results



Graph Description

The graphic for Atherogenic Coefficient (AC) shows a black dot corresponding your Non-High-Density Lipoprotein Cholesterol (non-HDL-c) —plotted on the X-axis— and High-Density Lipoprotein Cholesterol (HDL-c) —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border). The AC has been calculated according to the equation stated by Dobiášová M et al. in 2000.



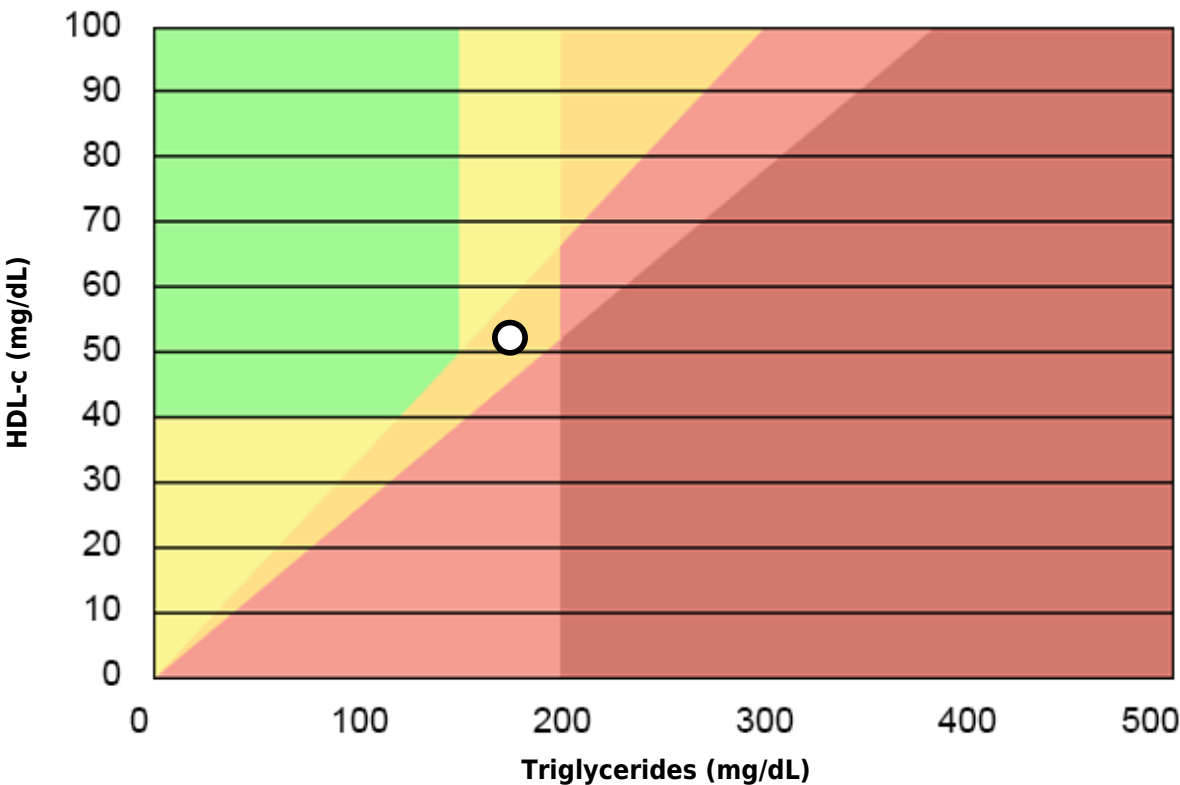
Atherogenic Indices (AIP)



Results

According to Atherogenic Index of Plasma (AIP), there is a moderate risk of an atherogenic disease.

Graphical Representation of the Results



Graph Description

The graphic for Atherogenic Index of Plasma (AIP) shows a black dot corresponding your Triglycerides (TG) —plotted on the X-axis— and High-Density Lipoprotein Cholesterol (HDL-c) —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border). The AIP has been calculated according to the ecuation stated by Dobiášová M et al. in 2001.

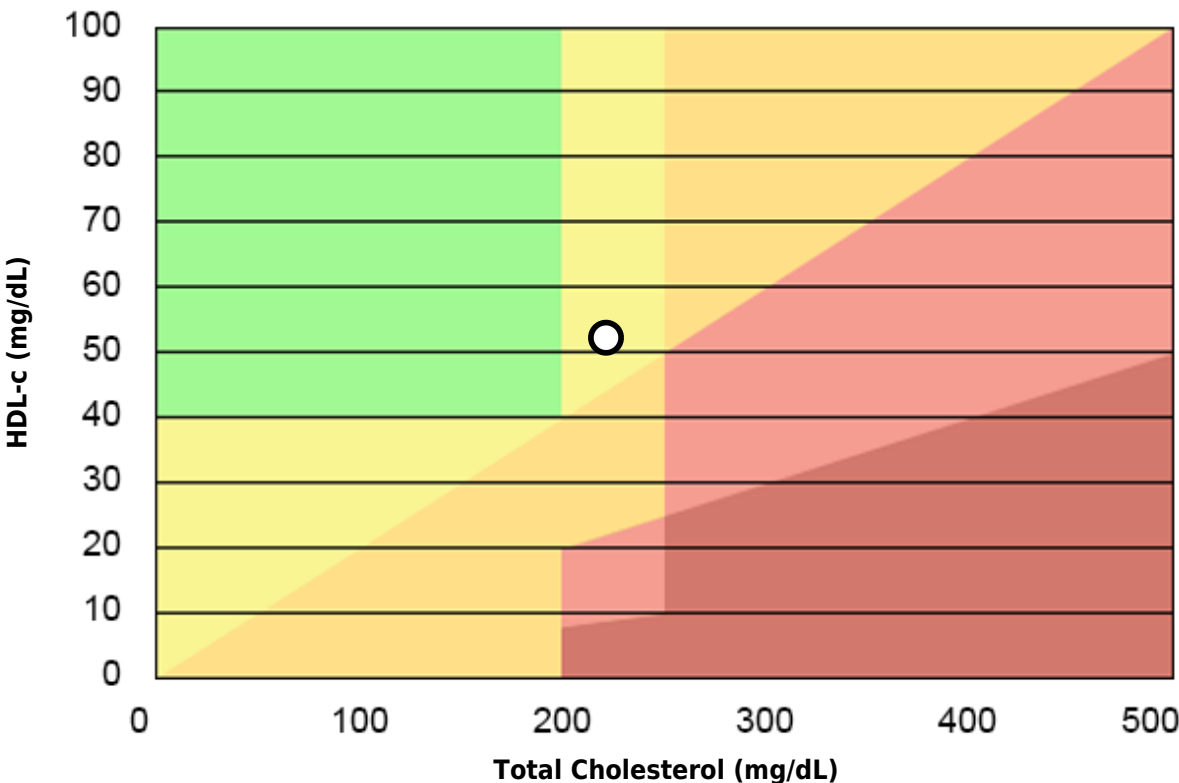
Atherogenic Indices (CRI-I)



Results

According to Castelli Risk Index I (CRI-I), the estimated atherogenic risk is low.

Graphical Representation of the Results



Graph Description

The graphic for Castelli Risk Index - I (CRI-I) shows a black dot corresponding your Total Cholesterol (TC) —plotted on the X-axis— and High-Density Lipoprotein Cholesterol (HDL-c) —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border). The CRI-I has been calculated according to the equation stated by Castelli WP et al. in 1983.

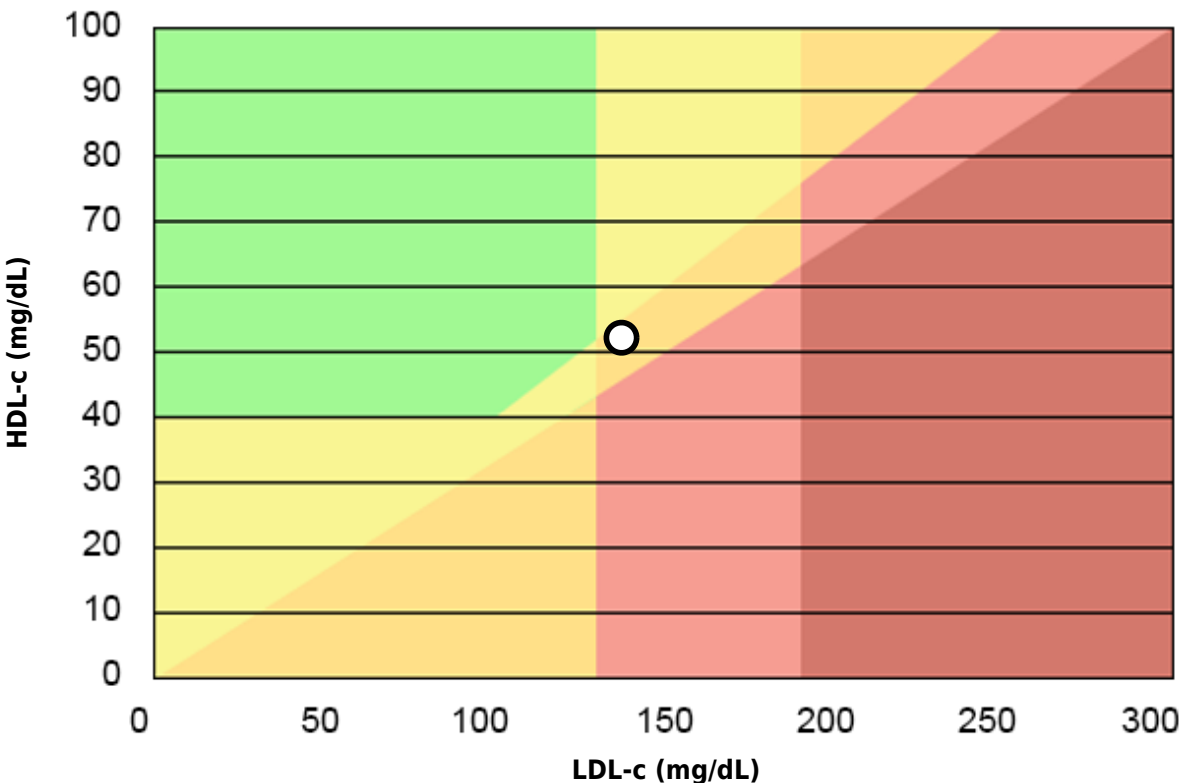
Atherogenic Indices (CRI-II)



Results

According to Castelli Risk Index II (CRI-II), there is a moderate risk of an atherogenic disease.

Graphical Representation of the Results



Graph Description

The graphic for Castelli Risk Index - II (CRI-II) shows a black dot corresponding your Low-Density Lipoprotein Cholesterol (LDL-c) —plotted on the X-axis— and High-Density Lipoprotein Cholesterol (HDL-c) —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border). The CRI-II has been calculated according to the equation stated by Castelli WP et al. in 1983.



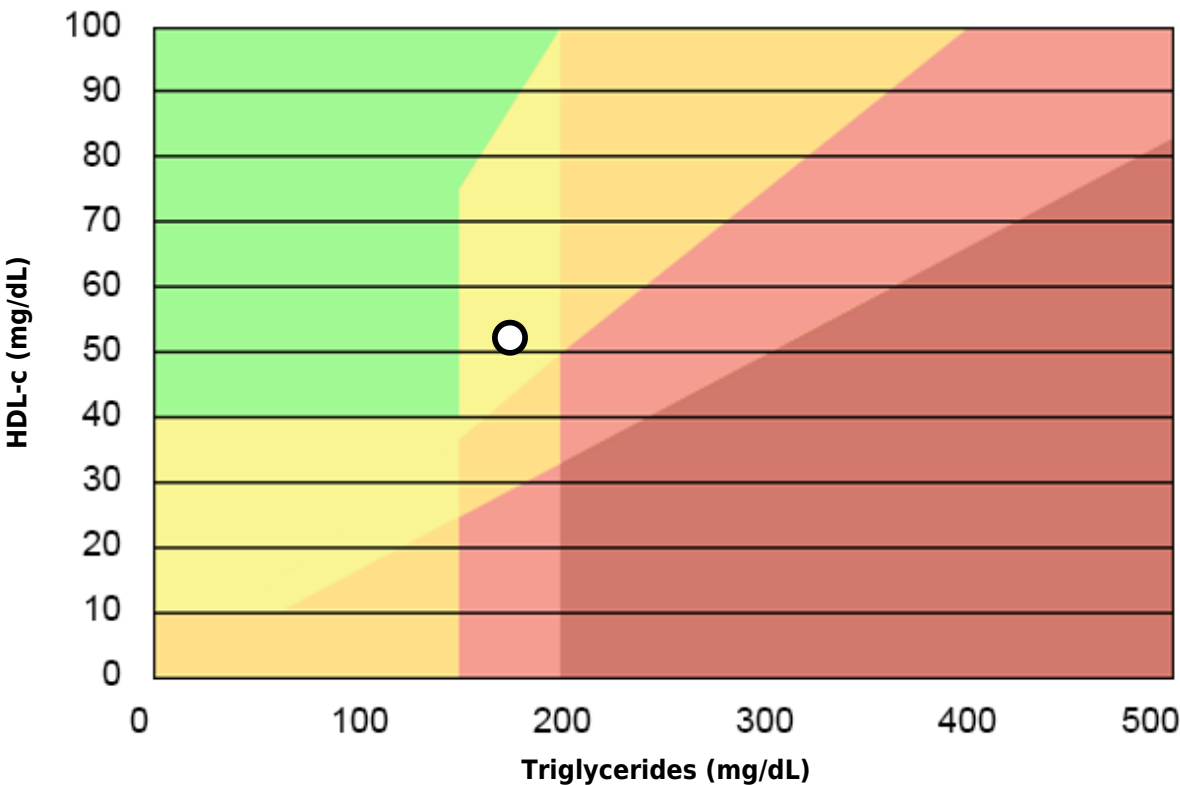
Atherogenic Indices (TG/HDL-c Index)



Results

According to Triglycerides/HDL Cholesterol (HDL-c) Index, the estimated atherogenic risk is very low.

Graphical Representation of the Results



Graph Description

The graphic for Triglycerides/Cholesterol HDL Index shows a black dot corresponding your Triglycerides (TG) —plotted on the X-axis— and High-Density Lipoprotein Cholesterol (HDL-c) —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border). The Triglycerides/Cholesterol HDL Index has been calculated according to the equation stated by Gaziano JM et al. in 1997.

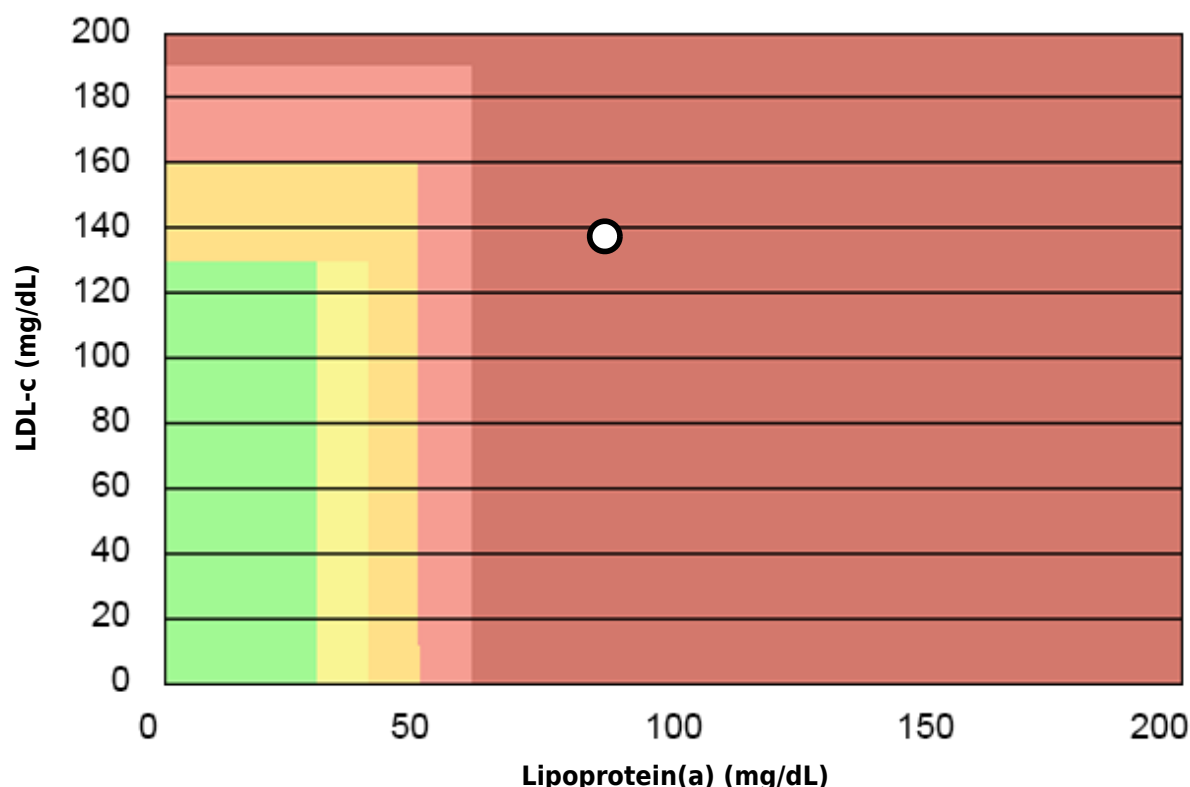
**Atherogenic Indices (Lipoprotein(a)/LDL-c Index)**



**Results**

Low-Density Lipoprotein Cholesterol (LDL-C) is outside the reference range and, Lipoprotein(a) levels indicate a potentially relevant increase in cardiovascular risk that should be interpreted together with the overall risk profile of the patient. Elevated Lipoprotein(a) is one of the main hereditary dyslipidemias associated with early-onset coronary events —particularly in younger individuals—.

**Graphical Representation of the Results**



**Graph Description**

The graphic for Lipoprotein(a)-to-Low-Density Lipoprotein Cholesterol shows a black dot corresponding your Lipoprotein(a) —plotted on the X-axis— and Low-Density Lipoprotein Cholesterol (LDL-c) —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border).

**Conclusions**

We suggest consulting the doctor who ordered this test (or your general practitioner if you requested the test yourself), in order to get advice on healthy lifestyle habits to manage overall cardiovascular risk, as well as to evaluate the convenience of genetic testing of the LPA gene to confirm an inherited elevation of Lipoprotein(a) and consider screening close family members.

**Suggestions**

In order to make the most of the doctor appointment, remember to make a list of all your symptoms, key medical information, family history and medications, vitamins or supplements you take.

## Glucose Metabolism



### Results

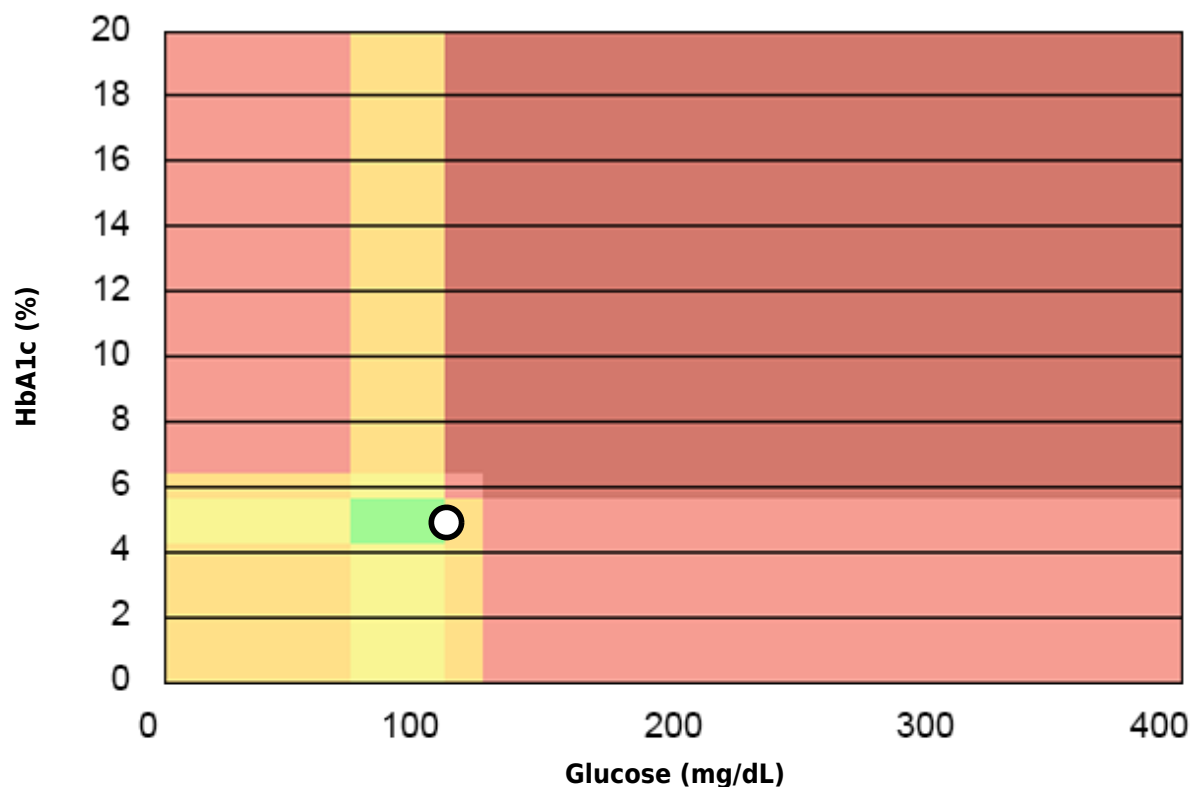
Glucose is outside the reference range and suggest hyperglycemia, possible prediabetes.

According to guidelines from leading health organizations, such as the American Diabetes Association (ADA), a prediabetes diagnosis is established when abnormal results are obtained in two separate tests.

In this regard, experts state that if a patient presents fasting glucose levels between 100 and 125 mg/dL in two different measurements —usually separated by an interval of one to two weeks—, the patient is confirmed to have prediabetes.

However, according to Diabetes Risk Calculator (DRC), there is a high 7.5-year risk of developing Type 2 Diabetes Mellitus (DM2). Specifically, there is a risk of 38.11 percent if at least one parent or sibling has Diabetes Mellitus (DM). However, if this is not the case, there is a risk of 27.57 percent.

### Graphical Representation of the Results



### Graph Description

The graphic for glucose metabolism function shows a black dot corresponding your levels of glucose —plotted on the X-axis— and glycated hemoglobin (Hb1Ac) —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border).

### Conclusions

If you notice any of following signs or symptoms (frequent urination, increased thirst, blurred vision,



fatigue and/or headache), and are overweight or obese or have a family history of Diabetes, you should schedule an appointment with your General Practitioner (GP) to be screened. Please note microvascular complications of Diabetes can occur prior to diagnosis, so the sooner you receive treatment, the better.

## Suggestions

In order to make the most of the doctor appointment, remember to make a list of all your symptoms, key medical information, family history and medications, vitamins or supplements you take.



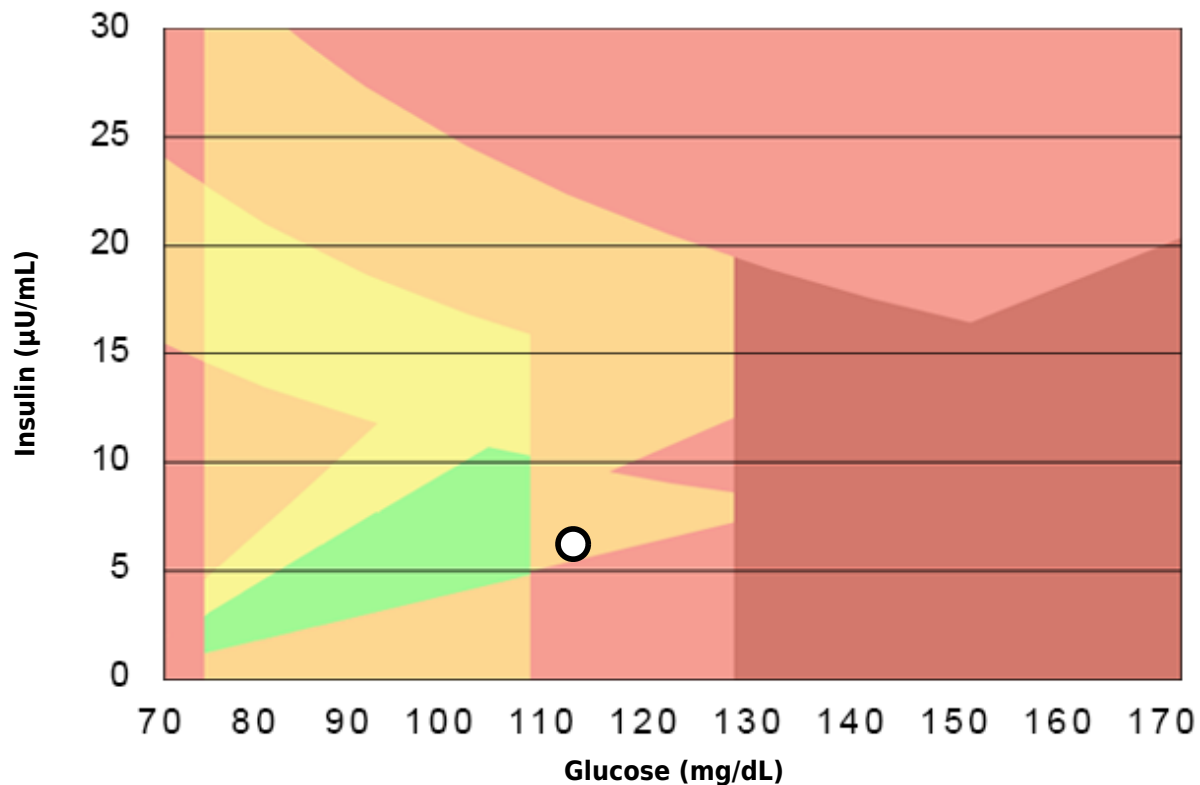
## Pancreatic Endocrine Function



### Results

Although HOMA-IR is low, insulin levels suggest a a possible hypersensitivity to insulin, or the beginning of Beta-secretion claudication —it does not translate into a high hyperglycemia because Insulin Sensitivity (IS) is still quite good—.

### Graphical Representation of the Results



### Graph Description

The graphic for HOMA-IR Index shows a black dot corresponding your levels of glucose —plotted on the X-axis— and insulin —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border).

### Conclusions

We suggest consulting the doctor who ordered this test (or your general practitioner if you requested the test yourself), in order to get advice on good eating and healthy lifestyle habits, as the best prevention against Type 2 Diabetes Mellitus (DM2).

### Suggestions

In order to make the most of the doctor appointment, remember to make a list of all your symptoms, key medical information, family history and medications, vitamins or supplements you take.

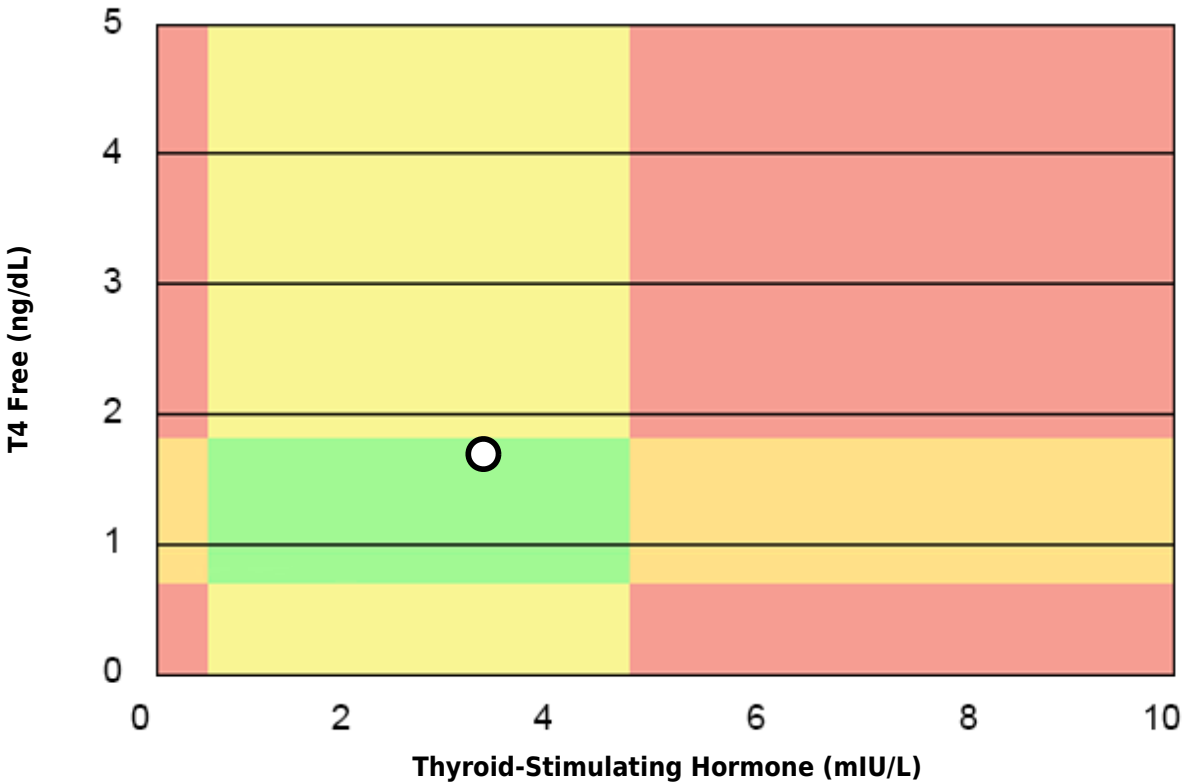
Thyroid Function and Hypothalamic-Pituitary Axis



Results

Both Thyroid Stimulating Hormone (TSH) and T4 Free (T4F) are inside the reference range and do not suggest any thyroid function disorder.

Graphical Representation of the Results



Graph Description

The graphic for thyroid function shows a black dot corresponding your Thyroid Stimulating Hormone (TSH) —plotted on the X-axis— and Thyroid T4 Free Hormone (T4 Free) —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border).

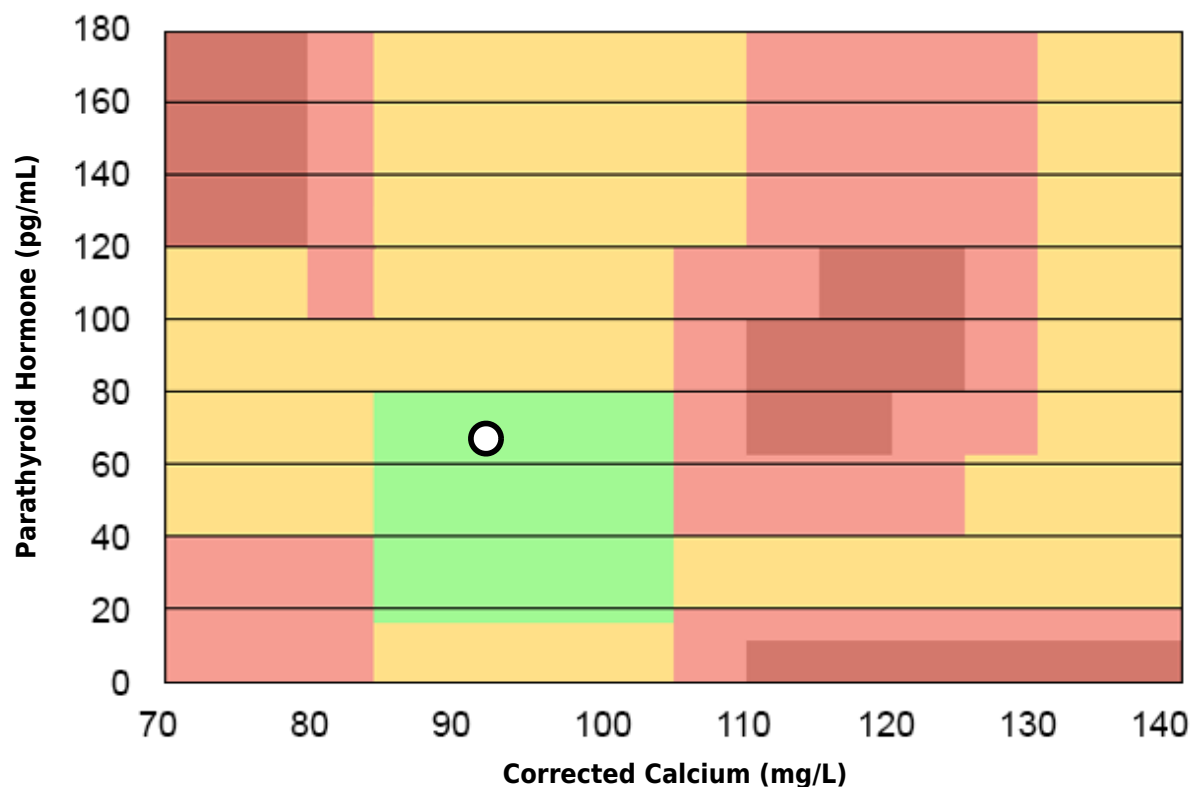
## Parathyroid Function



### Results

Both calcium and parathyroid hormone (PTHi) are inside the reference range and do not suggest any parathyroid function disorder.

### Graphical Representation of the Results



### Graph Description

The graphic for parathyroid function shows a black dot corresponding your albumin-corrected calcium —plotted on the X-axis— and intact Parathyroid Hormone (PTHi) —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border).

## Vitamin D Function

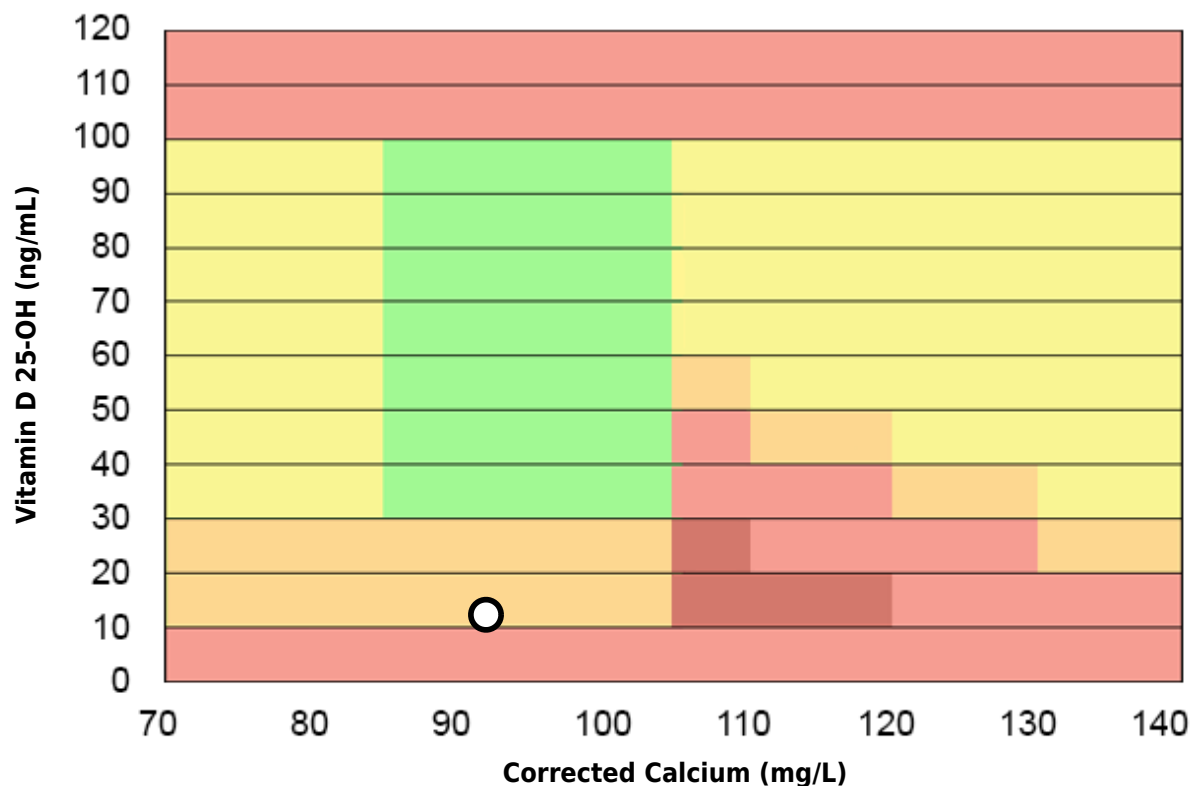


### Results

Vitamin D is below the reference range and suggest vitamin D insufficiency (possibly due to not enough vitamin D is obtained from the diet or there is not enough sun exposure).

It is important to note that vitamin D is a fat-soluble vitamin, so it is advisable to eat foods rich in vitamin D (such as salmon, tuna, sardines, mackerel, egg yolk, beef liver or whole dairy products, among others), along with healthy fats (such as avocado, olive oil, nuts or seeds, among others), to improve its absorption.

### Graphical Representation of the Results



### Graph Description

The graphic for vitamin D function shows a black dot corresponding your albumin-corrected calcium —plotted on the X-axis— and vitamin D 25-OH —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border).

### Conclusions

We suggest consulting the doctor who ordered this test (or your general practitioner if you requested the test yourself).

### Suggestions

In order to make the most of the doctor appointment, remember to make a list of all your symptoms, key medical information, family history and medications, vitamins or supplements you take.



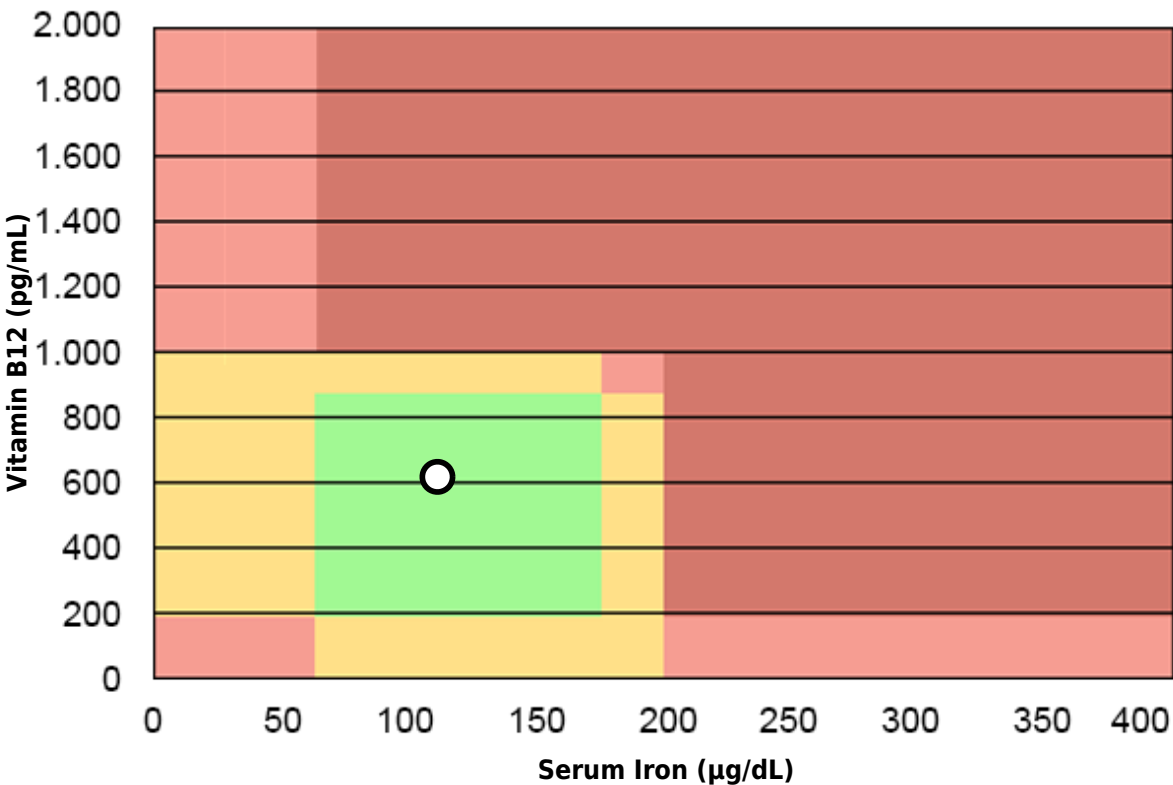
Vitamin B12 Function



Results

Vitamin B12 is inside the reference range and does not suggest any vitamin B12 insufficiency.

Graphical Representation of the Results



Graph Description

The graphic for vitamin B12 function shows a black dot corresponding your serum iron —plotted on the X-axis— and vitamin B12 —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border).

## Gastrointestinal Tract

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### Results

Negative *Helicobacter pylori* IgG Antibody do not suggest any digestive tract disorder related to a *H. pylori* infection.

### Suggestions

Although there is currently no clinical guideline that recommends re-testing every year after a negative result or a confirmed eradication, within a preventive healthcare model, we suggest repeating this test periodically since an *H. pylori* infection can be present without causing any symptoms and clearing the infection is one of the recognized ways to reduce gastric cancer risk. Ultimately, the need for further testing should be individualized according to your symptoms, medical history, and risk factors, so we suggest consulting your General Practitioner (GP) to discuss the right timing.

## Liver and Biliary Function



### Results

GGT is outside the reference range and could suggest an undetermined —but mild—, liver function disorder, probably related to alcohol intake.

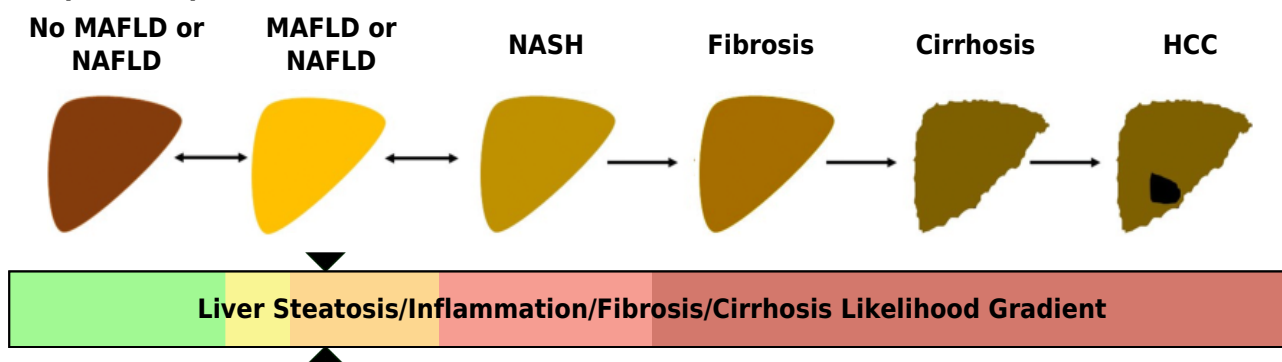
Besides, according to Fatty Liver Index (FLI), Liver Fat Score (LFS), Hepatic Steatosis Index (HSI), K-NAFLD Score, NAFLD Logit Score and NAFLD Ridge Score, there is a high risk for Metabolic Dysfunction-Associated Fatty Liver Disease (MAFLD) and/or Non-Alcoholic Fatty Liver Disease (NAFLD).

Moreover, the NAFLD/NASH Indices evaluated do not identify an increased risk of Non-Alcoholic Steatohepatitis (NASH).

Furthermore, the NASH/Fibrosis Indices evaluated do not identify an increased risk of Non-Alcoholic Steatohepatitis (NASH) with fibrosis.

On the other hand, according Chronic Liver Disease (CLivD) Score, the estimated risk of developing Chronic Liver Disease (CLD) within the next 15 years is mild (2 percent). However, this may not be the case in the future —this percentage can be increased—, if you do not control your weight, since a high-calorie diet (fast food type foods or diets rich in refined carbohydrates —especially fructose, saturated fats and sugary drinks—), along with little physical activity leads to overweight and obesity, which are among the main risk factors of Metabolic Dysfunction-Associated Fatty Liver Disease (MAFLD) and/or Non-Alcoholic Fatty Liver Disease (NAFLD), which can lead to NASH and fibrosis.

### Graphical Representation of the Results



### Conclusions

We suggest consulting the doctor who ordered this test (or your general practitioner if you requested the test yourself).

### Suggestions

In order to make the most of the doctor appointment, remember to make a list of all your symptoms, key medical information, family history and medications, vitamins or supplements you take.

## Pancreatic Exocrine Function

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### Results

Main pancreatic enzymes are inside the reference range and do not suggest any pancreatic exocrine function disorder.



## Muscular System

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### Results

Both Creatine kinase (CK) and LDH levels are inside the reference range and do not suggest any muscle damage.

CK is the most specific and sensitive indicator of acute muscle injury, while LDH rises more consistently, reflecting metabolic damage. Besides, LDH rises later than CK and remains detectable in the blood for a longer period.



## Renal Function

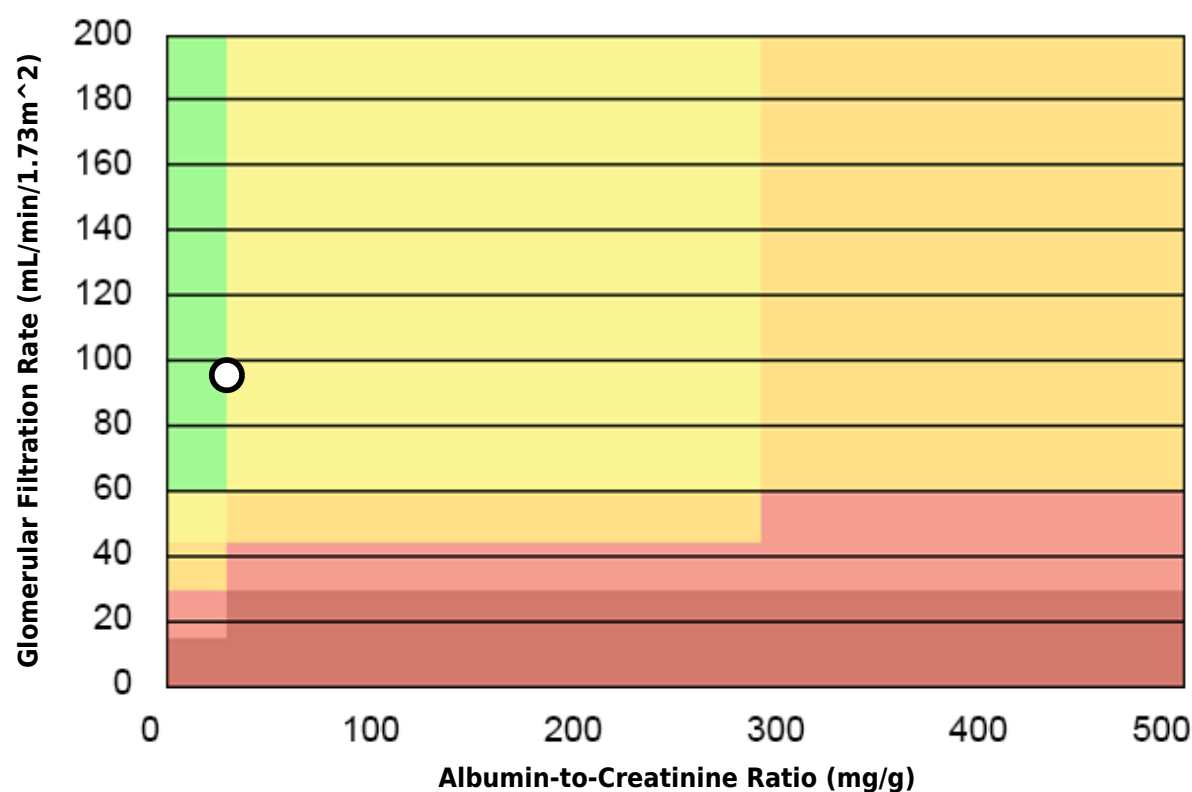


### Results

Both estimated Glomerular Filtration Rate (eGFR) as well as Albumin-to-Creatinine Ratio (ACR) do not suggest any renal function disorder (grade G1/A1).

Note: Estimated Glomerular Filtration Rate (eGFR) has been calculated using the CKD-EPI 2021 equation based on creatinine. Creatinine is a metabolic waste product generated by normal muscle breakdown and excreted by the kidneys. While it remains the standard first-line biomarker for assessing renal filtration, its serum levels are inherently tied to physical constitution. Consequently, factors such as high muscle mass, recent intensive training, or creatine supplementation can artificially lower the eGFR score, whereas low muscle mass or sarcopenia may overestimate kidney function.

### Graphical Representation of the Results



### Graph Description

The graphic for renal function shows a black dot corresponding your Albumin-to-Creatinine Ratio (ACR) —plotted on the X-axis— and estimated Glomerular Filtration Rate (eGFR) —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border). Both eGFR and ACR have been calculated according Kidney Disease Improving Global Outcomes (KDIGO) Guidelines, a global organization developing and implementing evidence-based clinical practice guidelines in kidney disease.

## Hydroelectrolytic Metabolism

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### Results

Some serum electrolytes are slightly outside the reference range and could suggest a very slight hydroelectrolytic metabolism disorder.

### Results Detail

Imbalanced electrolytes are:

- Serum phosphorus is slightly outside the reference range and could suggest very slight hypophosphatemia —slightly low phosphorus levels in the blood serum—.

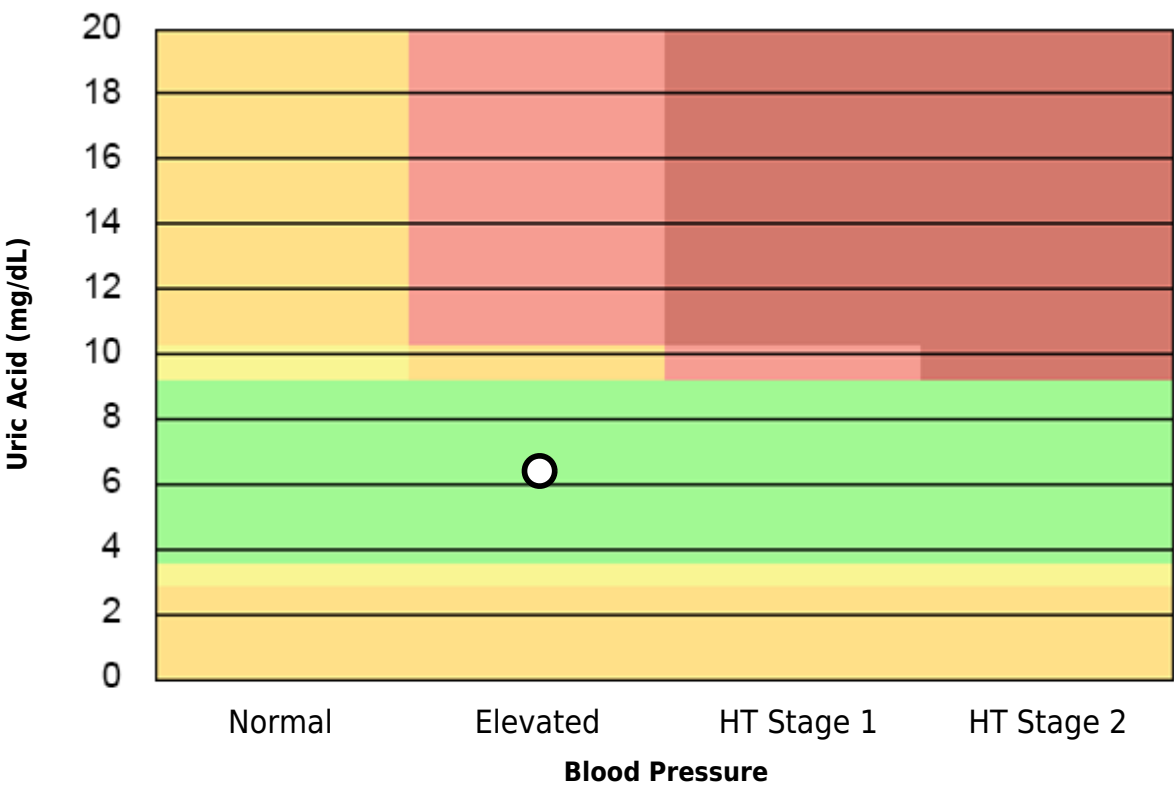
Uric Acid Metabolism



Results

Uric acid is inside the reference range and does not suggest neither hyperuricemia nor hypouricemia.

Graphical Representation of the Results



Graph Description

The graphic for uric acid metabolism shows a black dot corresponding your blood pressure —plotted on the X-axis— and uric acid —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border).

## Prostate Function

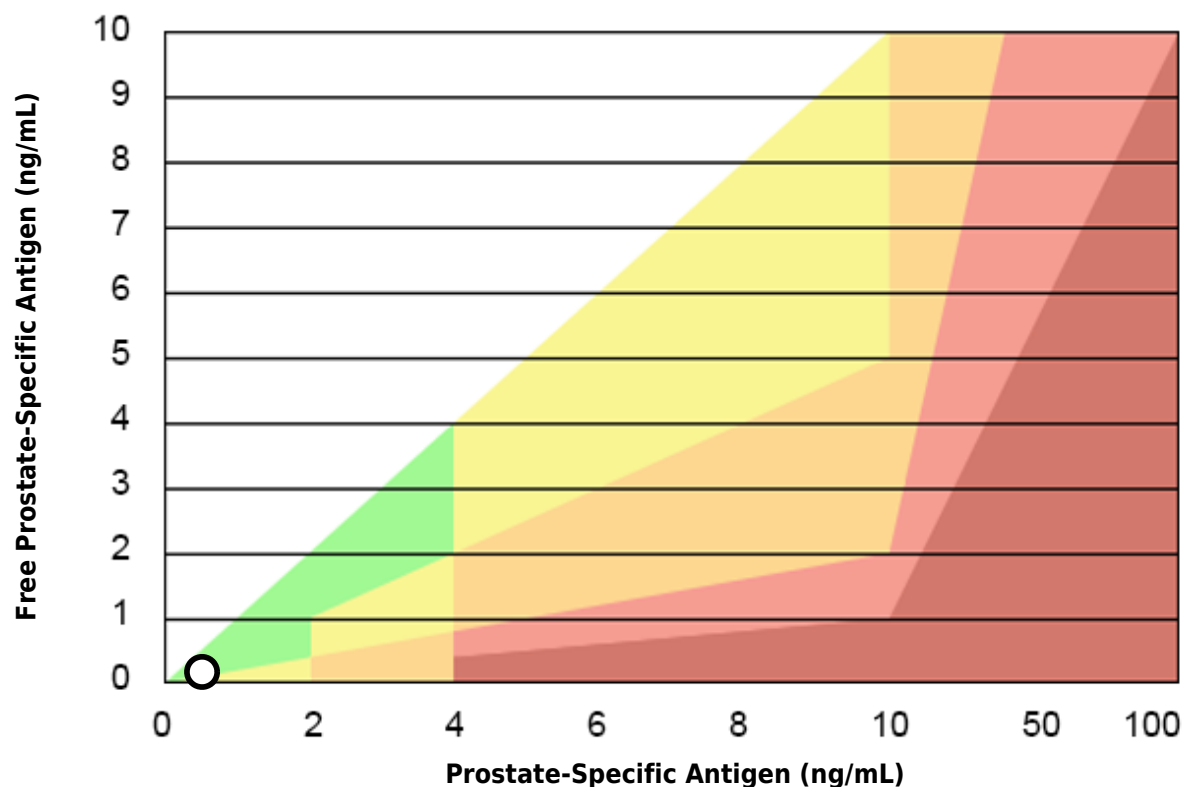


### Results

Main prostate specific antigens are inside the reference range and do not suggest any prostate function disorder.

Clinical Note: Although Total PSA and Free PSA levels may fall within reference ranges (even below 1 ng/mL) —which is an excellent indicator of prostate health that largely rules out the presence of malignancy—, as men age, particularly after 50, the prostate naturally tends to enlarge. In this way, since the prostate surrounds the urethra —the tube that carries urine out of the body—, this benign growth can mechanically compress the urinary tract. Therefore, if you notice difficulty starting to urinate, a weak urine stream, a flow that stops and starts several times, or a feeling of incomplete bladder emptying, it is highly likely that you are developing early-stage Benign Prostatic Hyperplasia (BPH), as these obstructive symptoms are classic signs of BPH. Because it is a structural issue, BPH can cause significant daily discomfort without elevating blood markers. Consequently, it is advisable to consult your General Practitioner (GP) for a physical evaluation or an ultrasound to measure the actual volume of your prostate.

### Graphical Representation of the Results



### Graph Description

The graphic for prostate function shows a black dot corresponding your Prostate-Specific Antigen (PSA Total) —plotted on the X-axis— and free Prostate-Specific Antigen (PSA Free) —plotted on the Y-axis—, over a colored background (if any value is greater or smaller than X-axis or Y-axis ranges of the graphic, the dot is colored in red and placed over the corresponding border).

## Inflammatory Response



### Results

Although main inflammatory-related analytes are inside the reference range and do not suggest any Chronic Inflammatory Disease (CID), some Acute-Phase Reactants (APR) —such as Erythrocyte Sedimentation Rate (ESR), C-Reactive Protein (CRP) or Ferritin—, are outside the reference range and could suggest a Chronic Inflammatory State (CIS), as well a potential seronegative Rheumatoid Arthritis (RA), mainly if symptoms related to joint involvement are present.

### Conclusions

We suggest consulting the doctor who ordered this test (or your general practitioner if you requested the test yourself).

### Suggestions

In order to make the most of the doctor appointment, remember to make a list of all your symptoms, key medical information, family history and medications, vitamins or supplements you take.

## Sex Hormones Balance



### Results

The combined results obtained from E2-to-SHBG Ratio, E2-to-TT Ratio and Free Androgen Index (FAI), could suggest a mild risk for sex hormones imbalance, specifically, a mild increased —but balanced—, aromatization —the body converts an excessive amount of testosterone into estrogen (estradiol), but manages to maintain testosterone levels within normal ranges at the cost of very high androgen production—.

## Supplements



### **Disclaimer: About Supplement Safety**

ALTHOUGH SUPPLEMENTS ARE GENERALLY SAFE FOR MOST ADULTS WHEN USED AT RECOMMENDED DOSES AND DURATIONS, EXCESSIVE INTAKE MAY CAUSE GASTROINTESTINAL DISCOMFORT. IN THIS WAY, CAUTION IS NEEDED WHEN COMBINING SUPPLEMENTS WITH MULTIVITAMIN OR MULTIMINERAL COMPLEXES, AS OVERLAPPING INGREDIENTS MAY LEAD TO EXCESSIVE INTAKE.

ALWAYS READ THE PRODUCT LABEL CAREFULLY, INCLUDING EXCIPIENTS AND ADDITIVES, AND CONSULT YOUR DOCTOR OR PHARMACIST IF IN DOUBT. THIS IS ESPECIALLY IMPORTANT FOR INDIVIDUALS WITH A HISTORY OF ALLERGIES, AUTOIMMUNE CONDITIONS, GASTROINTESTINAL DISORDERS, OR THOSE ON CHRONIC MEDICATION.

BEFORE STARTING ANY SUPPLEMENTATION, WE SUGGEST GENERAL PRACTITIONER (GP) CONSULTATION IF YOU HAVE HEART CONDITIONS, LIVER OR KIDNEY DISEASE, A HISTORY OF KIDNEY STONES, EPILEPSY OR BIPOLAR DISORDER. IT IS NOT RECOMMENDED TO INITIATE SUPPLEMENTATION WITH MINERALS, VITAMINS, OR ANY OTHER NUTRACEUTICAL WITHOUT PRIOR CLINICAL OR LABORATORY EVALUATION —SUCH AS THE ONE INCLUDED IN THIS TEST—, TO JUSTIFY ITS NECESSITY —UNNECESSARY USE MAY LEAD TO SEVERE SIDE EFFECTS—.

### **Warning: Supplements do not Replace a Proper Diet**

While nutritional supplements can help correct deficiencies, enhance specific functions, or support targeted treatments, they should not replace a healthy, varied, and balanced diet. In this way, recent studies emphasize the importance of consuming up to 40 different foods per week from the following categories: vegetables rich in fiber, vitamins, and antioxidants; fruits that provide fiber, water, and micronutrients; nuts, seeds, and legumes; healthy animal and plant-based proteins; whole grains, tubers, and natural derivatives; dairy and fermented options; healthy fats; and natural herbs and spices.

Finally, once serum levels are normalized by improving your diet or recommended supplementation, reducing to a maintenance dose —or stopping completely—, may be appropriate, depending on ongoing clinical and laboratory evaluation.

### **Supplements Protocol and Prioritization Strategy**

Following this supplement introduction page, the next three categories are dedicated to "Recommended Supplements to enhance Functional and Systemic Support", "Recommended Supplements to reduce Oxidative Stress" and "Recommended Supplements to enhance Longevity". Please note that these three categories are dynamic, that is, not all of them will appear in every report, as their inclusion depends strictly on individual laboratory results.

In this way, among the categories generated, priority should always be given to the first section, that is, Recommended Supplements to enhance Functional and Systemic Support. Resolving these core issues may naturally improve and correct both oxidative stress scores and longevity markers, potentially eliminating the need for immediate secondary supplementation.

If there are no recommendations in the "Recommended Supplements to enhance Functional and Systemic Support" category, we suggest Longevity Specialist (LS) consultation to address those supplement recommendations related to oxidative stress and longevity.



## Recommended Supplements to enhance Functional and Systemic Support € €

The supplements included in this section have been specifically selected based on the results of laboratory analyses and the clinical findings observed. Their purpose is to correct any identified nutritional deficiencies and to support metabolic and functional balance in areas where alterations have been detected. This recommendation is aimed at optimizing overall health and preventing potential associated complications.

NOTE: Some supplements may cause mild digestive discomfort, such as heartburn or reflux, especially at the beginning of treatment, as well as in predisposed individuals. If these symptoms occur, it is recommended to take the supplements with food and, if the discomfort persists, we suggest General Practitioner (GP) consultation to assess the need for specific gastric protectors, through the appropriate prescription.

### Supplementation to enhance Cardiovascular System

Given your clinical profile, which includes excess body weight and/or possible metabolic disturbances, it could be advisable to begin daily supplementation with Omega-3 fatty acids.

Therefore, we suggest General Practitioner (GP) consultation to evaluate starting supplementation with Omega-3 fatty acids, specifically EPA (eicosapentaenoic acid) and DHA (docosahexaenoic acid), defining the dosage according to your needs. This supplementation is best taken with a main meal. Additionally, it is advisable to use high-purity, concentrated supplements, such as re-esterified triglycerides or ethyl esters, which allow therapeutic efficacy to be reached with fewer capsules.

A follow-up blood test should be performed to assess whether the potential metabolic disturbances have improved or resolved.

Omega-3 fatty acids have demonstrated significant benefits in lowering triglycerides, improving insulin sensitivity, modulating systemic inflammation, and supporting cardiovascular health—especially in individuals with excess body weight, metabolic risk, dyslipidemia, or insulin resistance.

### Supplementation to enhance Metabolic Function

Your blood test results suggest mild-to-moderate metabolic dysfunction, such as overweight and/or an unfavorable lipid profile.

Although these changes are not yet classified as advanced dyslipidemia or diabetes, they represent an early stage of metabolic imbalance that may increase your future risk for cardiovascular disease, type 2 diabetes mellitus, and hepatic steatosis if not properly addressed.

To correct these early abnormalities and prevent progression to more severe disease, we suggest General Practitioner (GP) consultation to evaluate starting supplementation with berberine, a natural plant-derived compound with glucose-lowering and lipid-regulating properties, defining the dosage according to your needs. This supplementation is preferably taken with meals.

A follow-up blood test should be performed to evaluate improvements in lipid parameters, fasting glucose, and insulin sensitivity.

Berberine activates AMP-activated protein kinase (AMPK), a key metabolic regulator, improving insulin signaling, reducing hepatic glucose production, and enhancing lipid clearance. The efficacy of this compound is particularly beneficial in men with mild metabolic dysfunction, abdominal fat accumulation, or early signs of dyslipidemia.

### **Supplementation to enhance Vitamin D Function**

Your blood test results suggest vitamin D insufficiency according to the reference interval used in this report. We suggest General Practitioner (GP) consultation to assess whether supplementation is appropriate and to define the dosage and follow-up target according to your medical history and individual risk factors.

A follow-up blood test should be performed to ensure that levels have returned to the optimal range.

Additionally, if supplementation is initiated, it is best taken with a fat-containing meal to improve absorption. In certain cases, your healthcare professional may consider combining vitamin D3 with vitamin K2, taking into account your diet, medications, bone health, and overall clinical situation.

Vitamin D is an essential nutrient that plays a key role in maintaining healthy bones, supporting the immune system, regulating calcium and phosphorus metabolism, and contributing to muscle function and inflammation control.

## Recommended Supplements to reduce Oxidative Stress



Although there is no single age, medical evidence often points to 30 as a critical biological turning point for considering preventative supplementation against oxidative stress. At this age, the organism could begin to decrease its optimal ability to autonomously neutralize free radicals, which are unstable molecules generated by factors such as solar radiation, environmental pollution, and cellular metabolism.

This early intervention acts as a biological support. By helping to mitigate oxidative stress in time, it could help to prevent accumulated damage from accelerating premature tissue senescence and support the long-term vitality of the organ systems.

In this way, the nutraceuticals included in this section have been specifically selected following an evaluation of the markers of Oxidative Stress identified in the laboratory results, such as hematologic, hepatic, or inflammatory oxidation levels, among others.

The primary purpose of these compounds is to support the neutralization of excess free radicals and reinforce endogenous antioxidant defense mechanisms, which remain critical for mitigating premature cellular damage. This strategy aims to reduce systemic oxidative load and protect tissue integrity against accelerated aging pathways.

NOTE: Some compounds may cause mild digestive discomfort, such as heartburn or reflux, especially at the beginning of the protocol or in predisposed individuals. If these symptoms occur, it is suggested to take the chosen nutraceuticals with food. If the discomfort persists, we suggest General Practitioner (GP) consultation to assess the need for specific gastric protectors or targeted pharmacological alternatives through the appropriate prescription.

## Recommended Supplements to enhance Longevity



Although there is no single age, medical evidence often points to 40 as a critical biological turning point for considering preventative interventions focused on longevity. It is during this decade that the decline of essential coenzymes, such as Nicotinamide Adenine Dinucleotide (NAD+), could become more pronounced, potentially affecting the inherent cellular ability to undergo proper DNA repair.

By introducing targeted NAD+ precursors and sirtuin activators (which are enzymatic pathways associated with cellular maintenance), such as resveratrol, the primary objective is to optimize the metabolic pathways that sustain cellular energy. These advanced nutraceuticals could help cells maintain a more resilient functional state, thereby enhancing overall cellular defense mechanisms.

At this physiological level, the goal transitions from merely protecting against external environmental factors to actively supporting the regenerative capacity of the organism. This strategy is designed to extend healthy lifespan, aiming to maintain physical activity and mitigate the progression of age-associated degenerative processes over time.

In this way, the nutraceuticals included in this section have been specifically selected following an evaluation of the Longevity Score and the analysis of key biomarkers related to metabolic health, renal function, or cellular senescence, among others.

The purpose of these specific compounds is to modulate the biological pathways of aging, optimize mitochondrial efficiency, and promote the clearance of senescent cells to foster a longer healthy life expectancy. This recommendation is aimed at decelerating biological wear and tear while enhancing the long-term resilience of the systemic architecture.

NOTE: Some compounds may cause mild digestive discomfort, such as heartburn or reflux, especially at the beginning of the protocol or in predisposed individuals. If these symptoms occur, it is suggested to take the chosen nutraceuticals with food. If the discomfort persists, we suggest General Practitioner (GP) consultation to assess the need for specific gastric protectors or targeted pharmacological alternatives through the appropriate prescription.

## Tips for Cancer Prevention



### About Prevention

Cancer is the second leading cause of death worldwide, and exposure to risk factors plays an important role in the biology and burden of many cancer types.

Although some cancer cases are not preventable, you can by yourself to minimize exposure to known cancer risk factors.

In epidemiology there are 5 levels for prevention:

The first one, Primordial Prevention was described in 1978 —the most recent addition to preventive strategies—. It consists of risk factor reduction targeted towards an entire population through a focus on social and environmental conditions. Such measures typically get promoted through laws and national policy, such as increasing taxes on cigarettes or decreasing advertisement of tobacco, for example.

Secondly, Primary Prevention, or the prevention of a cancer developing, is a particularly cost-effective strategy aimed at a susceptible population or individual. However, it must be paired with more comprehensive efforts to address cancer burden, including Secondary Prevention initiatives, such as screening programs, and ensuring effective capacity to diagnose and treat those with cancer.

As part of cancer control strategies, prevention requires identification of causal risk factors, determination of contribution to local cancer burden, and development of effective strategies for their mitigation, such as the New York State's Tobacco Control Program (TCP), for example.

Third, Secondary Prevention in medicine consists of detecting and applying treatment to diseases in very early stages. The intervention takes place at the beginning of the disease, being its main objective to prevent or delay its development. In this way, through population screening —its target is healthy-appearing individuals with subclinical forms of the disease—, the early detection of the disease is pursued, looking for diagnostic anticipation or early detection of the disease when it is possible to apply an effective treatment —by preventing the progression of the biological lesion or disease in patients who are asymptomatic or have low morbidity—, such as mammography —for early detection of breast cancer—, or colonoscopies —for early detection of colon cancer—, for example. In fact, this test —as well as our other VenientSx tests— can provide additional preventive information about risk factors and findings that may require more specific medical evaluation. It does not replace or provide an equivalent alternative to recommended screening procedures, such as mammography or colonoscopy, which should be performed according to each person's age, medical history and individual risk profile.

In this way, there are two types of screening interventions.

The first one, is passive screening: in primary care, the most widely used strategy is opportunistic detection or active search for cases (case finding), in which a series of tests are carried out according to age, sex and the possible risk factors present in the person who consults for any stuff; mass screening or tracking (screening) is a population strategy whose effectiveness and efficiency for the detection of chronic pathologies does not seem to be sufficient to recommend them globally, since non-compliance by the presumed sick individual with respect to the recommendations for treatment is frequent.

In such manner, according to the Frame and Carlson Criteria for disease screening regarding the condition to be prevented, it must be:

- Common cause of morbidity and mortality.
- Detectable and treatable in presymptomatic stage.

- The tests to diagnose it must be effective and efficient.
- Early treatment should be better than treatment at the usual symptomatic or diagnostic stage.
- The potential damage of the intervention should be less than that of non-early treatment.

On the other hand, the second one, is active screening: self-examination or self-exploration are self-applied actions by the individual to detect a disease.

Fourth, Tertiary Prevention involves the prevention of complications in people who have already developed disease, and in whom disease prevention is no longer an option—it is implemented in symptomatic patients and aims to reduce the severity of the disease as well as of any associated sequelae—, such as help the patients and their caregivers to deal with the disease, for example.

While Secondary Prevention seeks to prevent the onset of illness, Tertiary Prevention aims to reduce the effects of the disease once established in an individual. For these patients, the goal of Tertiary Prevention is to maximize the outcomes and prevent further morbidity from the disease process.

Fifth and finally, Quaternary prevention —according to the Wonca International Dictionary for General/Family Practice—, is: *"action taken to identify patients at risk of overmedicalization, to protect him from new medical invasion, and to suggest to him interventions, which are ethically acceptable"*. However, the definition has undergone recent modification as *"an action taken to protect individuals (persons/patients) from medical interventions that are likely to cause more harm than good"*. In this way, the use of hormone replacement therapy led to an increased number of cases of breast cancers, stroke, and thromboembolic events.

## Current Evidence

The last systematic analysis for the Global Burden of Disease (GBD) Study 2019 —published in Lancet 2022; 400: 563-91—, stated the leading risk factors at the most detailed level globally for risk-attributable cancer deaths and Disability-Adjusted Life-Years (DALYs) in 2019 for both sexes combined were smoking, followed by alcohol use and high Body Mass Index (BMI).

However, risk-attributable cancer burden varied by world region and Socio-Demographic Index (SDI), with smoking, unsafe sex, and alcohol use being the three leading risk factors for risk-attributable cancer DALYs in low SDI locations in 2019, whereas DALYs in high SDI locations mirrored the top three global risk factor rankings.

From 2010 to 2019, global risk-attributable cancer deaths increased by 20.4 percent and DALYs by 16.8 percent, with the greatest percentage increase in metabolic risks by 34.7 percent.

In summary, the leading risk factors contributing to global cancer burden in 2019 were behavioral, whereas metabolic risk factors saw the largest increases between 2010 and 2019. Reducing exposure to these modifiable risk factors would decrease cancer mortality and DALY rates worldwide.

## Conclusions

In order to reduce your risk for cancer —according to your data—, you should reduce alcohol intake and lose weight.

Please note, many cancers are not preventable and may be due to genetic factors. But we know that 1 in 3 cancer cases can be prevented through health lifestyle choices. That's 6 million avoidable cancer cases each year worldwide —according to the International Agency for Research on Cancer (IARC)—. Everyone can reduce their cancer risk by adopting certain lifestyle behaviors like the ones explained below.

**Reduce Alcohol Intake**

You might think that a regular glass of red wine or other alcoholic beverages might be good for your heart. But that may not be true, or true only for light sippers (less than one drink a day). If you use more than that, cutting back or quitting may lower your blood pressure, levels of fat called triglycerides, chances of heart failure as well as several cancers.

Your liver's job is to filter toxins. And alcohol is toxic to your cells. Heavy drinking—at least 15 drinks for men and eight or more for women a week—, can take a toll on the organ and lead to fatty liver, cirrhosis, several types of cancers—including liver cancer, but also esophagus cancer, mouth cancer, throat cancer, and breast cancer—, as well as other problems. The good news: your liver can repair itself and even regenerate. So it is always worth drinking less or quitting.

Enjoying alcohol socially in reasonable amounts can boost your mood and help you bond with others. But if you drink alone, or down multiple drinks a day, it could turn into an unhealthy habit. If you can not control it, it may lead to a condition called Alcohol Use Disorder (AUD).

In this way, giving up drinking may let you focus on your relationships, work, and health. It also may ease any depression and anxiety and elevate your self-esteem.

**Lose weight**

To lose weight it is necessary for the body to enter a Caloric Deficit (CD). The CD is the state in which the body is when it consumes more calories than it receives. In other words, it is about maintaining a negative caloric balance, either by increasing the body's metabolic rate through physical exercise, by reducing calories in the diet, or by a combination of both if you want to get results quickly.

Without a CD, you do not lose weight or burn more fat, regardless of the diet used and the exercises performed. The most effective way to lose weight and reduce body fat is simply to maintain a caloric deficit for a certain time (depending on the results you want to achieve) by increasing physical activity, reducing calories consumed or a combination of both.

In this way, based on your age (54 years), your height (173.00 cm), and current your weight (83.50 kg), your Basal Metabolic Rate (BMR) is 1651.25 kcal/day, so to enter a CD you must ensure that the equation "calories ingested in the diet - basal metabolic rate - calories burned with daily exercise" is less than zero. However, if you lose weight until your Body Mass Index (BMI) is less than 25 kg/m<sup>2</sup> (that is, lose weight up to 74.82 kg), your BMR will drop to 1564.48 kcal/day, which means your BMR will have dropped by 86.77 kcal/day (5.25 percent), so this equation should be adjusted as you lose weight. No more secrets: without a CD, you do not lose weight or burn more fat, regardless of the diet used and the exercises performed. The most effective way to lose weight and reduce body fat is simply to maintain a caloric deficit for a certain time (depending on the results you want to achieve) by increasing physical activity, reducing calories consumed or a combination of both.

According to US Food and Drug Administration (FDA), it is recommended to balance the number of calories you eat and drink with the number of calories your body uses. 2,000 kcal/day is used as a general guide for nutrition advice, so if you are planning to start a 1,500 kcal/day (or lower), slimming diet, we highly suggest General Practitioner (GP) consultation in to avoid losing lean tissue and fluids instead of fat, since experts recommend a slow and steady rate of weight loss, which means no more than 1 kg (2 lb) per week—7,000 kcal balance per week (1,000 kcal balance per day)—. That means you should plan between 28 and 29 weeks to achieve a BMI under 25 kg/m<sup>2</sup>—normal weight—.

In this way—by way of comparison with a carrot, which has 25 kcal—, a Big Mac has 550 kcal (740 kcal for Double Quarter Pounder with Cheese). Besides, regular French Fries have 320 kcal (480 kcal for large French Fries). Moreover, a Sundae has 330 kcal. Furthermore, McFlurry with OREO Cookies has 510 kcal

(640 kcal if McFlurry with M&M's Candies). That means a complete menu can easily exceed the BMR of a person with normal weight (BMI below 25 kg/m<sup>2</sup>). McDonald's restaurants in the United States began to include information on the calories contained in their products in 2014 —information also available online at <https://www.mcdonalds.com/us/es-us/about-our-food/nutrition-calculator.html> (kcal can be also expressed as Cal)—, after the notice by the Supreme Court to control food in this type of establishment in order to combat obesity (a disease that it is already the fifth leading cause of death among Americans).

Finally, a healthy eating routine is important at all stages of life and can have positive effects that add up over time. It's important to eat a variety of fruits, vegetables, grains, protein, and fortified dairy or soy products. When deciding what to eat or drink, choose options that are high in nutrients. Make every bite count.