TEST REPORT

8605 SW Creekside Place
Beaverton, OR 97008
Phone: 503-466-2445 Fax: 503-466-1636

ZRT LABORATORY

 # D2026 03 23 095 U

Ordering Provider:
Getuwell

Samples Received
03/23/2026

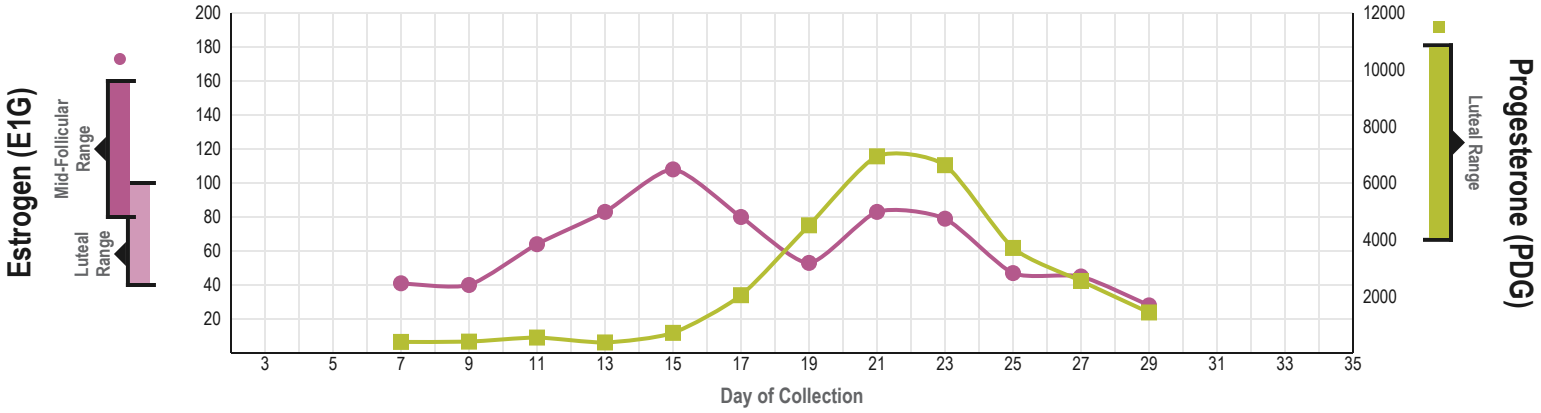
Report Date
03/29/2026

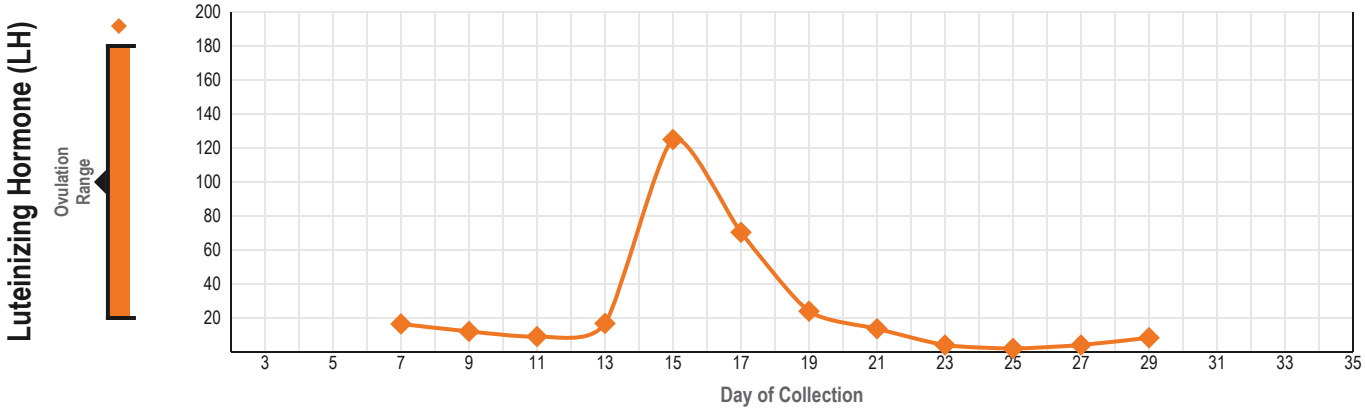
Samples Collected

Urine - 02/17/26 09:00
Urine - 02/19/26 08:00
Urine - 02/21/26 11:00
Urine - 02/23/26 09:00
Urine - 02/25/26 10:00
Urine - 02/27/26 07:00
Urine - 03/01/26 07:30
Urine - 03/03/26 07:00
Urine - 03/05/26 06:45
Urine - 03/07/26 08:00
Urine - 03/09/26 09:00
Urine - 03/11/26 09:15

Patient Name: Dried Urine Menstrual Cycle Mapping
Patient Phone Number:

Gender	DOB	Menses Status	Last Menses	Height	Weight
Female	1/1/1990 (36 yrs)	Pre-Menopausal	2/11/2026	5 ft 7 in	140 lb





Day	7	9	11	13	15	17	19	21	23	25	27	29
E1G ng/mg Cr	42	41	63	82	107	81	52	82	78	46	46	27
PDG ng/mg Cr	392	400	547	374	710	2038	4502	6950	6639	3718	2547	1427
Ratio: PDG/E1G	9	11	8	5	8	25	86	85	83	76	57	53
LH mIU/mg Cr	16.6	12.0	9.2	16.7	125.3	70.3	24.1	13.6	4.0	2.2	4.0	8.5
CRTN mg/mL	1.58	1.54	1.78	1.61	1.65	0.79	1.34	0.82	0.78	1.52	1.98	2.01

Estrogen (E1G) Ranges	Progesterone (PDG) Ranges	Luteinizing Hormone (LH) Ranges
Baseline Follicular 16.3-58.7 ng/mg Cr Mid-Follicular 76.6-160.9 ng/mg Cr Luteal 41.9-102.5 ng/mg Cr	Baseline Follicular 346-1719 ng/mg Cr Luteal 3994-10860 ng/mg Cr	Baseline Follicular 4.6-20.7 mIU/mg Cr Ovulation 30.2-175.1 mIU/mg Cr

< or > dl = Less than or greater than the detectable limit. N/A = Not applicable; 1 or more values used in this calculation is less or greater than the detectable limit.

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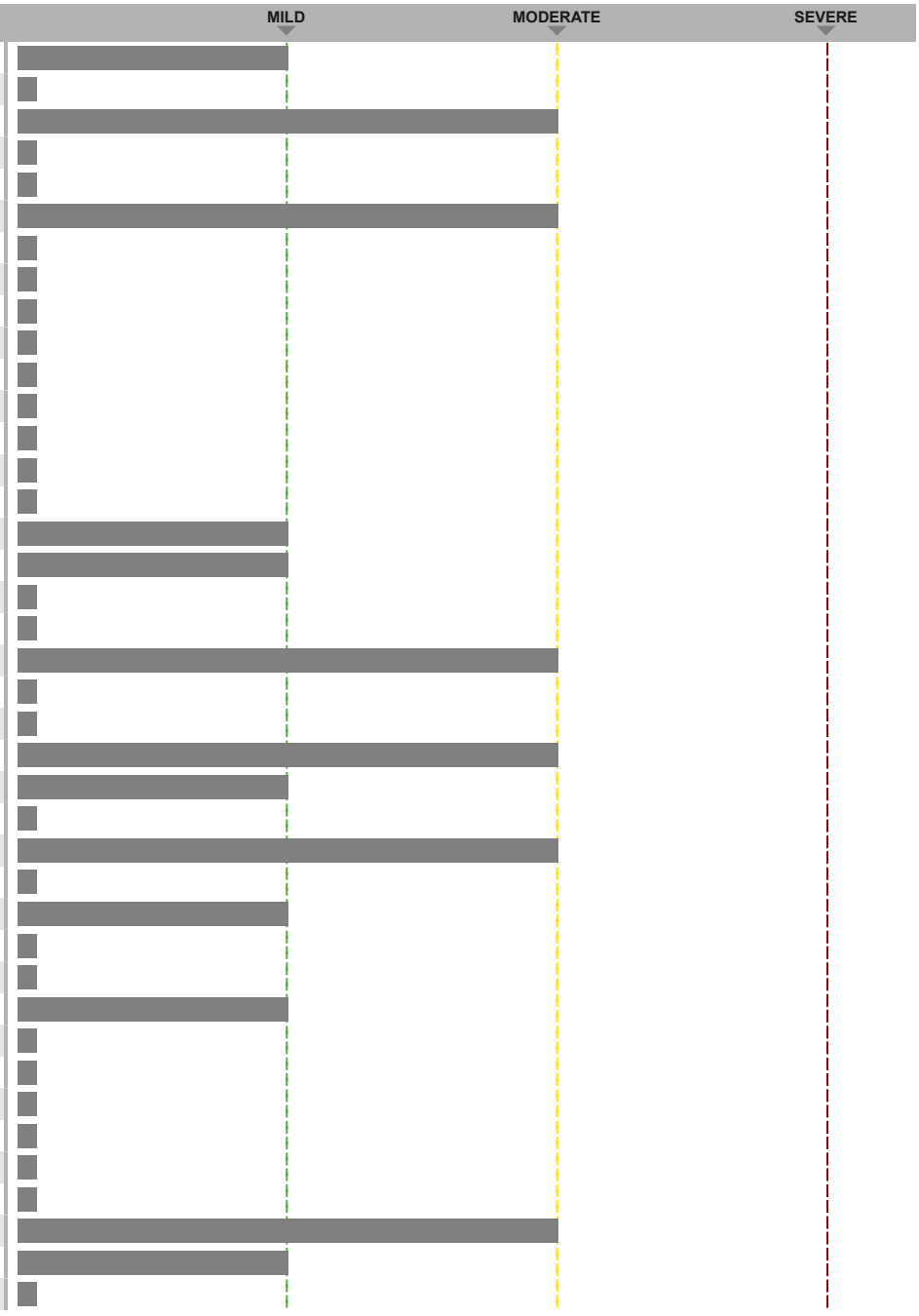
The above results and comments are for informational purposes only and are not to be construed as medical advice. Please consult your healthcare practitioner for diagnosis and treatment.

David T. Zava, Ph.D.
Laboratory Director

Alison McAllister, ND.
(Ordering Provider unless otherwise specified on page 1)

Disclaimer: Symptom Categories below show percent of symptoms self-reported by the patient compared to total available symptoms for each category. For detailed information on category breakdowns, go to www.zrtlab.com/patient-symptoms.

SYMPTOM CATEGORIES	RESULTS | 02/17/26
Estrogen / Progesterone Deficiency	20%
Estrogen Dominance / Progesterone Deficiency	17%
Low Androgens (DHEA/Testosterone)	22%
High Androgens (DHEA/Testosterone)	2%
Low Cortisol	23%
High Cortisol	28%
Hypometabolism	21%
Metabolic Syndrome	0%



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SYMPTOM CHECKLIST	MILD	MODERATE	SEVERE
Memory Lapse			
Mood Swings			
Muscle Size Decreased			
Nails Breaking or Brittle			
Nervous			
Night Sweats			
Numbness - Feet or Hands			
OCD			
Panic Attacks			
PreMenstrual Dysphoric Disorder			
Pulse Rate Slow			
Rapid Aging			
Rapid Heartbeat			
Skin Thinning			
Sleep Disturbed			
Stamina Decreased			
Stress			
Sugar Cravings			
Sweating Decreased			
Swelling or Puffy Eyes/Face			
Tearful			
Triglycerides Elevated			
Urinary Urge Increased			
Uterine Fibroids			
Vaginal Dryness			
Water Retention			
Weight Gain - Hips			
Weight Gain - Waist			

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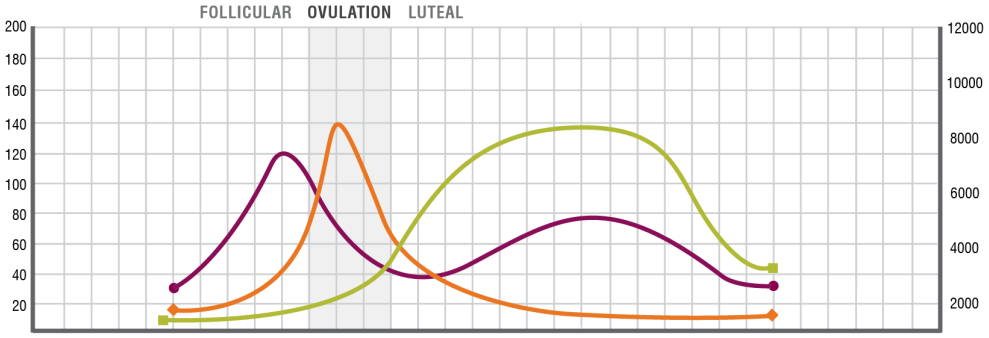
Common Menstrual Cycle Maps

LEGEND: E1G PDG LH

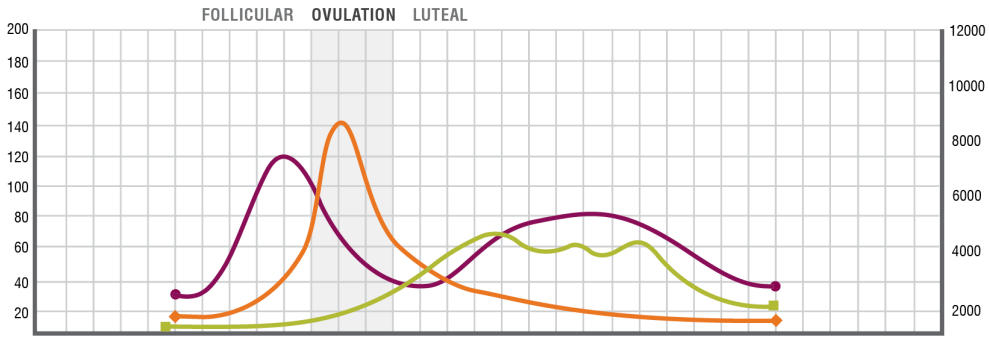
Example 1



Ovulatory Menstrual Cycle

This is an average menstrual cycle. The cycle is marked by a clear LH peak with a corresponding rise in estrogen showing a strong ovulation. There is a strong rise in progesterone and a secondary rise in estrogen peaking half-way between ovulation and the first day of the next period. A sudden drop of estrogen and progesterone occur just prior to the start of the next period.

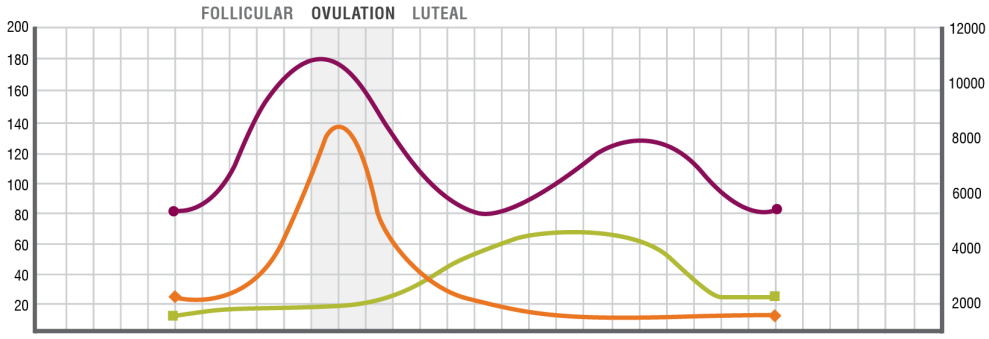
Example 2



Luteal Phase Defect Cycle

This cycle shows a clear LH peak with an associated luteal phase rise in estrogen. However, progesterone rises to a lower level than normal, resulting in a lower Pg/E2 ratio. This imbalance of progesterone and estrogen in the luteal phase can lead to symptoms of estrogen dominance, PMS symptoms, earlier menses or spotting before menses.

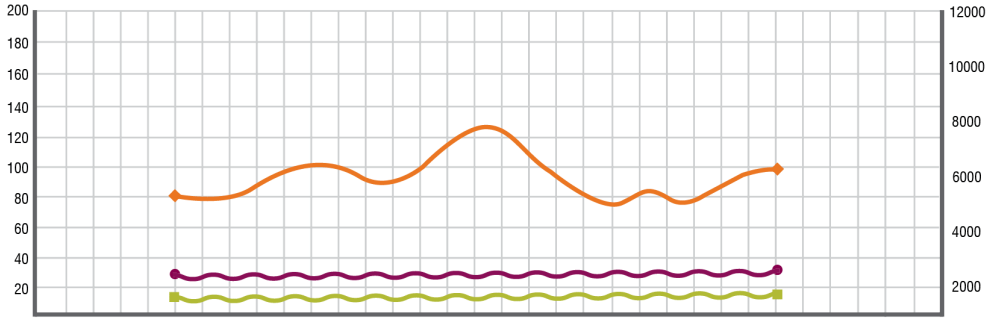
Example 3



Peri-Menopausal Cycle

This cycle represents the earlier stage of peri-menopause. It shows a pattern of higher estrogen excretion, a lower overall LH peak and lower progesterone excretion. Also, the progesterone does not rise above estrogen after the LH peak. As peri-menopause moves toward the post-menopausal state, the LH peak will disappear as LH will start to become more elevated and estrogen will drop.

Example 4



Postmenopausal Cycle

This cycle shows that ovulation is not occurring. LH levels are consistently elevated. Estrogen levels are more uniform and lower as compared to an ovulatory cycle and progesterone levels are consistently low. The period does not come before the final strip has been collected.

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Lab Comments

YOUR CYCLE
Ovulation is thought to have occurred on day 15.

This cycle shows a textbook ovulatory cycle with LH peak and a strong ovulation with robust progesterone and estrogen levels throughout the luteal phase. The progesterone peaks and troughs seen here are a typical finding during the normal mid-luteal phase but if symptoms are noted with the cycle, they are more likely due to these physiologic changes in progesterone levels rather than insufficient levels.

UNDERSTANDING THE CYCLE
Menstrual mapping tests for the hormones estrone-3-glucuronide (E1G), progesterone (pregnanediol glucuronide, PDG), and luteinizing hormone (LH). These 3 hormones show excellent correlation with ovarian ultrasounds to the timing of ovulation. The early phase of the menstrual cycle is called the follicular phase. During this phase, the egg (ovum) is maturing within the follicle, and the follicle is enlarging significantly. This produces a corresponding increase in estrogen, building until estrogen peaks at approximately the same time as LH, stimulating ovulation. During the follicular phase, estrogen is thickening the endometrium (lining of the uterus) as well as proliferating breast glandular tissue. During the luteal phase (after ovulation), estrogen is expected to return to follicular levels.

LH levels peak approximately 12-36 hours prior to ovulation.

During the second half of the cycle, progesterone levels rise after ovulation has occurred. In an optimal cycle, progesterone levels rise relative to estrogen and peak approximately 7 days after ovulation. Progesterone levels are expected to fall after the luteal peak in the absence of pregnancy. During this time, hormones are produced by the corpus luteum, the remnant of the follicle capsule after ovulation. The endometrium, in preparation for the possibility of pregnancy, stops the proliferation of the uterine lining and changes it into a secretory endometrium which secretes nutrients into the uterus for healthy embryo implantation and growth. During cycles where pregnancy does not occur, which is most menstrual cycles, progesterone still serves to oppose the growth-stimulating effects of estrogen. Most PMS symptoms start when progesterone levels start to fall after the progesterone peak and generally worsen 3 days prior to the period, resolving with menses.

Hormonal symptoms typically arise due to changes in hormone levels. Thus, symptoms are common during the period when hormones are low, during the rise in estrogen at the end of the period, the peaks of ovulation, and when progesterone and estrogen plummet at the end of the menstrual cycle. Optimizing ovulation through herbal therapies (e.g., Vitex agnes-castus (Chaste tree berry), Maca), use of fertility medication (e.g., Clomid, Letrozole), and/or directly supplementing hormones (e.g., estradiol, Biest, or progesterone) are commonly beneficial in alleviating symptoms.

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