

Take this to your doctor

The page to hand your physician, and how to have the conversation.

Your physician has ten to fifteen minutes with you, a panel of several thousand patients, and guidelines built around population outcomes rather than individual ones. The system is organized to identify disease, and much less well organized around the fifteen years before a diagnosis, during which values drift in a direction anyone could have seen. That is not a failure of your doctor, it is how the system is funded and timed, and walking in knowing it changes the conversation. None of which makes this an anti-medicine position: if you develop a serious condition you want a physician, not a health book.

What to ask for

Bring the list on paper. Ask for it as a package rather than one test at a time, and ask for the actual numbers rather than an assurance that everything looked fine.

Test	Why you want it	☐
Standard lipid panel, with non-HDL calculated	Non-HDL captures all atherogenic cholesterol and costs nothing extra.	
ApoB	Counts atherogenic particles rather than measuring their cargo. When apoB and LDL-C disagree, apoB is the one that tracks outcomes. Typically \$15 to \$30, no fasting needed. The single highest-value addition to a standard panel.	
Lp(a), once in your life	Largely genetically determined and essentially fixed. A high result does not change your treatment directly, but it changes how hard you control everything else.	
hs-CRP	A marker of systemic inflammation. Do not draw it during an illness or shortly after intense exercise, both of which raise it transiently.	
HbA1c, fasting glucose and fasting insulin together	Ordered as a set so HOMA-IR can be calculated. Insulin resistance develops years before glucose becomes abnormal, and fasting insulin is the part most commonly left out.	
Comprehensive metabolic panel	Kidney and liver function, electrolytes. Standard, and the baseline against which everything later is compared.	
Complete blood count	Anemia, and a broad screen.	
TSH	Thyroid function. A common and treatable cause of fatigue.	
Ferritin	Iron deficiency without anemia is common, particularly in menstruating women, and produces fatigue and exercise intolerance before hemoglobin falls. A normal CBC does not exclude it. Ask for ferritin specifically.	

Targeted rather than routine: a coronary artery calcium scan if you are between 40 and 75, at borderline or intermediate risk, and the statin decision is undecided. Uric acid, ALT and GGT if there is metabolic risk. Vitamin D only if there is a specific reason, since the Endocrine Society's 2024 guideline advises against routine testing in healthy adults.

Not worth ordering: advanced lipoprotein particle-size panels beyond apoB, IgG food sensitivity panels, and most direct-to-consumer micronutrient screens. And do not ask for homocysteine. The trials that lowered it did not improve outcomes.

If your physician will not order apoB. In most states you can order it yourself, with a blood draw at one of their labs and results online, through [Quest](https://questhealth.com) (questhealth.com) or [Labcorp OnDemand](https://ondemand.labcorp.com) (ondemand.labcorp.com). Then bring the result back to your physician.

How to have the conversation

The framing that works is *I want to understand my numbers*, not *I read something on the internet*. Physicians are not dismissive of engaged patients. They are, reasonably, wary of patients who arrive with a printout and a conclusion already attached.

Ask in advance and in writing	Send the list through the patient portal a week before the appointment rather than producing it at minute nine of a fifteen-minute visit. This is the single highest-yield move on this page.
Lead with the reason, not the test	"I have a family history of early heart disease and I would like to understand my particle-based risk" gets a different response than "I want an apoB."
Ask what it would change	"If this came back high, what would we do differently?" is the question your physician is already asking silently, and asking it out loud marks you as someone reasoning rather than collecting.
Accept a no with a reason	If your doctor declines a test and explains why, that is a substantive answer. If the reason is insurance coverage rather than clinical judgment, ask what it would cost to pay for directly. Several of these are inexpensive, and apoB can be ordered directly (page one).
Bring a complete list of what you take	Including things you think of as merely nutritional. Mention creatine specifically before any blood draw, since it raises serum creatinine without affecting kidney function.
Ask for a copy of everything	You are entitled to your results, and tracking them yourself over years is where most of the value is.

What your physician is right to push back on

Some of the pushback you meet is correct, and you should be able to tell which. They are right to be skeptical of screening tests with no clear action attached; a test whose result would not change anything is not free, because it generates incidental findings, follow-up imaging and anxiety. They are right that reference ranges are population statistics rather than individual targets. They are right to decline whole-body MRI screening and most direct-to-consumer panels, where the false-positive burden is real and documented. They are right to be unimpressed by a supplement regimen, and right to warn you about interactions: fish oil and anticoagulants, St. John's wort and half the formulary, potassium with ACE inhibitors.

And they are right that a wearable's numbers are not clinical data. Your ring does not measure sleep stages accurately, and your watch's VO_2 max estimate can be off by around 10 mL/kg/min in either direction.

When to see a specialist

Ask for a referral when the question is outside primary care's scope: a lipidologist or preventive cardiologist for a high Lp(a), a strong family history of early cardiovascular events, or lipids that will not respond; an endocrinologist for thyroid disease, unexplained metabolic findings, or complicated diabetes; a registered dietitian for kidney disease, celiac disease, inflammatory bowel disease or an eating disorder; a sleep physician for witnessed apneas, loud snoring with daytime sleepiness, or insomnia that has not responded to good habits; a gastroenterologist for persistent digestive symptoms, particularly with weight loss or bleeding.

See someone promptly, rather than adjusting your program

Chest pain or pressure with exertion. Unexplained weight loss. New severe fatigue that does not resolve with adequate sleep and food. Fainting. Blood where there should not be any. Those are not troubleshooting problems.

This page is an extract from The Energy Guidebook, fifth edition, and is general information rather than medical advice. Decisions about testing and treatment belong to you and your physician.