Patient ID: _____ Clinic: _____ Date: ____/____/____

METABOLIC SYNDROME SAFETY LABS

Date labs were measured (mm/dd/yyyy):			
	Measured?	**Result**	**Units**
Triglycerides	○ Yes ○ No		
Total Cholesterol	○ Yes ○ No		
HDL	○ Yes ○ No		
LDL	○ Yes ○ No		
Hemoglobin A1c	○ Yes ○ No		