DESIGN A PLAN THAT WORKS FOR YOU

How to build your own midlife stack

What to test, what to ask, and how to build a stack around your own data.



Cool girls are stacking. Smart girls test first.

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Let's cut through the noise

You've seen all the talk online, at the medspa, and in the group chat about peptides, HRT, and a whole host of wild longevity treatments. And you're left wondering: what's the right dose for me? Do I need to try a little of everything?

Unfortunately, I can't answer that for you, and honestly, no one should. A dose without your labs, your history, and your goals attached to it is just a number that worked for somebody else.

But here's what more than a decade of this work with midlife women has shown me. You deserve to be in control of your body, and you should understand all of your options.

In the pages that follow I'm going to do what no other provider will: break down the actual strategy I use for helping my patients navigate the changing landscape of perimenopause and figuring out what works for them.

We'll talk about precisely what to test and ask for before you ask your doctor about adding anything.

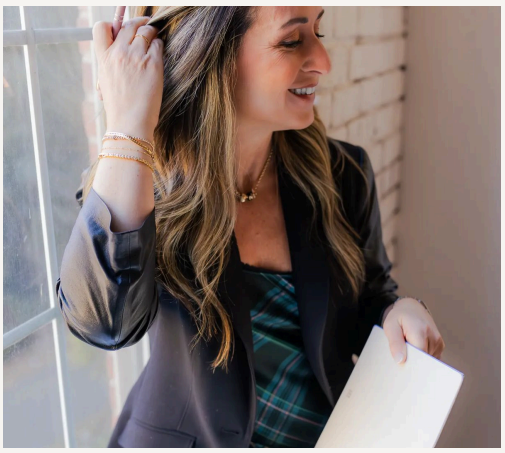
And if your version of this story involves 3am, brain fog, and a tiredness no supplement has touched, stay to the last page.

Jackie

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WHAT THE BEST STACKS SHARE

- **Hormone therapy, tuned.** Built from labs, symptoms, and history, then adjusted over time. Never adopted from a friend.
- **Fewer things, better chosen.** Short, deliberate stacks where every piece has a job.
- **Peptides with oversight.** A prescriber, a licensed pharmacy, and a defined endpoint. When this goes wrong, one of those three was missing.
- **Ritual deprescribing.** The women doing best remove as deliberately as they add.



THE FOUR RULES I PRACTICE BY

1. **Test, don't guess.**
   Baseline labs before anything new. Your data over someone's comment section.
2. **Stabilize before you stack.**
   Sleep, protein, strength, and blood sugar do the heavy lifting. You cannot out-supplement a life that is fundamentally overwhelming.
3. **One variable at a time.**
   Add one thing, hold it four to eight weeks, and define in advance what "working" looks like.
4. **Lowest effective dose.**
   Precision over more. And with your clinician, deprescribe what is no longer earning its place.

1 Hormones

THE FOUNDATION

What's actually happening. Progesterone typically falls first as ovulation becomes inconsistent, while estrogen swings high and low for years before it declines. That chaos, not just "low hormones," is why sleep fragments, cycles shift, moods sharpen, and 3am becomes a standing appointment long before a last period.

What the cool girls get wrong. Copying a friend's estradiol dose. Treating one FSH value as a verdict. Accepting "your labs are normal" as the end of the conversation, when perimenopause is diagnosed by your symptoms and cycle history, with labs as supporting cast. Hormone therapy is not one thing at one dose; the right protocol is built off your body, not borrowed off someone else's.

Ask your provider: "Are my symptoms consistent with perimenopause even if my labs look normal? What would hormone therapy look like for me specifically, and what are my personal risks and benefits?"

THE WORKUP CONVERSATION

The full picture to discuss:

- **Estradiol, FSH:** test but interpret within context of symptoms
- **TSH + free T4:** thyroid mimics and magnifies everything
- **Ferritin + iron studies:** energy, brain, hair
- **Fasting insulin, glucose, A1c:** the metabolic backdrop
- **Lipid panel + ApoB, vitamin D:** the long game

SMART GIRL MOVES THIS WEEK

- Keep a two-week symptom and cycle log before your appointment. Patterns are what convince a skeptical provider.
- Work with someone menopause-trained who reads labs against how you actually feel.

2 Peptides

POWERFUL TOOLS WHEN USED CORRECTLY

What they are. Short chains of amino acids that act as signals, telling cells to repair, secrete, calm, or grow. This is legitimate pharmacology: insulin was the first therapeutic peptide, and the GLP-1s everyone discusses at dinner are peptides too. The science is real and moving fast. So is the hype.

Where I draw the line. There is a world of difference between a pharmaceutical-grade peptide prescribed and monitored by a clinician through a regulated compounding pharmacy, and a vial marked "for research use only" that arrived from a website. Purity, sterility, dosing accuracy, and follow-up are the entire game. "My friend takes it" isn't a viable reason to experiment here.

Ask a qualified provider: "What specific outcome is this peptide for? What's the evidence level? Which pharmacy sources it? How will we monitor, and what's the exit plan?"

RED FLAGS: WALK AWAY

- Vials labeled **"for research purposes only"** sold for human use
- No prescriber, no labs, no monitoring, no certificate of analysis
- Dosing advice from a group chat or comment section
- The person selling it is also the person "prescribing" it

SMART GIRL MOVES

- Define the goal. A peptide is a tool for a job. Name the job first. Then investigate the peptide.
- Decide in advance what would prove it's working, and when you'll reassess.

3 Metabolic & Longevity

WHERE "MORE" BACKFIRES

What's actually happening. As estrogen declines, insulin sensitivity shifts, fat redistributes toward the middle, and muscle, your metabolic sink, erodes unless you fight hard for it. This is why the routines that worked at 35 stop working at 48. GLP-1s, statins, NAD and its precursors can all be powerful tools here, but they can't fix everything.

Two cautions worth repeating. NAD-adjacent supplementation deserves extra thought with a personal or family cancer history. And anything statin- or GLP-1-related is a prescriber conversation built on your numbers, not a podcast decision. The aim, always: the lowest effective anything.

Ask your provider: "Beyond my cholesterol, what do my fasting insulin, ApoB, and inflammatory markers say about my actual risk?"

LABS THAT MOVE DECISIONS

- **Fasting insulin:** in my opinion, the most under-ordered lab in midlife medicine; it rises years before glucose does
- **A1c + fasting glucose:** the standard pair
- **ApoB:** a truer read on cardiovascular particle burden than LDL alone
- **Lp(a):** largely genetic; usually tested once, though levels can drift up after menopause
- **hs-CRP:** the inflammation backdrop; only meaningful when you're well

"Normal" is a population statistic, not a personal target. What's optimal for you is a conversation.

SMART GIRL MOVES THIS WEEK

- Anchor breakfast with ~30g protein
- Strength train two to three times weekly. Muscle is one of the most powerful longevity levers we have.
- Walk 10 minutes after your largest meal

4 Hair

A WHOLE-BODY SIGNAL IN A COSMETIC DISGUISE

The reframe that matters. Midlife shedding is rarely just a hair problem. Estrogen helps hold follicles in their growth phase; as it declines, the estrogen-to-androgen balance shifts and unmasks any inherited follicle sensitivity, so hair rests and sheds more than it grows. Layer in low iron, thyroid, stress, or rapid weight loss ("GLP-1 shedding" is usually about speed and protein, not the medication alone) and it can signal what's going on inside your body.

Before you test. High-dose biotin can distort thyroid and even cardiac lab assays; many providers will have you pause it for about two days before a draw, and it rarely moves the needle unless you're truly deficient. As for the low-dose oral minoxidil everyone asks me to dose in the comments: that's prescription territory.

Ask your provider: "Is my ferritin merely normal, or is it optimal?"

THE WORKUP BEHIND THE SHEDDING

- **Ferritin + iron studies:** the classic miss; can read falsely "normal" with inflammation
- **TSH + free T4**, thyroid antibodies if indicated
- **Hormones:** estradiol, testosterone, DHEA-S
- **Vitamin D, zinc:** supporting cast

SMART GIRL MOVES

- Photograph your part monthly. Data beats panic.
- Sudden shedding two to three months after illness, stress, or rapid weight change is often telogen effluvium: find the cause.

The Stack Audit

This is the exercise I've walked hundreds of women through in clinic before changing a single thing in their stack, and it's the fastest way to find the products performing wellness without producing it.

1. **Inventory everything.**
   Prescriptions, supplements, powders, drips, patches. All of it, in one place.
2. **Write the "why" next to each.**
   One sentence. "A podcast said" is an answer; it's just not a good one.
3. **Circle what has data behind it.**
   Your data. A lab value, a symptom you're tracking, a provider's plan. Not vibes.
4. **Flag the orphans.**
   Anything with no "why" and no data is a candidate to discuss deprescribing with your clinician.
5. **Choose your one variable.**
   The single change you'd test next, and the labs you'd want first. That's how a stack becomes a strategy.

WHAT YOU WON'T FIND HERE

A single dose. Doses belong between you and a provider who knows your labs and your history. Anyone handing out milligrams in a caption is guessing with your body.

THE MICRO STANDARD

Lowest effective dose. Precision over more. Your data over someone's comment section.



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