Welcome to Rushmore Compounding Pharmacy!

Thank you for choosing us to help you with your hormone replacement therapy journey.

Please take a few minutes to read this information sheet. It will answer the most frequently asked questions and explain the process of testing your hormones. If you have any further questions, please feel free to contact us.

- All hormones require a prescription. If you have a current provider, we can work with them. If you do not have a provider, please reach out to us as we do have a provider list.
- The next step is to complete a ZRT kit. These are free from our pharmacy, and you pay ZRT directly for your labs. After ZRT processes the labs, they are sent to us to review.
    - Types of ZRT kits
        - Saliva kits are preferred for most patients, for sex hormones (e.g. estradiol, progesterone, DHEA, and testosterone) and cortisol levels.
        - Blood spot kits are also available for patients who cannot produce enough saliva. If patients are using a topical hormone cream, contamination can occur resulting in inaccurate labs. This kit is not recommended for patients interested in cortisol levels, who experience fatigue, trouble sleeping, high stress, or burnout symptoms.
    - Each kit has full instructions on collection and mailing. **For the most information, we recommend S-142 | LCMS Hormones 7 with 4-point cortisol**. This includes sex hormone testing and an adrenal profile (DHEA and cortisol).
    - Please speak with the pharmacist if you are currently on birth control (including IUDs and implants). There are special considerations and labs may not be helpful.
    - Please speak with the pharmacist if you are currently a smoker, as hormones may not be indicated.
- In addition to a ZRT kit, **each patient will fill out a questionnaire. This should be returned to us before your consultation as we will use this information**, along with your labs, to make recommendations to your provider. **Please do not send it in with your labs, ZRT will dispose of it.** The questionnaire can be scanned and emailed, mailed or faxed back to us.
- When we receive your test results, we will call you to schedule a consultation with a pharmacist. These are done over the phone, and the consult fee is $75. The pharmacist will discuss prescription and over the counter options, and send a recommendation to your provider, if appropriate. Pending approval from your provider, we will call you when your prescription is ready for pickup. Please note that these medications are compounded specifically for you and can take 2-3 business days for us to make. We also do not contract with any insurance companies, so the cost of each prescription is an out-of-pocket expense. We can supply you with a reimbursement form that you can submit to your insurance company.

RUSHMORE COMPOUNDING PHARMACY

1308 MT. RUSHMORE RD
RAPID CITY, SD 57701
PHONE: 605-721-0831

Today's date: _____

Name: _____ **Birth Date:** _____ **Age:** _____

Address: _____ **Phone** _____

City: _____ **State:** _____ **Zip Code:** _____

Height: _____ **Weight:** _____ **Desired Weight:** _____

Doctor we should contact for this therapy:
Name: _____
Address: _____
Phone: _____ **Fax:** _____

How often and how much?
Do you use tobacco? ____ yes ** ____ no **Please note that hormones may not be recommended
Do you use alcohol? ____ yes ____ no _____
Do you use caffeine? ____ yes ____ no _____

Allergies: Please list all that apply.
Drugs: _____
Foods: _____
Other: _____
Please describe the allergic reaction and when it occurred: _____
_____
_____

Please list all over the Over-The-Counter (OTC) items you currently or occasionally use, such as antacids, pain relievers, acid blockers, laxatives, antihistamines, decongestants, cough suppressants, anti-diarrheals, sleep aids, etc. (NOT INCLUDING NUTRITIONAL SUPPLEMENTS):

_____
_____

Medical Conditions/Diseases: Please check all that apply to you.

___ Heart disease	___ High cholesterol	___ High blood pressure	___ Cancer
___ Ulcers	___ Thyroid disease	___ Hormonal related issues	___ Lung condition
___ Blood clotting problems	___ Diabetes	___ Arthritis or joint problems	___ Depression
___ Epilepsy	___ Headaches/Migraines	___ Eye disease	___ Bipolar Disorder
___ Chronic Fatigue Syndrome	___ Lyme Disease	___ Schizophrenia	___ Infection: please list
___ Parkinson's Disease	___ Irritable Bowel Syndrome	___ Traumatic Brain Injury	___ Other please list

_____
_____

How many pregnancies have you had? ____ How many children? ____ Ages: _____
Have you had a hysterectomy? _____ If yes when: _____
What was the cause of the hysterectomy? _____
Were your ovaries removed? _____ Have you had a tubal ligation? _____ If yes when: _____

Do you have a family history of any of the following?

Uterine Cancer	_____	Family member(s) _____
Ovarian Cancer	_____	Family member(s) _____
Fibrocystic Breast	_____	Family member(s) _____
Breast Cancer	_____	Family member(s) _____
Heart Disease	_____	Family member(s) _____
Alzheimer's disease	_____	Family member(s) _____
Osteoporosis	_____	Family member(s) _____

Have you had any of the following tests performed?

Mammography ____	Date: _____	Outcome: _____
PAP Smear ____	Date: _____	Outcome: _____
Bone Density ____	Date: _____	Outcome: _____

At what age did your periods begin? _____
Since then have you ever had what YOU would consider to be abnormal cycles? ____ If yes please tell when this occurred and what symptoms you experienced: _____
_____
_____

When was your last period? _____ How many days did it last? _____

Do you have Premenstrual Syndrome (PMS)? _____ If yes please explain symptoms:
_____
_____

Nutritional/Natural Supplements: Please identify and list the products you are using:
- This includes vitamins, supplements, nutritional foods, probiotics, herbs, etc.

_____
_____
_____
_____
_____
_____

Patient Name: _____

Current Hormone Therapies:

Name	Strength	Date Started	How often per day

List hormones previously taken.

Name	Date Started	Date Stopped	Reason

Current Prescription Medications:

Name	Strength	Date Started	How often per day

Have you ever used contraceptives? _____ Any problems? _____ If yes please describe:

_____
_____
_____
_____
_____

How frequently do you have a bowel movement? _____

Is this a change from normal frequency? _____

Patient Name _____

How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy (BHRT)?

Doctor ___ Self ___ Friend/Family Member ___ Other _____

What are your goals with BHRT or natural hormone replacement use?

_____
_____
_____

Please write down any questions you have about BHRT?

_____
_____
_____
_____
_____
_____
_____

Are you sexually active? ☐ Yes ☐ No

Do you ever experience pain with intercourse or sexual activity?

☐ Rarely ☐ Sometimes ☐ Often

Do you ever experience vaginal dryness with intercourse or sexual activity? ☐ Yes ☐ No

How would you describe your stress level?

_____
_____
_____
_____

Do you Exercise? YES NO
If yes describe what type and how often:

_____
_____
_____
_____

Patient Name: _____

Symptom Survey

Instructions: Please enter the appropriate response number to each question in the columns below.

0 = None/ Absent 1 = Mild or Rare 2 = Moderate 3 = Severe

Add an * (asterisk) if symptom is intermittent or "comes & goes".

___ Hot flashes
___ Night sweats
___ Vaginal Dryness
___ Incontinence
___ Bleeding changes
___ Uterine fibroids
___ Water retention
___ Tender Breast
___ Fibrocystic Breast
___ Increased Forgetfulness
___ Foggy Thinking
___ Tearful
___ Depressed
___ Mood Swings
___ Stress
___ Morning fatigue
___ Evening fatigue
___ Difficulty sleeping
___ Decreased stamina

___ Anxiety
___ Irritability
___ Nervousness
___ Fibromyalgia
___ Allergies
___ Headaches
___ Sugar cravings
___ Dizziness
___ Cold body temperature
___ Goiter
___ Hoarseness
___ Dry or brittle hair
___ Brittle or breaking nails
___ Constipation
___ Slow pulse rate
___ Rapid heartbeat
___ Heart Palpitations
___ Infertility problems
Other: _____

___ Acne
___ Increased facial or body hair
___ Scalp hair loss
___ Weight gain in the hips
___ Weight gain in the waist
___ High Cholesterol
___ Elevated triglycerides
___ Decreased Libido
___ Decreased muscle size
___ Thinning skin
___ Ringing in the ears
___ Rapid Aging
___ Aches and Pains
___ Bone Loss
___ Panic Attacks
___ ADD/ADHD
___Compulsions/Addictions

How old are you? _____ **How old do you feel? _____**

Patient Name _____