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 _____
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 you 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
If yes, please check how frequently you have sex: ☐ Rarely ☐ Sometimes ☐ Often
Are you satisfied with this level of sexual activity? ☐ 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
We have a more thorough female sexual function evaluation. Would you like to explore and talk further about female sexual dysfunction? ☐ 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	___ Anxiety	___ Acne
___ Night sweats	___ Irritability	___ Increased facial or body hair
___ Vaginal Dryness	___ Nervousness	___ Scalp hair loss
___ Incontinence	___ Fibromyalgia	___ Weight gain in the hips
___ Bleeding changes	___ Allergies	___ Weight gain in the waist
___ Uterine fibroids	___ Headaches	___ High Cholesterol
___ Water retention	___ Sugar cravings	___ Elevated triglycerides
___ Tender Breast	___ Dizziness	___ Decreased Libido
___ Fibrocystic Breast	___ Cold body temperature	___ Decreased muscle size
___ Increased Forgetfulness	___ Goiter	___ Thinning skin
___ Foggy Thinking	___ Hoarseness	___ Ringing in the ears
___ Tearful	___ Dry or brittle hair	___ Rapid Aging
___ Depressed	___ Brittle or breaking nails	___ Aches and Pains
___ Mood Swings	___ Constipation	___ Bone Loss
___ Stress	___ Slow pulse rate	___ Panic Attacks
___ Morning fatigue	___ Rapid heartbeat	___ ADD/ADHD
___ Evening fatigue	___ Heart Palpitations	___Compulsions/Addictions
___ Difficulty sleeping	___ Infertility problems	
___ Decreased stamina	Other: _____	

_____

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

Patient Name _____