Keystone Pharmacy's Consulting Services

4021 Cascade Road SE • Grand Rapids, MI 49546 •
Phone (616) 974-9792• Fax (616) 464-3469

Hours of Operation:
Monday – Thursday 8:30-2:30pm
(Appointments will be accommodated outside of these hours as per patient's needs)

About Our Consultation Services

Keystone Pharmacy's Consulting Services are available to men and women of any age. Consultations are done by **appointment only** either in person or on the telephone. We provide our clients with a Consultation Personal & Health History Questionnaire prior to his/her appointment. Following the consultation and/or attaining test results, we will recommended (if appropriate) a hormone therapy dosage to your physician. This recommendation is then faxed to our client's physician for approval. There is a possibility, although diminutive, a physician may not approve our recommendation (please ask for a list of recommended physicians or have physician sign Authorization to Consult form in advance). We ask that our clients verify their prescription has been approved before stopping in to pick it up or expecting it to be shipped. **Upon approval by the physician, you may pick your prescription up within 24 business hours.**

To make an appointment: Please call 616-974-9792 or email us at info@keystonerx.com to schedule an appointment. We ask our patients to leave their name, telephone number and address where they can be reached. Our consulting pharmacists will then send a letter confirming the appointment, along with a Consultation Personal & Health History Questionnaire for our client to complete and turn in prior to his/her appointment [**please email the completed form to** maryp@keystonepharm.com or **fax** (616)-464-3469]. We ask that the staff be informed if there are time limitations involved with scheduling (ex. I have no more than 20 minutes). Arriving more than **10 minutes late** may cause your appointment to be cancelled and **rescheduled**. Less than 24 hour cancellation may be subject to a $25.00 fee. Please bring all prescription medications, over the counter medications, vitamins, supplements and herbal treatments with you to your appointment. The actual containers or bottles are important.

Achieving hormonal balance: It is important to know regaining hormonal balance is a delicate and sometimes lengthy process. Hormone dosing is unique to each patient and proper diet, nutrition and exercise all play a role in effectively balancing hormones. Therefore, it may take a number of months before results become manifest. Recommended **adjustments** to your prescription, submitted to your physician for approval, **will not** be considered prior to the second month of therapy. Adjustments, if necessary, can only be assessed per scheduled follow up consultation.

Life Style Modifications: Adequate exercise and stress management are important to implement, as they play an important role in our health. Excessive use of alcohol/recreational drugs, prescription medications and certain disease states may affect our well-being.

Supplements: A healthy diet is key to optimal health. A diet rich in: vegetables, fruits, whole grains, essential fats, fat-free or low-fat milk and milk products, lean meats, poultry, fish, beans, eggs, and nuts is recommended. Unfortunately, the fast-paced lifestyle of many Americans very often leads to a diet lacking the essential foods that should be present in a healthy diet. Supplementation and nutraceuticals can be used to regain these vital nutrients. Most of our BHRT patients begin the following regimen (there are exceptions based on individual needs):

- OsteoSheath (Calcium/Magnesium /Vitamin D)
- Indole-3-Carbinol or DIM
- Probiotic Therapy
- Multi-Vitamin and B complex
- EPA/DHA (essential fatty acids)
- Alpha Lipoic Acid or other super anti-oxidant

The Consultation fees are as follows:

Initial Consult	$299.00

The consultation includes:

- An initial 1 hour consultation with
- Scheduled 15 minute follow up consultations at no additional charge within one calendar year.

Extension of consultation services for one year for established patients	$199.00

Additional services* (may be needed for assessment and therapy recommendation).

Saliva Testing:	Complete panel	$170.00
	Individual Hormones	$ 50.00
Adrenal stress index		$185.00

Mary Heim, R.Ph, Anti-Aging & Functional Medicine Fellow

Mary Heim is a registered pharmacist and graduate of Ferris State University School of Pharmacy. In addition to her extensive training in traditional pharmacy topics, Mary is uniquely qualified to work with prescribers to customize hormone therapies. She has received advanced training in clinical aspects of women's health including proper consideration and use of hormones for men and women. In addition to women's health issues, she has completed her fellowship in Anti-Aging & Functional Medicine (a title rare to Pharmacists) and become board certified as a Health Practioner by The American Board of Anti-Aging.

* Please note that most insurance companies do not cover saliva hormone testing or Consultations. Various insurances, however, cover hormone replacement. We do not bill insurances for consultations or saliva testing, although we will attempt to bill your prescription to insurance.

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CONSULTATION PERSONAL & HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

PERSONAL and BILLING INFORMATION				
Name *(Last, First, M.I.):* **{** FORMTEXT **}**				
{ FORMCHECKBOX **}** M **{** FORMCHECKBOX **}** F	**DOB: {** FORMTEXT **}**	**MI Driver license# {** FORMTEXT **}**	**Height {** FORMTEXT **}**	**Weight {** FORMTEXT **}**
Address { FORMTEXT **}**		**City {** FORMTEXT **}**		**Zip:{** FORMTEXT **}**
Home Phone { FORMTEXT **}**	**Work Phone {** FORMTEXT **}**	**Cell Phone {** FORMTEXT **}**	**Email {** FORMTEXT **}**	
Marital status { FORMCHECKBOX } Single { FORMCHECKBOX } Partnered { FORMCHECKBOX } Married { FORMCHECKBOX } Separated { FORMCHECKBOX } Divorced { FORMCHECKBOX } Widowed				
Previous or referring doctor { FORMTEXT **}**		**Date of last physical exam {** FORMTEXT **}**		
Doctor's Address { FORMTEXT **}**		**City {** FORMTEXT **}**		**State {** FORMTEXT **}**
Doctor's phone # { FORMTEXT }		**Doctor's fax # {** FORMTEXT **}**		
Occupation { FORMTEXT **}**		**Employer {** FORMTEXT **}**		
Name of Prescription Insurance { FORMTEXT **}**		**Insurance ID/Contract # {** FORMTEXT **}**		
Insurance Group # { FORMTEXT **}**	**Insurance Cardholder's name { FORMTEXT }**	**Cardholder's Relation to self {** FORMTEXT **}**		
Phone number on the back of your card for customer service { FORMTEXT **}**				
***If request shipping* of medications provide credit card**	**Credit Card # {** FORMTEXT **}**	**Expiration {** FORMTEXT **}**		
Cardholder's name as it reads on the card **{ FORMTEXT }**				
Portage Pharmacy, Keystone or Sturgis Family Pharmacy is authorized to bill my credit card for consultation services and/or product wanted by myself and has my permission to keep on file and bill appropriate shipping fees if applicable: { FORMCHECKBOX } YES { FORMCHECKBOX } NO				

PERSONAL HEALTH HISTORY
List any medical problems that other doctors have diagnosed
{ FORMTEXT **}**
{ FORMTEXT **}**
{ FORMTEXT **}**
{ FORMTEXT **}**
Surgeries

Year	**Reason**	**Hospital**
{ FORMTEXT **}**	**{** FORMTEXT **}**	**{** FORMTEXT **}**
{ FORMTEXT **}**	**{** FORMTEXT **}**	**{** FORMTEXT **}**
{ FORMTEXT	**{** FORMTEXT **}**	**{** FORMTEXT **}**

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}		
{ FORMTEXT }	{ FORMTEXT }	{ FORMTEXT }

Other hospitalizations		
Year	**Reason**	**Hospital**
{ FORMTEXT }	{ FORMTEXT }	{ FORMTEXT }
{ FORMTEXT }	{ FORMTEXT }	{ FORMTEXT }
{ FORMTEXT }	{ FORMTEXT }	{ FORMTEXT }

List your prescribed drugs, over-the-counter drugs, supplements, vitamins, inhaler and any hormone replacements that you take EVERY DAY or ON OCCASSION		
Name the Drug	**Strength**	**Frequency Taken**
{ FORMTEXT }	{ FORMTEXT }	{ FORMTEXT }
{ FORMTEXT }	{ FORMTEXT }	{ FORMTEXT }
{ FORMTEXT }	{ FORMTEXT }	{ FORMTEXT }
{ FORMTEXT }	{ FORMTEXT }	{ FORMTEXT }
{ FORMTEXT }	{ FORMTEXT }	{ FORMTEXT }
{ FORMTEXT }	{ FORMTEXT }	{ FORMTEXT }
{ FORMTEXT }	{ FORMTEXT }	{ FORMTEXT }
{ FORMTEXT }	{ FORMTEXT }	{ FORMTEXT }

Allergies to medications	
Name the Drug	**Reaction You Had**
{ FORMTEXT }	{ FORMTEXT }
{ FORMTEXT }	{ FORMTEXT }
{ FORMTEXT }	{ FORMTEXT }

HEALTH HABITS

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	**{ FORMCHECKBOX } Sedentary (No exercise)**		
	{ FORMCHECKBOX } Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	{ FORMCHECKBOX } Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	{ FORMCHECKBOX } Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	**Are you dieting?**	**{ FORMCHECKBOX } Yes**	**{ FORMCHECKBOX } No**
	If yes, are you on a physician prescribed medical diet?	**{ FORMCHECKBOX } Yes**	**{ FORMCHECKBOX } No**

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					}	}
	# of meals you eat in an average day? { FORMTEXT }					
	Rank salt intake	{ FORMCHECKBOX } Hi	{ FORMCHECKBOX } Med	{ FORMCHECKBOX } Low		
	Rank fat intake	{ FORMCHECKBOX } Hi	{ FORMCHECKBOX } Med	{ FORMCHECKBOX } Low		
	Are you binge eating?	{ FORMCHECKBOX } Yes	{ FORMCHECKBOX } No	If, so how often?		
Caffeine	☐ None	{ FORMCHECKBOX } Coffee	{ FORMCHECKBOX } Tea	{ FORMCHECKBOX } Cola		
	# of cups/cans per day? { FORMTEXT }					
Alcohol	Do you drink alcohol?				{ FORMCHECKBOX } Yes	{ FORMCHECKBOX } No
	If yes, what kind? { FORMTEXT }					
	How many drinks per week? { FORMTEXT }					
	Are you concerned about the amount you drink?				{ FORMCHECKBOX } Yes	{ FORMCHECKBOX } No
	Have you considered stopping?				{ FORMCHECKBOX } Yes	{ FORMCHECKBOX } No
	Have you ever experienced blackouts?				{ FORMCHECKBOX } Yes	{ FORMCHECKBOX } No
	Are you prone to "binge" drinking?				{ FORMCHECKBOX } Yes	{ FORMCHECKBOX } No
	Do you drive after drinking?				{ FORMCHECKB Yes	{ FORMCHECKB No

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					OX }	OX }
Tobacco	**Do you use tobacco?**				{ FORMCHECKBOX } **Yes**	{ FORMCHECKBOX } **No**
	{ FORMCHECKBOX } Cigarettes – pks./day { FORMTEXT }	**{ FORMCHECKBOX } Chew - #/day { FORMTEXT }**	**{ FORMCHECKBOX } Pipe - #/day { FORMTEXT }**	**{ FORMCHECKBOX } Cigars - #/day { FORMTEXT }**		
	{ FORMCHECKBOX } # of years { FORMTEXT }	**{ FORMCHECKBOX } Or year quit { FORMTEXT }**				
Drugs	**Do you currently use recreational or street drugs?**				{ FORMCHECKBOX } **Yes**	{ FORMCHECKBOX } **No**
	Have you ever given yourself street drugs with a needle?				{ FORMCHECKBOX } **Yes**	{ FORMCHECKBOX } **No**
Sex	**Are you sexually active?**				{ FORMCHECKBOX } **Yes**	{ FORMCHECKBOX } **No**
	If yes, are you trying for a pregnancy?				{ FORMCHECKBOX } **Yes**	{ FORMCHECKBOX } **No**
	If not trying for a pregnancy list contraceptive or barrier method used: { FORMTEXT }					
	Any discomfort with intercourse?				{ FORMCHECKBOX } **Yes**	{ FORMCHECKBOX } **No**
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?				{ FORMCHECKBOX } **Yes**	{ FORMCHECKBOX } **No**

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FAMILY HEALTH HISTORY					
	AGE	**SIGNIFICANT HEALTH PROBLEMS**		**AGE**	**SIGNIFICANT HEALTH PROBLEMS**
Father	{ FORMTEXT }	{ FORMTEXT }	**Children**	{ FORMCHECKBOX } M { FORMCHECKBOX } F	{ FORMTEXT }
Mother	{ FORMTEXT }	{ FORMTEXT }		{ FORMCHECKBOX } M { FORMCHECKBOX } F	{ FORMTEXT }
Sibling	{ FORMCHECKBOX } M { FORMCHECKBOX } F	{ FORMTEXT }		{ FORMCHECKBOX } M { FORMCHECKBOX } F	{ FORMTEXT }
	{ FORMCHECKBOX } M { FORMCHECKBOX } F	{ FORMTEXT }		{ FORMCHECKBOX } M { FORMCHECKBOX } F	{ FORMTEXT }
	{ FORMCHECKBOX } M { FORMCHECKBOX } F	{ FORMTEXT }	**Grandmother** *Maternal*	{ FORMTEXT }	{ FORMTEXT }
	{ FORMCHECKBOX }	{ FORMTEXT }	**Grandfather** *Maternal*	{ FORMTEXT }	{ FORMTEXT }

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	M { FORMCHECKBOX }F				
	{ FORMCHECKBOX }M { FORMCHECKBOX }F	{ FORMTEXT }	**Grandmother** *Paternal*	{ FORMTEXT }	{ FORMTEXT }
	{ FORMCHECKBOX }M { FORMCHECKBOX }F	{ FORMTEXT }	**Grandfather** *Paternal*	{ FORMTEXT }	{ FORMTEXT }

MENTAL HEALTH

Is stress a major problem for you?	**{ FORMCHECKBOX } Yes**	**{ FORMCHECKBOX } No**
Do you feel depressed?	**{ FORMCHECKBOX } Yes**	**{ FORMCHECKBOX } No**
Do you panic when stressed?	**{ FORMCHECKBOX } Yes**	**{ FORMCHECKBOX } No**
Do you have problems with eating or your appetite?	**{ FORMCHECKBOX } Yes**	**{ FORMCHECKBOX } No**
Do you cry frequently?	**{ FORM Yes**	**{ FORM No**

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	CHECKBOX		CHECKBOX	
Have you ever seriously thought about hurting yourself?	{FORMCHECKBOX}	**Yes**	{FORMCHECKBOX}	**No**
Have you ever attempted suicide?	{FORMCHECKBOX}	**Yes**	{FORMCHECKBOX}	**No**
Do you have trouble sleeping?	{FORMCHECKBOX}	**Yes**	{FORMCHECKBOX}	**No**
Have you ever been to a counselor?	{FORMCHECKBOX}	**Yes**	{FORMCHECKBOX}	**No**

MAIN REASON FOR SCHEDULING A CONSULT TODAY
WHAT ARE THE GOALS YOU HOPE TO ACHIEVE FROM THIS CONSULT
HOW DID YOU FIND OUT ABOUT KEYSTONES BHRT CONSULTING SERVICES?

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WOMEN ONLY			
Age at onset of menstruation: { FORMTEXT }	**Would you consider your cycles to be normal? {** FORMTEXT **}** If yes, explain:		
Date of last menstruation: { FORMTEXT }	**How many days did it last? {** FORMTEXT **}**		
Period every { FORMTEXT } days			
Heavy periods, irregularity, spotting, pain, or discharge?	**{ FORMCHECKBOX }**	**Yes**	**{ FORMCHECKBOX } No**
Number of pregnancies { FORMTEXT } Number of live births { FORMTEXT }			
Are you pregnant or breastfeeding?	**{ FORMCHECKBOX }**	**Yes**	**{ FORMCHECKBOX } No**
Have you had a D&C, hysterectomy, or Cesarean?	**{ FORMCHECKBOX }**	**Yes**	**{ FORMCHECKBOX } No**
Have you had or do you have a family history of the following? **{ FORMCHECKBOX } Uterine CA { FORMCHECKBOX } Fibrocystic breasts { FORMCHECKBOX } Heart disease { FORMCHECKBOX } Ovarian CA { FORMCHECKBOX } Breast CA { FORMCHECKBOX } Endometriosis { FORMCHECKBOX } Osteoporois**			
Have your ever			
Any urinary tract, bladder, or kidney infections within the last year?	**{ FORMCHECKBOX }**	**Yes**	**{ FORMCHECKBOX } No**

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Any blood in your urine?	**{ FORMCHECKBOX }**	**Yes**	**{ FORMCHECKBOX }**	**No**
Any problems with control of urination?	**{ FORMCHECKBOX }**	**Yes**	**{ FORMCHECKBOX }**	**No**
Any hot flashes or sweating at night?	**{ FORMCHECKBOX }**	**Yes**	**{ FORMCHECKBOX }**	**No**
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	**{ FORMCHECKBOX }**	**Yes**	**{ FORMCHECKBOX }**	**No**
Experienced any recent breast tenderness, lumps, or nipple discharge?	**{ FORMCHECKBOX }**	**Yes**	**{ FORMCHECKBOX }**	**No**
Date of last: { FORMCHECKBOX } Pap _____ pos/neg { FORMCHECKBOX } Rectal exam _____ pos/neg { FORMCHECKBOX } Mammogram_____ pos/neg				
CURRENT SYMPTOMS				

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Symptom	ABSENT	MILD	MODERATE	SEVERE
Weight gain				
Heavy/Irregular menses				
Hot Flashes/Night Sweats				
Dry skin/hair and/or Hair loss				
Anxiety				
Depression				
Vaginal Dryness				
Headaches				
Irritability/Mood Swings				
Breast Tenderness				
Sleep disturbances/insomnia				
Extreme cramps				
Fluid retention/bloating				
Breakthrough bleeding				
Fatigue				
Loss of memory				
Loss of bladder control symptoms				
Decreased libido/sex drive				

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MEN ONLY				
Have you noticed any of the following physical symptoms?				
{ FORMCHECKBOX } Less body hair? **{ FORMCHECKBOX } Obesity** **{ FORMCHECKBOX } Gynecomastia (breast enlargement)** **{ FORMCHECKBOX } Decreased muscle mass** **{ FORMCHECKBOX } Osteoporosis** **{ FORMCHECKBOX } Repeated inability to achieve or maintain an erection sufficient for sexual intercourse**				
Do you experience difficulty getting urination started?	**{ FORMCHECKBOX }**	**Yes**	**{ FORMCHECKBOX }**	**No**
Do you usually get up to urinate during the night?	**{ FORMCHECKBOX }**	**Yes**	**{ FORMCHECKBOX }**	**No**
If yes, # of times { FORMTEXT }				
Do you feel pain or burning with urination?	**{ FORMCHECKBOX }**	**Yes**	**{ FORMCHECKBOX }**	**No**
Any blood in your urine?	**{ FORMCHECKBOX }**	**Yes**	**{ FORMCHECKBOX }**	**No**
Do you feel burning discharge from penis?	**{ FORM**	**Yes**	**{ FORMCHEC**	**No**

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	CHECKBOX}		KBOX}	
Has the force of your urination decreased?	{FORMCHECKBOX}	**Yes**	{FORMCHECKBOX}	**No**
Have you had any kidney, bladder, or prostate infections within the last 12 months?	{FORMCHECKBOX}	**Yes**	{FORMCHECKBOX}	**No**
Do you have any problems emptying your bladder completely?	{FORMCHECKBOX}	**Yes**	{FORMCHECKBOX}	**No**
Any difficulty with erection or ejaculation?	{FORMCHECKBOX}	**Yes**	{FORMCHECKBOX}	**No**
Any testicle pain or swelling?	{FORMCHECK	**Yes**	{FORMCHECKBOX}	**No**

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	B O X }	
Date of last prostate and rectal exam? { FORMTEXT }		

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Informed Consent Form

Date: { FORMTEXT }
Name: { FORMTEXT } DOB: { FORMTEXT }

Address: { FORMTEXT }
City: { FORMTEXT } State: { FORMTEXT } Zip: { FORMTEXT }
Phone/Home: { FORMTEXT } Cell: { FORMTEXT }

I hereby release Keystone Pharmacy and its employees and affiliates from any and all responsibility or liability arising from or in any way connected with screenings, consultations or our weight management programs. I understand that:

1. The data and/or results derived from such screenings, testing, consultations and programs are to be considered preliminary only. The results are in no way conclusive and do not constitute a diagnosis of a medical condition.
2. The responsibility for initiating any follow-up care to confirm the results through screenings or testing and obtain professional medical assistance is mine alone, and not that of Keystone pharmacy and its affiliates.
3. My personal medical file will be shared with the prescribing physician. No other person will have access to my file without my express verbal or written permission. Aggregate data may be used for statistical and research purposes only.

_____Signature