MASTERS FAMILY MEDICAL

MFM

Family Practice

www.MastersFamilyMedical.com

234 West Central Ave
Jamestown, TN 38556
(931) 879-8139

117 West Commercial Ave
Monterey, TN 38574
(931) 310-2900

PATIENT INFORMATION

NAME_____ **DOB**_____
LAST FIRST INITIAL

DENTIST_____ **OPTOMITRIST**_____ **PHARMACY**_____

CURRENT MEDICATIONS (PLEASE LIST BY NAME, DOSE AND FREQUENCY TAKEN DAILY):_____

_____

_____

_____

_____

ALLERGIES: _____

PLEASE LIST ANY SPECIALISTS YOU FOLLOW UP WITH (i.e. HEART, LUNG, KIDNEY, ARTHRITIS DOCTORS etc.):_____

_____

_____

_____

PLEASE LIST ALL MAJOR SURGERIES AND DATES PERFORMED: _____

_____

_____

_____

CHECK WHETHER OR NOT YOU HAVE HAD THE LISTED PREVENTATIVE PROCEDURES:

	YES	NO	DATE		YES	NO	DATE
COLONOSCOPY	☐	☐	_____	**MAMMOGRAM**	☐	☐	_____
PAP SMEAR	☐	☐	_____	**DEXA SCAN**	☐	☐	_____

SOCIAL HISTORY

OCCUPATION:_____
DAILY CAFFEINE INTAKE:_____ **TOBACCO USE TYPE/AMOUNT:**_____
ALCOHOL USE TYPE/AMOUNT:_____ **DRUG USETYPE/AMOUNT:**_____

IMMUNIZATIONS

PLEASE CHECK WHICH APPLIES TO YOU AND LIST THE DATE IF APPLICABLE

YES	NO	DATE		YES	NO	DATE	
☐	☐	_____	**TETANUS**	☐	☐	_____	**COVID-19**
☐	☐	_____	**PNEUMONIA**	☐	☐	_____	**SHINGLES**
☐	☐	_____	**INFLUENZA**	☐	☐	_____	**HEPATITIS B SERIES**

MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY TO YOU

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	ARTHRITIS	☐	☐	COPD/EMPHYSEMA	☐	☐	HIV/AIDS	☐	☐	ADD/ADHD
☐	☐	DEPRESSION	☐	☐	KIDNEY DISEASE	☐	☐	ALLERGIES	☐	☐	DIABETES
☐	☐	KIDNEY STONES	☐	☐	ALCOHOLISM	☐	☐	CANCER	☐	☐	MIGRAINES
☐	☐	ANEMIA	☐	☐	GOUT	☐	☐	MULTIPLE SCLEROSIS	☐	☐	ANXIETY
☐	☐	HTN	☐	☐	PACEMAKER	☐	☐	DEFIBRILLATOR	☐	☐	ANOREXIA
☐	☐	HEART DISEASE	☐	☐	PROSTATE DISEASE	☐	☐	ASTHMA	☐	☐	HEART FAILURE
☐	☐	HYPOTHYROID	☐	☐	HYPERTHYROID	☐	☐	BLOOD DISORDER	☐	☐	HEART ATTACK
☐	☐	STROKE/CVA/TIA	☐	☐	BLOOD TRANSFUSION	☐	☐	HIGH CHOLEST.	☐	☐	STD/HERPES
☐	☐	BRONCHITIS	☐	☐	HEPATITIS	☐	☐	SEIZURES	☐	☐	CATARACTS

FAMILY HISTORY

PLEASE CHECK ALL THAT APPLY TO YOU

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	ARTHRITIS	☐	☐	COPD/EMPHYSEMA	☐	☐	LUPUS	☐	☐	HEART ATTACK
☐	☐	ASTHMA	☐	☐	KIDNEY DISEASE	☐	☐	GOUT	☐	☐	HEART DISEASE
☐	☐	ALCOHOLISM	☐	☐	CANCER	☐	☐	HTN	☐	☐	DIABETES
☐	☐	HYPOTHYROID	☐	☐	HYPERTHYROID	☐	☐	HIGH CHOLESTEROL			

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY HEALTHCARE PROVIDER OR ANY MEMBERS OF HIS/HER STAFF RESPONSIBLE FOR ANY ERROR OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

_____

PRINTED NAME

_____

SIGNATURE **DATE**