MASTERS FAMILY MEDICAL
MFM
Family Practice
www.MastersFamilyMedical.com

234 West Central Ave
Jamestown, TN. 38556
Phone: (931) 879-8139
Fax: (931) 879-6819

117 W Commercial Ave
Monterey, TN. 38574
Phone: (931) 310-2900
Fax: (972) 947-516

Date: _____

Medical History

Name: _____ Date of Birth: _____

Primary Provider_____ Pharmacy: _____

Occupation: _____

Medications: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc.

Medication	Dose (e.g., mg/pill)	How many times per day?

Allergies or intolerance to medications (include type of reaction): ☐ **NONE**

_____
_____

Medical Problems: Have you had (or do you have) any of the following medical problems (please circle):

High Blood Pressure	Cancer	Asthma	Lung Disease
Abnormal PAP Smear	Heart Disease	Arthritis	Urinary Tract Infection
Heart Attack	Tuberculosis	Seizure Disorder	Liver Disease/Hepatitis
Pancreas Disorder	Stroke	Sickle Cell	Blood Transfusion
Diabetes	Anemia	STDs	Thyroid Dz/Cancer
Kidney Disease	HIV/AIDS	Other:_____	

List any other providers/specialists that you see: _____
_____

Semaglutide/Tirzepatide Consent Form

Semaglutide/Tirzepatide is a human-based glucagon-like peptide-1 receptor agonist prescribed as an adjunct to a reduced calorie diet and increased physical activity for chronic weight management in adults with an initial0=[];[]

]]]] body mass index (BMI) that is considered outside a healthy range.

While using Semaglutide/Tirzepatide , it is highly recommended that you:

♣ Eat a fibrous diet. Focus on fruits and vegetables that are high in fiber.
♣ Eat small, high protein meals as digestion is slowed down while on this medication. ♣ Avoid foods high in fat as they take longer to digest.
♣ Limit alcohol intake as this medication can lower blood pressure.
♣ Drink at least 32 oz of water a day to avoid constipation.

Do not take this medication if:

♣ You have a personal or family history of medullary thyroid carcinoma (Thyroid Cancer)
♣ Multiple Endocrine Neoplasia syndrome type 2
♣ You are pregnant or plan to become pregnant while taking this medicine.
♣ You are diabetic and/or taking any medications related to lowering your blood sugar levels without speaking with your endocrinologist.

♣ Specifically, if you are prescribed Insulin because the combination may increase your risk of hypoglycemia (low blood sugar) and dosage adjustments by your provider may be necessary.
♣ You have a history of Pancreatitis.
♣ You are allergic to BPC-157, Semaglutide,Tirzepatide or any other GLP-1 agonist such as: Adlyxin®, Byeta®, Bydureon®, Ozempic®, Rybelsus®, Trulicity®, Victoza®, Wegovy®;

♣ If you have other allergies. This product may contain inactive ingredients, which can cause allergic reactions or other problems. Talk to your pharmacist for more details. Before using this medication, tell your doctor/pharmacist your medical history.

Possible drug interactions: Anti-diabetic agents, specifically: Insulin and Sulfonylureas (e.g., glyburide, glipizide, glimepiride, tolbutamide) due to the increased risk of hypoglycemia (low blood sugar). Do not take with other GLP-1 agonist medicines such as: Adlyxin®, Byeta®, Bydureon®, Mounjaro, Ozempic®, Rybelsus®, Trulicity®, Victoza®, Zepbound, Wegovy® (THIS IS NOT AN ALL-INCLUSIVE LIST). Other medications used in diabetes, please tell your provider about any medications that may lower your blood sugar.

_ Possible side effects: Nausea, diarrhea, vomiting, constipation, abdominal pain, headache, fatigue, dyspepsia, dizziness, abdominal distension, belching, hypoglycemia, flatulence, gastroenteritis, and gastroesophageal reflux disease. Subcutaneous Injections: common injection site reactions characterized by itching, burning at site of administration with or without thickening of the skin(welting). If you notice other side effects not listed above, contact your doctor or pharmacist.

A very serious allergic reaction to this drug is rare. However, get medical help right away if you notice any symptoms of a serious allergic reaction, including rash, itching/swelling (especially of the face/tongue/throat), severe dizziness, trouble breathing. Report adverse side effects to your doctor or pharmacist. In the event of any emergency, call 911 immediately.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THIS TREATMENT, OR ANY QUESTIONS CONCERNING THIS PROPOSED TREATMENT OR OTHER POSSIBLE TREATMENTS, ASK THE STAFF NOW BEFORE SIGNING THIS CONSENT FORM.

By signing, I certify that I have read and understand the contents of this form. I am aware of the possible side effects and drug interactions and give my consent for treatment. I have informed the medical staff of any known allergies to drugs or other substances, and any past adverse reactions I've experienced. I have informed the medical staff of all medications and supplements I'm currently taking. I understand there are other ways and programs that can assist me in my desire to decrease my body weight and acknowledge that no guarantees have been made to me concerning my results. I understand by signing I am giving consent to Masters Family Medical, PLLC treat me for weight loss.

Patient Name:_____ Date_____
Print

Patient Signature:_____

Hippa Policy

Patient Name: _____ DOB_____

I understand that under HIPPA I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct treatment and follow- up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from the third party payers
- Conduct normal healthcare operations, such as quality assessments and provider certification.

I have been provided a Notice of Privacy Practice containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practice.

I understand that I may revoke this consent in writing at any time, except to the extent you have taken action relying on this content.

I give Masters Family Medical, PLLC authorization to release information including the diagnosis, records, lab results, examination rendered to me and claims information to the following individuals :

Name:	**Relationship to patient**
_____	_____
_____	_____
_____	_____

Communication:

Please call this number to reach me:_____

If unable to reach me : ☐ Leave a detailed message ☐ Leave a message to return call

☐ **Do not** leave a message

Signed: _____ Date: _____

Witness: _____ Date:_____