William Cross Dudney, MD
205 S MacDill Avenue
Tampa, FL 33609
(813) 873-2036

Instructions

Thank you for taking the time to fill out this paperwork. Dr. Dudney uses this form to help develop an initial understanding of your individual medical circumstances, and to provide you with important information concerning your rights and responsibilities as a patient of this practice.

The information you provide here will be kept completely confidential, and will never be released without your permission.

There are three required sections of this form:

- Personal Information (page 2)
- Medical History (page 3)
- Informed Consent Form (page 7)

If you are seeking treatment for weight management, please also read the Weight Loss Consumer Bill of Rights on page 7.

Additionally, there are three sections that, while not required, will help expedite your evaluation:

- Mood & Emotional Inquiry (page 4)
- Attention Deficit Disorder Symptom Screening (page 5)

Please bring the completed forms with you to your first visit.

Note: Dr. Dudney's clinic *must* acquire a copy of your photo identification during your first visit, as required by Florida regulations. Therefore, please bring your driver's license, passport, military ID, or any other state or federally-issued identification bearing your photograph to your first visit.

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Personal Information – Required

Full Name: _____

Address: _____

Address (cont.): _____

City, State & ZIP: _____ State: _____ ZIP: _____

Email Address: _____ Phone: _____

Date of Birth: _____ Occupation: _____

Typical Work Schedule: _____

Marital Status: _____

Spouse's Occupation: _____

Please select yes or no for the following questions:

☐ Yes ☐ No I have a primary care physician. His/her name is: _____

☐ Yes ☐ No I have an annual physical exam most years.

☐ Yes ☐ No I have seen a primary care physician within the last three (3) months.

☐ Yes ☐ No I can provide Dr. Dudney with blood test results taken within the last three (3) months that include my cholesterol, sugar, and thyroid.

Referred By (check all that apply):

☐ Doctor
☐ Friend or family member
☐ Newspaper
☐ Magazine
☐ Internet
☐ Other _____

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Medical History – Required

Please check any medical condition below you currently have, or have previously had:

- ☐ Heart trouble
- ☐ Strokes
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Seizures
- ☐ Glaucoma
- ☐ Stomach acid
- ☐ Headaches
- ☐ Gall stones
- ☐ Severe depression
- ☐ Manic / bipolar
- ☐ Obesity in family
- ☐ Tired / fatigue
- ☐ Other: _____

If you use tobacco products, indicate type and amount: _____

If you consume alcohol, indicate amount per day: _____

Please select which medications, if any, you are <u>currently</u> taking:

- ☐ Hormones
- ☐ Birth control pills
- ☐ Steroids
- ☐ Water pills
- ☐ Blood pressure medication
- ☐ Anti-depressants, lithium, MAOI, or any other psychiatric medications
- ☐ Other (including vitamins and herbals): _____

I am allergic to the following medications: _____

One or more family members have been treated for:

- ☐ Cancer
- ☐ Diabetes
- ☐ Stroke
- ☐ Cholesterol
- ☐ Thyroid
- ☐ Obesity
- ☐ Heart disease
- ☐ Blood pressure

I have been hospitalized and/or required surgery in the past for: _____

_____

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Mood and Emotion Inquiry – Optional

Please check yes or no to the following questions:

☐ Yes	☐ No	I frequently experience sharp, irritable moods.
☐ Yes	☐ No	I may have issues with temper or anger control.
☐ Yes	☐ No	I frequently have feelings of crisis, dread, or being overwhelmed
☐ Yes	☐ No	I often experience sad, "blue," gloomy, or depressed moods.
☐ Yes	☐ No	I may have issues with anxiety or obsessive worrying.
☐ Yes	☐ No	I sometimes have thoughts of hurting myself or others.
☐ Yes	☐ No	I often have difficulty focusing, concentrating, or staying on task.
☐ Yes	☐ No	I can be mean, "bitchy," "cranky," or hard to get along with.
☐ Yes	☐ No	I am interested in discussing medical options for my mood and/or emotional management with Dr. Dudney.

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Attention Deficit Disorder (ADD) Symptom Screening – Optional

Please check yes or no to the following statements if they are true most of the time:

☐ Yes	☐ No	While at home or work, my mind wanders off task.
☐ Yes	☐ No	I find it difficult to concentrate on written material.
☐ Yes	☐ No	I find it hard to stay focused.
☐ Yes	☐ No	I have a quick temper and short fuse; fly off the handle too often.
☐ Yes	☐ No	I say things quickly that I later regret.
☐ Yes	☐ No	I am often told I am not following someone's conversation well.
☐ Yes	☐ No	I have trouble planning a series of tasks in proper order.
☐ Yes	☐ No	I try to work on several projects, but fail to finish some of them.
☐ Yes	☐ No	My mind gets so cluttered it becomes inefficient.
☐ Yes	☐ No	I am distressed by the disorganized way my brain works.
☐ Yes	☐ No	I have successfully benefitted from ADD meds in the past.
☐ Yes	☐ No	I am interested in talking with Dr. Dudney about whether ADD medications might be right for me and my unique circumstances.

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Informed Consent – Required

Please carefully read the following statements, and please sign below indicating your understanding and agreement.

A. **My Responsibilities:** I understand that it is my responsibility to follow my physician's instructions carefully and to report any medical problems immediately. I am currently not pregnant and agree to report any pregnancy to my physician immediately.

B. **Risks of Proposed Treatment:** The use of any medication poses various risks, including but not limited to, pulmonary hypertension, nervousness, sleeplessness, headaches, dry mouth, allergies, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could occasionally be serious or even fatal.

C. **Risks Associated with Being Overweight or Obese:** I understand that remaining overweight poses certain risks, among them high blood pressure, diabetes, heart disease, arthritis at the joints, and certain cancers. I understand that these risks may be modest if I am not very overweight, but that these risks increase significantly with any weight gain.

D. **No Guarantees:** I understand that much of the success of this program will depend on my efforts. I understand that there are no guarantees or assurances that the program will be successful. I also understand that I will have to continue watching my weight all my life if I am to be successful.

E. **Duplicate Medications:** I understand under Florida regulations, duplicate controlled medications cannot be obtained from another doctor.

F. **This is a "No Insurance" Office:** Dr. Dudney's practice does not accept medical insurance of any kind, although it is occasionally listed by some insurance companies, in error, as a provider. I understand that all financial arrangements are two-party only, between myself and Dr. Dudney. I understand Dr. Dudney's clinic has neither a billing department nor staff who will file claims, call, authorize, write letters or otherwise communicate with any insurance company for any reason.

G. **Patient's Consent:** I have read and fully understand this consent form, the attached Florida Weight Loss Consumer Bill of Right (if applicable), and understand it is my responsibility to share related concerns with Dr. Dudney.

Patient's Signature: _____ Date: _____

Patient's Printed Name: _____ Date: _____

Physician's Signature: _____ Date: _____