PHILIP L. LEGGETT, M.D.
GENERAL AND LAPAROENDOSCOPIC SURGERY
Board Certified
Fellow American College of Surgeons
Fellow International College of Surgeons
Clinical Assistant Professor of Surgery, University of Texas

RELEASE OF MEDICAL INFORMATION

To: _____

_____

_____

I, _____, authorize you to release all medical records for _____. The date of birth for the patient is _____.

Please release to: Philip L. Leggett, M.D.
800 Peakwood, Suite 8B
Houston, Texas 77090
Phone: (281) 580-6797
Fax: (281) 580-6693

Signature: _____

Date: _____

Witness: _____

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PLEASE PRINT AND FILL OUT COMPLETELY

Patient's Name			Male ☐ Female ☐	Age	Date of Birth
Address City State Zip			Area Code Home ( ) Business Phone ( )		
Your Occupation			Social Security Number		
Your Employer, Company Name	Employer's Street Address	City	State	Zip	Phone Number
Spouse's Name	Spouse's Social Security Number		Spouse's Occupation		
Spouse's Employer, Company Name	Employer's Street Address	City	State	Zip	Phone Number
In case of emergency please notify: Name	Phone		Relationship		

We gladly file insurance for surgical procedures, however, payment in full is due within 45 days from date of service. You should keep in contact with the office concerning the status of your claim. Your account is your responsibility, not your insurance company's. This office accepts major credit cards or personal checks.

Your Insurance Co. Name	Street Address	City	State	Zip
Policy Holder's Name and Date of Birth	Group Number and/or Certificate Number	Insurance Company Phone Number		
Spouse's Insurance Co. Name	Street Address	City	State	Zip
Policy Holder's Name and Date of Birth	Group Number and/or Certificate Number	Insurance Company Phone Number		
Medicare #	Medicaid #			

Reason For Today's Visit. (what do you wish to discuss with Doctor?)	If Illness Date of first Symptoms	Any known Allergies:
Patient Medical History and past Surgeries		Any Drug Allergies:
Referring Physician or Doctor		

AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment directly to **Philip L. Leggett, M.D.** for surgical and/or medical benefits.

I hereby authorize **Philip L. Leggett, M.D.** to release any information acquired in the course of my examination and treatment.

Signature Insured

Patient's Signature Date

We kindly request payment for services rendered at the time of first consultation visit.

Patient Medical and Weight Loss History

Patient Name: _____

Allergies to Medications: _____

Primary Care Physician: _____ Phone: _____

Medications (please list all medications you are currently taking)

Name of Medication	Dosage	Frequency	Indication

Past surgical History (please list all surgical procedures and operations)

Procedure	Date	Location	Indications

Family History (please indicate family members diagnosed with the following illnesses)

	Mother	Father	Maternal G-mother	Maternal G-father	Paternal G-mother	Paternal G-father	Siblings	Children
Obesity								
Diabetes								
Hypertension								
Heart Disease								
Cancer								
Seizures								
Asthma								
Arthritis								
Kidney Disease								
Early Death								

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How many years have you been overweight? _____

Previous Weight Loss Surgery NO_____ YES_____ (please indicate below)

Surgery Type	Date	Surgeon	Weight Loss

Diet Programs and Supplements (please indicate which of the following diets or plans you have attempted)

Program	Dates	Duration	MD Supervised	Weight Loss
Atkins Diet				
Grapefruit Diet				
Herbalife				
Jenny Craig				
Liquid Diets				
Medifast				
Metabolife				
Nutri-System				
Optifast				
Pritikin Diet				
Slim Fast				
TOPS				
Weight Watchers				
Other				

Weight Loss Medication History (please indicate which of the following medications you have taken)

Medication	Dates	Dosage	MD Supervised	Weight Loss
Amphetamines				
Phentermine (Adipex, Fastin, Pondimen)				
Phen-Fen				
Redux (Dexafenaflouramine)				
Xenical (Orlistat)				
Meridia (Sibutramine)				
Other Diet Medication				

Non-Dietary Therapies (please indicate if you have attempted any of the following weight loss treatments)

Therapy	Dates	Duration	MD Supervised	Weight Loss
Regular Exercise				
Hypnosis				
Behavior Modification				
Acupuncture				

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Patient Name: _____

Social History

Do you use tobacco? **YES** **NO**

Number of packs per day: _____

Number of years smoking: _____

Do you use alcohol? **YES** **NO**

Amount and Frequency: _____

Have you ever been treated for depression? **YES** **NO**

Are you currently in treatment? **YES** **NO**

If yes, please indicate the name and phone number of your physician or therapist

_____

Have you ever been hospitalized for mental illness? **YES** **NO**

System Review (Please circle all that apply)

Constitutional:
Fatigue
Tiredness
Recent Weight Loss
Fever
Night Sweats
Abnormal Bleeding

Head and Neck:
Blurred Vision
Double Vision
Loss of Vision
Loss of Hearing
Vertigo
Sinus Congestion
Sinus Infection
Runny Nose
Sneezing
Loss of Smell
Sore Throat
Difficulty Swallowing
Pain Swallowing
Hoarseness
Lump in Neck

Cardiovascular:
Chest Pain
Pain in Arm/Neck
Heart Attack
Palpitations
Heart Pounding
Stroke
Heart Murmur
Pain in Legs
Cold Feet
Loss of Pulses
Low Blood Pressure
High Blood Pressure
Abnormal Heartbeat

Respiratory:
Shortness of Breath
Asthma
Wheezing
Coughing
Bloody Sputum
Emphysema
Pneumonia
Bronchitis
Difficulty Sleeping Flat
Waking at night
Shortness of Breath

Gastrointestinal:
Jaundice
Hepatitis
Cirrhosis
Vomiting
Nausea
Heartburn
Abdominal Pain
Diarrhea
Constipation
Painful Bowel Movements
Blood in Stool
Hemorrhoids
Change in Stool Size
Irritable Bowel
Colitis

Genitourinary:
Blood in Urine
Frequent Urination
Leakage of Urine
Painful Urination
Trouble Starting Urine
Kidney Stones
Bladder Infection

Musculoskeletal:
Painful Joints
Swelling of Joints
Muscle Aches
Arthritis
Pain in Hips
Pain in Knees
Pain in Ankles
Pain in Feet
Low Back Pain
Herniated Disk
Sciatica
Numbness of Legs/Feet
Abnormal Lumps/Masses

Neurological:
Seizures
Convulsions
Fainting
Vertigo
Light Headedness
Falling
Muscle Weakness
Numbness
Tremors
Loss of Consciousness

Psychological:
Depression
Nervousness
Anxiety
Suicidal Thoughts
Suicide Attempts
Schizophrenia
Anorexia
Bulimia
Binge Eating
Hospitalization

Endocrine:
Hyperthyroid
Hypothyroid
Goiter
Previous Radiation
Diabetes
Adrenal Tumors
Previous Steroid Use
Swollen Glands

Skin/breast:
Skin Cancer
Abnormal Moles
Burns
Rash
Breast Mass
Nipple Discharge
Mammogram Within Year

Men:
Discharge From Penis
Loss of Erection

Women:
Vaginal Discharge
Abnormal Bleeding
Irregular Periods
Hysterectomy
Pap Exam Within Year

Patient Name: _____

Obesity Related Medical History

Do you have, or have you ever had, any of the following illnesses or symptoms?

Heart Disease	YES	NO	Year of Diagnosis _____
Angina	YES	NO	Year of Diagnosis _____
MI (Heart Attack)	YES	NO	Year of Diagnosis _____
Coronary Bypass Surgery	YES	NO	Year of Surgery _____
Palpitations (Abnormal Heartbeat)	YES	NO	Year of Diagnosis _____
Congestive Heart Failure	YES	NO	Year of Diagnosis _____
High Blood Pressure	YES	NO	Year of Diagnosis _____
Elevated Cholesterol	YES	NO	Year of Diagnosis _____
Elevated Triglycerides	YES	NO	Year of Diagnosis _____
Asthma	YES	NO	Year of Diagnosis _____
Reflux	YES	NO	Year of Diagnosis _____
Heartburn	YES	NO	Year of Diagnosis _____
Esophagitis	YES	NO	Year of Diagnosis _____
Hiatal Hernia	YES	NO	Year of Diagnosis _____
Sleep Apnea	YES	NO	Year of Diagnosis _____
Do you use a CPAP/BiPAP machine?	YES	NO	
Shortness of Breath	YES	NO	
You can walk _____ blocks			
You can climb _____ flights of stairs			
Snoring	YES	NC	
Awakening at Night	YES	NC	
Daytime Drowsiness	YES	NC	
Observed Apnea Episodes	YES	NC	
Morning Headaches	YES	NC	
Venous Stasis	YES	NC	
Leg or Ankle Edema	YES	NO	
Leg Ulceration	YES	NO	
Pain of Arthritis	YES	NO	
In Ankles	YES	NO	
In Knees	YES	NO	
In Hips	YES	NO	
Limits Ability to Walk	YES	NO	
Limits Ability to Exercise	YES	NO	
Low Back Pain/Sciatica	YES	NO	
Limits Ability to Walk	YES	NO	
Limits Ability to Exercise	YES	NO	

Patient Name: _____

Diabetes	YES	NO	
Juvenile Onset	YES	NO	Year of Diagnosis _____
Gestational (Pregnancy)	YES	NO	Year of Diagnosis _____
Adult Onset	YES	NO	Year of Diagnosis _____
Diet Controlled	YES	NO	
Oral Medications	YES	NO	
Insulin Dependent	YES	NO	
Urinary Incontinence	YES	NO	Year of Diagnosis _____
Leaking Urine with Coughing	YES	NO	
Leaking Urine with Sneezing	YES	NO	
Leaking Urine with Straining	YES	NO	
Migraine	YES	NO	Year of Diagnosis _____
Frequency _____			
Deep Venous Thrombosis	YES	NO	Year of Diagnosis _____
Pulmonary Embolism	YES	NO	Year of Diagnosis _____
Abdominal Wall Hernia	YES	NO	Year of Diagnosis _____
Incisional	YES	NO	
Umbilical	YES	NO	
Number of hernia Repairs _____			
Have you ever had:			
Blood Transfusion	YES	NO	Year of Transfusion _____
Hepatitis	YES	NO	Year of Diagnosis _____
Exposure to HIV/AIDS	YES	NO	Year of Exposure _____
Abused Intravenous Drugs	YES	NO	

Past Medical History

Please list all other medical conditions, illnesses, or other important information not previously mentioned:

_____

_____

_____

_____

_____

_____

_____

Patient Signature: _____ **Date:** _____

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