PENSACOLA ORTHOPAEDICS &
SPORTS MEDICINE
5147 North 9th Avenue, Suite 322
Pensacola, FL 32504

HISTORY FORM

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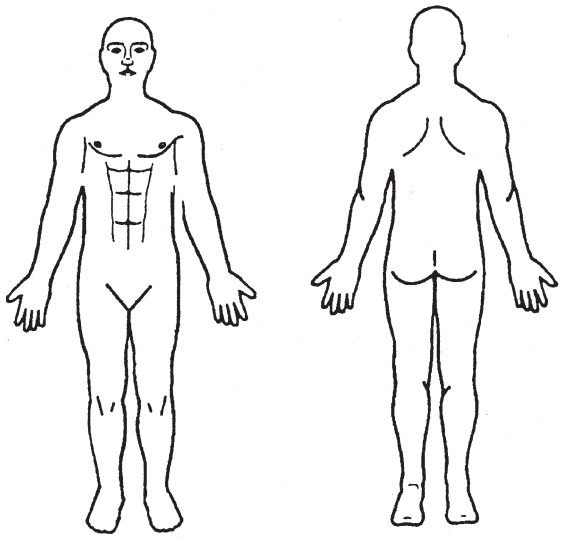
Mark T. Caylor, M.D.

NAME: _____ AGE: _____ HT: _____ WT: _____

Referring doctor: _____

1. Describe the pain and problems you are currently having. Please use the pain diagram to show the areas of involvement.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____



Using the diagram, mark the area of your pain with the symbols

<<<<<<<<<< aching ////////////////// sharp
++++++++++ burning OOOOOO numbness
XXXXXXXX pins & needles

2. When did your problems start? If you had an accident please describe in detail.

_____
_____
_____
_____
_____
_____

3. Which of your daily activities are you not able to do because of your problem?

_____
_____

4. Have you had a problem like this in the past? If so, when?

_____
_____
_____

5. What activities cause the most pain?

_____
_____

6. What makes the pain better?

_____
_____

7. Please list all the tests that have been done (xrays, CT scans, MRI scans, Nerve conduction or electromyogram tests).

_____
_____
_____

PLEASE FILL OUT OTHER SIDE

8. List all the treatments you have had for your current problem (medications, physical therapy, chiropractic, trigger point injections, epidural injections, etc.).

_____
_____
_____

9. What medical illnesses have you had **(Examples: depression, cancer, arthritis, hepatitis C, heart attack, high blood pressure, high cholesterol, thyroid problems, HIV, etc.)**?

_____
_____
_____
_____

10. Please list all the medications you take and how often (ex: Motrin 800 mg 3 times/day).

_____
_____
_____
_____
_____
_____
_____

11. If you smoke or used to smoke, please list the amount and number of years (example: 2.5 packs per day for 15 years, quit 2 years ago). _____

12. How much alcohol do you drink on an average day? _____ average week? _____ (example 3 cases of beer/week.)

13. List all drugs you are allergic to and the type reaction you have to each. (Example: Codeine makes me itch.)

_____
_____
_____

14. Please list all the surgeries you have had and the dates of each.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you for helping us keep your records accurate.

X _____ **Date** _____

Patient or Responsible Party Signature