Patient Questionnaire

Please complete as much as possible

Dr. Aleksa Cenic
Neurosurgeon

Patient Name: ____________________ Date: ____________________

Date of Birth: ____________________

Health Card #: ____________________

Home Address: ____________________

Home Telephone: ____________ Work Telephone: ____________ Cell: ____________

WSIB Claim Number (if applicable): ____________________

Family Physician: ____________________ Referring Physician: ____________________

Please circle whether you are: single married widowed divorced common-law

Do you have children? Please circle: none young children adult children

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Main Complaint: ____________________

Are you right or left handed?: ____________ Your height and weight: ____________

Are you currently employed?: Yes No (please provide more details below)

If **yes**, what is your current occupation?: ____________________

If **no**, on what date did you stop working?: ____________________

Have you had any past health issues? Please explain: ____________________

Have you had any previous operations? Please explain: ____________________

Are there any serious health issues in your family?: ____________________

Are there any medications you are allergic to?: ____________________

Are you currently taking presciption medications? Please list: ____________________

Are you a smoker?: Yes No For how many years?: ________ How many cigarettes per day?: ________

Do you consume alcohol?: Yes No How many alcoholic beverages do you consume per week?: ________

What hobbies/interests do you have outside of work?: ____________________

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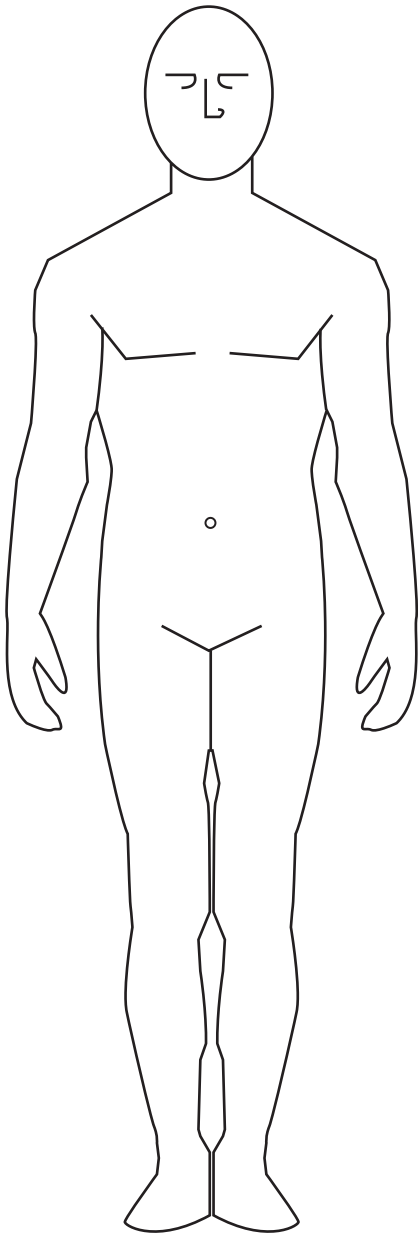
Neurosurgeon

Patient Name: ______________________________

If you are experiencing pain, numbess and/or weakness, use the diagrams below to circle the locations.
Please describe the type of pain or sensation in the area.



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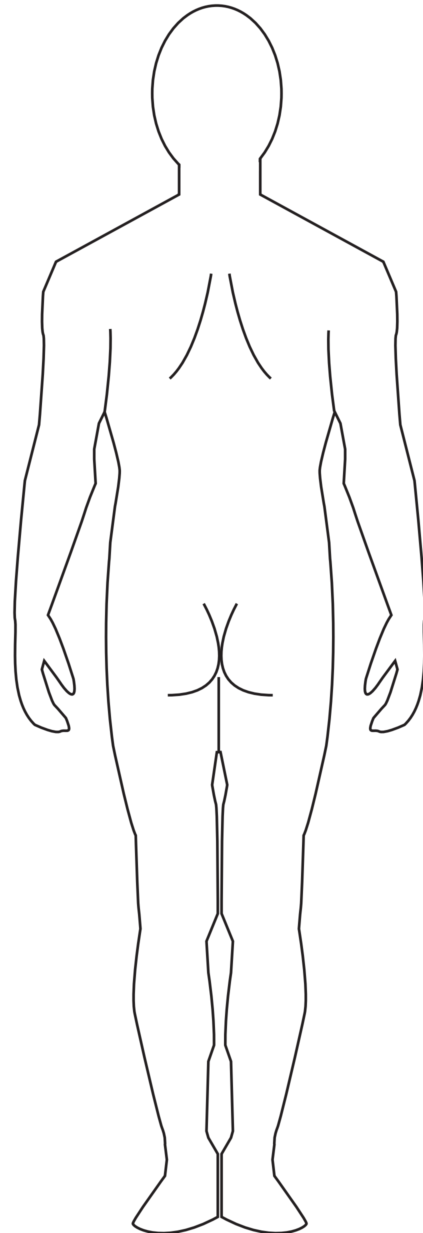

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DR. ALEKSA CENIC