|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title (please circle)  Mr / Mrs / Miss / Ms /  Dr / Other\_\_\_\_\_\_\_\_\_ | | First Names | | | | | | | | | Surname | | | | | |
| Date of Birth  \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ | | | | Occupation | | | | | | | | | Do you drive a motor vehicle?  Yes / No | | | |
| Residential Address | | | | | | | | | | | | | | | | Postcode |
| Email Address | | | | | | | | | | | | | | | |  |
| Telephone  Home: Work: Mobile: | | | | | | | | | | | | | | | | |
| Next of Kin:  Relationship:  Telephone Number: | | | | | | | | | | | | Are you right or left handed?  Right Left | | | | |
| Medicare card Ref. | Medicare Card Number | | | | | | | | | | | | | | Medicare Card expiry  \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ | |
| Private Health Fund Name | | | | | | | Membership Number | | | | | | Level of Cover | | | |
| Pension card Number (only age or disability accepted) | | | | | | | | | | Veteran’s Affairs Gold Card Number | | | | | | |
| Who is your referring Doctor? | | | | | | Address: | | | | | | | | | | |
| Who is your GP? | | | | | Address: | | | | | | | | | | | |
| Do you regularly see any other Specialists? | | | | | | | | Address: | | | | | | | | |
| Have you previously seen a Neurologist?  Yes / No | | | | | Name of Neurologist seen: | | | | | | | | What year were you last seen? | | | |
| **PLEASE TURN OVER AND CONTINUE ON OTHER SIDE OF FORM** | | | | | | | | | | | | | | | | |
| Please list all your medication (prescription and over the counter): | | | | | | | | | Please list any medications that you are allergic to: | | | | | | | |
| What illnesses have you had? | | | | | | | | | What operations have you had? | | | | | | | |
| Family history of illness (particularly neurological): | | | | | | | | | | | | | | | | |
| Smoking history:  Have you ever smoked?  Yes / No | | | What age did you start? | | | | | | What age did you stop? | | | | | Average per day: | | |
| Alcohol history:  Do you drink?  Yes / No | | | What age did you start? | | | | | | What age did you stop? | | | | | Average per day: | | |
| I certify that the information I have written in this form is true and correct.  Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |