|  |  |  |
| --- | --- | --- |
| 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 |  |
| TelephoneHome: 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |