**PEDIATRIC NEUROLOGY OUTPATIENT EVALUATION**

Thank you for referring this patient for a pediatric neurology consultation.

**Reason for consultation**:

**Referring MD / Service**:

**History**: History was obtained from chart and parents.

      is a       ,

**Past Medical and Surgical History**:

**Allergies:** There are no known drug allergies.

**Current Medications:**

**Birth History**:       was born , at      . Birth weight was      . Delivery was      .       was discharged home

**Antenatal History and Neonatal Course**:

**Growth and Development**:       achieved milestones at .       sat at the age of 6 months, crawled at 8-9 months, stood up with support at age 10-11 months, and walked at the age of 12 months.       started to speak monosyllables at the age of 7-8 months, spoke single words at 18 months and short (two-to-three word) sentences at 2 years.  was toilet trained by age 2½ years.

**Schooling**:       attends  school. is in       grade, and does well according to the parents. has never repeated any grades. There are no apparent school problems with peers

**Social and family history:**       lives with mother and father. has       brothers and sisters. Both parents are in apparent good health. Siblings are also healthy. There is no family history of speech delay, learning difficulties in school, mental retardation, epilepsy or neuromuscular disorders

**Adolescent history**:       achieved menarche at the age of       years. Last menstrual period was      . She sexually active and contraception (). denies use of alcohol, cigarette smoking or street drugs.

**Review of Systems**: There is no history of fevers, chills, malaise, loss of appetite, weight loss, or difficulty sleeping. Ophthalmologic, otolaryngologic, dermatologic, respiratory, cardiovascular, gastrointestinal, genitourinary, musculoskeletal, endocrine, psychiatric, and hematologic review of systems were negative.

**Physical examination**:

**Vital signs**: Temp -       Pulse -       Respiration -       BP -

Head circumference is       cm (      percentile). Weight is       kg (      percentile). Height is       cm (      percentile).

**General examination**:       is alert and active in no apparent distress. There are no dysmorphic features. Chest examination reveals normal breath sounds, and normal heart sounds with no cardiac murmur. Abdominal examination does not show any evidence of hepatic or splenic enlargement, or any abdominal masses or bruits. Skin evaluation does not reveal any café-au-lait spots, hypo or hyperpigmented lesions, hemangiomas or pigmented nevi.

**Neurologic examination**:

      is awake, alert, cooperative and responsive to all questions. follows all commands readily. Speech is fluent, with no echolalia. is able to name and repeat. is able to perform simple math (add, subtract) and can recall the memorized three objects after an interval of time.

**Cranial nerves**: Pupils are       mm, symmetric, circular and reactive to light. Fundoscopy reveals sharp discs with no retinal abnormalities. There are no visual field cuts. Extraocular movements are full in range, with no strabismus. There is no ptosis or nystagmus. Facial sensations are intact. There is no facial asymmetry, with normal facial movements bilaterally. Hearing is normal to finger-rub testing. Gag reflex is present. Palatal movements are symmetric. The tongue is midline.

**Motor assessment**: The tone is normal. Movements are symmetric in all four extremities, with no evidence of any focal weakness. Power is more than III / V in all groups of muscles across all major joints. There is no evidence of atrophy or hypertrophy of muscles. Deep tendon reflexes are 2+ and symmetric at the biceps, triceps, brachioradialis, knees and ankles. Plantar response is flexor bilaterally.

**Sensory examination**: Fine touch and pinprick testing does not reveal any sensory deficits.

**Co-ordination and gait**: Finger-to-nose testing is normal bilaterally. Fine finger movements and rapid alternating movements are within normal range. Mirror movements are not present. There is no evidence of tremor, dystonic posturing or any abnormal movements. Romberg’s sign is absent. Gait is normal with equal arm swing bilaterally and symmetric leg movements. Heel, toe and tandem walking are within normal range. He can easily hop on either foot.

**Developmental assessment**:

**Laboratory tests**:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **WBC** |  | **Hgb** |  | **Hct** |  | **Plt** |  |
| **N** |  | **L** |  | **M** |  |  |  |
| **Na** |  | **Cl** |  | **BUN** |  | **Ca** |  |
| **K** |  | **HCO3** |  | **Cr** |  | **Glu** |  |
| **AST** |  | **ALT** |  | **AP** |  | **TB** |  |
| **TP** |  | **Alb** |  |  |  |  |  |

**Neuroimaging**:

**E.E.G**.:

**Assessment**:

**Recommendations**:

Case Discussed with Attending Dr

Name of Resident/Fellow: MD

Date: