SUMMIT MEDICAL GROUP

What is your main concern?

Child's name or label

PEDS NEURO REVIEW OF SYSTEMS: Please list symptoms your child has (or has had in the past). Describe "yes" responses.

● **NEUROLOGICAL**

HYPERACTIVITY YES ☐ NO ☐ _____
STARING SPELLS YES ☐ NO ☐ _____
SEIZURES YES ☐ NO ☐ _____
FAINTING YES ☐ NO ☐ _____
TANTRUMS YES ☐ NO ☐ _____
SNORING YES ☐ NO ☐ _____
HEADACHES YES ☐ NO ☐ _____
TICS YES ☐ NO ☐ _____
INATTENTION YES ☐ NO ☐ _____
RIGID HABITS YES ☐ NO ☐ _____
IMPULSIVITY YES ☐ NO ☐ _____
WORKS SLOW YES ☐ NO ☐ _____
ABSENT-MINDED YES ☐ NO ☐ _____
CONCUSSION YES ☐ NO ☐ _____
WRITTEN EXPRESSION PROBLEMS YES ☐ NO ☐ _____
DECLINING SCHOOL PERFORMANCE YES ☐ NO ☐ _____
NEEDS HELP WITH HOMEWORK YES ☐ NO ☐ _____
POOR READING COMPREHENSION YES ☐ NO ☐ _____
EXCESSIVE DAYTIME SLEEPINESS YES ☐ NO ☐ _____
THROBBING / POUNDING HEADACHE YES ☐ NO ☐ _____
PROBLEMS WITH TRANSITIONS YES ☐ NO ☐ _____
DIZZINESS OR VERTIGO YES ☐ NO ☐ _____
WALKING OR TALKING IN SLEEP YES ☐ NO ☐ _____
SENSITIVITY TO LIGHT OR NOISE YES ☐ NO ☐ _____
NOT WORKING TO POTENTIAL YES ☐ NO ☐ _____
MIGRAINE OR HEADACHES IN FAMILY YES ☐ NO ☐ _____
EARLY INTERVENTION OR THERAPIES YES ☐ NO ☐ _____
PLAYS MOSTLY ALONE YES ☐ NO ☐ _____
COORDINATION PROBLEMS YES ☐ NO ☐ _____
MOTION SICKNESS YES ☐ NO ☐ _____
POOR EYE CONTACT YES ☐ NO ☐ _____
INVOLUNTARY MOVEMENTS YES ☐ NO ☐ _____
INVOLUNTARY NOISES YES ☐ NO ☐ _____
DEVELOPMENTAL DELAY YES ☐ NO ☐ _____
DISRUPTS CLASS YES ☐ NO ☐ _____
SOCIALIZATION PROBLEMS YES ☐ NO ☐ _____
POOR HANDWRITING YES ☐ NO ☐ _____
READING DIFFICULTIES YES ☐ NO ☐ _____
CANNOT FALL ASLEEP YES ☐ NO ☐ _____
ARTICULATION PROBLEMS YES ☐ NO ☐ _____

SPEECH DELAY YES ☐ NO ☐ _____
NEAR-DAILY HEADACHES YES ☐ NO ☐ _____
HAS 504 PLAN? YES ☐ NO ☐ _____ HAS IEP ? YES ☐ NO ☐ _____

● **CONSTITUTIONAL**

FEVER OR SWEATS YES ☐ NO ☐ _____
FATIGUE OR MALAISE YES ☐ NO ☐ _____
APPETITE TOO HIGH OR TOO LOW YES ☐ NO ☐ _____
WAS PREMATURE OR TWIN YES ☐ NO ☐ _____

● **BEHAVIORAL HEALTH**

WORRIES / ANXIETY YES ☐ NO ☐ _____
SCHOOL AVOIDANCE YES ☐ NO ☐ _____
SADNESS OR DEPRESSION YES ☐ NO ☐ _____
MOODINESS OR IRRITABILITY YES ☐ NO ☐ _____

● **EYES**

NEAR-SIGHTED OR FAR-SIGHTED YES ☐ NO ☐ _____
CROSSED EYES OR "LAZY" EYE YES ☐ NO ☐ _____
KNOWN EYE CONDITIONS YES ☐ NO ☐ _____

● **EAR, NOSE AND THROAT**

HEARING LOSS OR DEFICIT YES ☐ NO ☐ _____
AUDITORY PROCESSING ISSUES YES ☐ NO ☐ _____
SLEEP APNEA YES ☐ NO ☐ _____
TONSILS OR ADENOIDS SURGERY YES ☐ NO ☐ _____
VENTILATION TUBES YES ☐ NO ☐ _____

● **CARDIOVASCULAR**

RAPID OR IRREGULAR HEART BEAT YES ☐ NO ☐ _____
HEART MURMUR YES ☐ NO ☐ _____
CHEST PAIN OR EXERCISE INTOLERANCE YES ☐ NO ☐ _____

● **RESPIRATORY**

SHORTNESS OF BREATH YES ☐ NO ☐ _____
COUGH OR WHEEZING YES ☐ NO ☐ _____

● **GASTROINTESINAL**

NAUSEA OR VOMITING YES ☐ NO ☐ _____
ABDOMINAL PAIN YES ☐ NO ☐ _____
CONSTIPATION OR DIARRHEA YES ☐ NO ☐ _____

● **MUSCULOSKELATAL**

MUSCLE WEAKNESS OR PAIN YES ☐ NO ☐ _____
JOINTS PAIN OR DEFORMITY YES ☐ NO ☐ _____

● **ENDOCRINE**

EARLY OR LATE PUBERTY YES ☐ NO ☐ _____
THYROID PROBLEMS YES ☐ NO ☐ _____
SHORT STATURE OR GROWTH HORMONE DEFICIENCY YES ☐ NO ☐ _____

Parent's signature _____ Physician's signature _____ Date: _____