Pediatric History

Demographics:

* Name
* Age
* Sex (most likely obvious)
* CPR (when writing for cases)
* Source of history:
* Others

Chief complaint + duration:

* What brought you to the hospital?
* For how long did this happen?
* When did you come to the hospital/ how long after you noticed this did you come to the hospital?

History of present illness:

* Apply SOCRATES if applicable:
	+ Site
	+ Onset (what was he/she doing when this happened?)
	+ Character
	+ Relieving and aggravating factors
	+ Associated symptoms (Fever, rash, etc.)
	+ Timing (comes and goes, morning/night)
	+ Severity
* Applying SOCRATES for cough, pain, jaundice, seizures, sickle cell crises, asthma, etc. common conditions
	+ **Jaundice:**
		- On which day did it begin? How long has it lasted?
		- What color was it? Yellow, orange or olive green?
			* Olive green = conjugated
			* Yellow = unconjugated
			* Orange = mixed
		- When did you first notice it and where? On the face or eyes?
			* At lower levels (5 g/dL) it is noticed in the face
			* At slightly higher levels (10 g/dL) it is noticed in the abdomen
			* At high levels (20 g/dL) it is noticed in the soles of feet
		- Is it associated with abdominal distension?
		- Changes in urine color or stool color?
			* Pale stools, dark urine 🡪 think obstruction, conjugated bilirubinemia
		- Other associated signs/symptoms when this began? (Fever, lethargy, poor feeding, vomiting, etc.)
		- Any changes in sensorium? (photosensitivity, ask about neck stiffness)
		- In past medical history, ask about other children that may have had this
	+ **Fever:**
		- **Onset, duration, severity** (high grade, low grade)
		- **Timing** (does it spike/recur)
		- **Relieving** (paracetamol, antipyretics) and exacerbating factors
		- Associated symptoms such as coughing**, seizures, neck stiffness** (you **MUST ALWAYS RULE OUT MENINGITIS**), **diarrhea**, **vomiting,** **coughing**, dyspnea, **lethargy**, **poor feeding, disturbances in consciousness**
		- Ask about **sick contacts** and recent UTIs
	+ **Vomiting:**
		- **Onset** (how long?), **frequency** (how often?), **volume** (how much?)
		- **Color/staining** (**bloody, bilious, non-bilious, milk/feedings**)
		- **Relation to feeding** (outside of feeds, right after feeds)
		- **Projectile** or non-projectile
		- Aggravating and relieving factors
		- **Associated symptoms** such as **fever, diarrhea (gastroenteritis)**, abdominal pain, weight loss, failure to thrive, **headache (exclude meningitis)**
	+ Diarrhea:
		- **Onset, frequency, volume, consistency**
			* If > 14 days = chronic diarrhea
		- **Bloody or non-bloody** (hard blood or fresh red blood)
		- **Mucous or no mucous (مخات)**
		- **Timing** (did it begin with **breastfeeding or weaning** or when any **specific food is introduced** into the diet?)
		- **Smell (foul smelling)**
		- **Associated symptoms** such as **vomiting, fever, rashes, gases, abdominal pain, weight loss, dehydration**
		- Any history **of sick contacts, traveling**, beginning of school?
	+ Cough:
		- Onset, frequency, timing (morning, night), wet or dry, bloody or not, has discharge (yellowish, greenish, clear?)
		- Relation to feeding
		- Relieving and exacerbating factors (important)
		- Associated symptoms:
			* Fever, wheezing, dyspnea, cyanosis, stridor
	+ Rash:
		- Site (where it started, where it is now, did it spread?), onset, duration
		- Change in color and size, form (raised or not, has central clearing or not)
		- Associated with itching or discharge (and comment)
		- Associated with fever, allergy, neck stiffness or photophobia (rule out meningitis caused by Neisseria meningitidis)
		- Sick contacts (anybody at home has a rash?)
		- Exacerbating and relieving factors
	+ Convulsions
		- BEFORE (pre-ictal)
			* Photophobia, auras
			* What was he/she doing?
		- DURING (ictal)
			* Site (is it focal or/and became generalized? Which side is affected more? Where did it start?)
			* Character (what kind of seizure is it? Tonic, myoclonic, tonic-clonic, absence)
			* Observations (eye rolling, tongue biting, frothing, specific movements, incontinence/urination, cyanosis and abnormal sounds)
			* Timing (did it occur in the morning? – juveline myoclonic seizures)
			* Duration (For how long did it occur?)
			* Consciousness (did he/she lose consciousness)
		- AFTER (post-ictal)
			* Confusion, memory loss, poor feeding, consciousness
		- Ask about recurrences and how often did this occur or is it the first time?
		- Ask about history of fevers in childhood, family history of epilepsy or other conditions causing seizures
		- Rule out meningitis by asking about fever, neck stiffness, photophobia
	+ Pain (SOCRATES, for SCD – important)

**PAST MEDICAL HISTORY:**

* Antenatal history
	+ Mother age, nationality (vaccinated or not?)
	+ Blood group of mother, baby/father
	+ Ask about previous pregnancies and their outcomes
	+ Diet, medications during pregnancies (and if smoker)
	+ Any abnormalities that occurred during pregnancy (hypertension, gestational diabetes, infections)
* Natal and postnatal history
	+ Duration of gestation (term, preterm)
	+ Type of delivery (cesarean or vaginal)
	+ Presentation
	+ Any complications during and after delivery
		- Did they take the baby to NICU?
		- Did he/she have any trouble breathing or put him in an incubator
		- Did he/she get jaundice? If so, for how long and what did they do for him/her? Previous children and if they had the same problem?
	+ Birth weight (most important), and try to ask about signs to indicate apgar score
	+ Does he have any inherited diseases, blood diseases (SCD, thalassemia, G6PD)
	+ Did he have any heart conditions that needed to be fixed?
* Development and nutrition:
	+ He is being bottlefed or breastfed?
	+ Is he feeding well? Is he gaining weight?
	+ When did he begin weaning?
	+ Ask about milestones according to the age of the baby:
		- Ideally, ask 1 from gross motor, fine motor, speech/language and social/emotional/cognitive
		- Ask if he can walk or talk if over 1 year old
		- Can he smile (by 2 months or more)
		- Can he roll from side to side, sit upright, etc.
		- Ask her to relate to her other children if she has any, or ask if she feels like he is delayed in any way
		- You can instead ask about them in the past – when did he first start walking or talking or crawling?
	+ Ask about teething
	+ Ask about urination and defecation
	+ Ask about schooling, grades and sleeping pattern
	+ For older kids, ask about secondary characteristics (Sexual maturation)
* Allergies, vaccinations, childhood admissions and surgeries
	+ Is he up to date with his vaccinations?
	+ Does he have any allergies?
	+ Has he ever gone to the hospital for any reasons?
	+ Is he taking any medications?

FAMILY HISTORY:

* Does he have any siblings? Try to develop the pedigree
* Do any of them have any diseases? Remind yourself if any of them have similar problems to the patient
* Do you or your husband/wife have any diseases?
	+ SCD, G6PD, thalassemia, HTN, DM, etc.

PSYCHOSOCIAL HISTORY:

* Focus on living arrangement (do they live in a flat or house?)
* Ask if the mother works or not? Ask about the job of mom and dad
* Pets at home or not
* Relationship of child with his siblings
* Activities and exercise, etc.

SYSTEM REVIEW:

* General
	+ Fever
	+ Skin rashes, lesions, bruises, color changes
* Head and face:
	+ Does he have any trouble in seeing or moving his eyes?
	+ Is there any eye discharge?
	+ Does he have difficulty hearing or ear discharge or ear infection? Does he scratch his ears a lot?
	+ Does he have any nasal discharge? Does he scratch his nose a lot or is there is any bleeding per nose?
	+ Any swollen lymph nodes?
	+ Any drooling, toothache or problems in his mouth?
	+ Any swelling in his neck?
* CVS & respiratory?
	+ Does he turn blue upon feeding or crying? Does he squat?
	+ Does he have any trouble breathing?
	+ Does he cough? Wheeze?
* GI tract:
	+ Does he have vomiting or diarrhea?
	+ Does he have any pain in his abdomen?
* GU system:
	+ Does he urinate a lot or too little?
	+ Any change in the color of urine? Or pain while urinating?
* Musculoskeletal:
	+ Any trouble walking or muscle weakness or noticeable deformities?
	+ Any tremors
* Hematological:
	+ Do you feel he is pale?
* Nervous system:
	+ Did he ever get any seizures, paralysis, or found to be in an abnormal position
	+ Neck stiffness, photophobia

ASK ABOUT MOTHER/PATIENT FEELINGS, CONCERNS, EXPECTATIONS

PHYSICAL EXAMINATION:

* First steps:
	+ Introduction
	+ Permission
	+ Ask mother to unclothe child
	+ Position of examination
	+ Washing of hands before and after
	+ Warming of hands and stethoscope
	+ Getting the child to like you
* Vital signs:
	+ Temp, HR/Pulse, BP, RR, SPO2
* Growth parameters:
	+ Height/length, weight, head circumference
	+ Plot on chart
* General examination
* Specific examination (select according to history)

General examination:

1. Level of consciousness
	1. Patient is lying supine on the bed, conscious and awake
2. State
	1. He is relaxed and not in any apparent distress
	2. He does not appear to be toxic
	3. He is not in any abnormal postures
3. Connections
	1. He is connected or not to an IV line thru a cannula on his left/right hand
4. If he is an infant, feel for the sutures and fontanels and comment on their size, whether they’re bulging or sunken - comment on any abnormal head shape or size
5. The face
	1. Dysmorphic features (look at the nose, eyes and mouth)
		1. Low set ears
		2. Flat nasal bridge
		3. Button nose
		4. Hyper or hypotelorism
		5. Epicanthal folds
		6. Palpebral fissures (upslanting or downslanting)
		7. Cleft lip (or previous scar) or philthrum changes
		8. Micrognathia

* 1. Look at eyes
		1. Swollen or sunken
		2. In older kids check for pallor in the conjunctiva and jaundice in the sclera – in infants or neonates, you can pinch the nose for jaundice
		3. Note any abnormalities (colobomas, aniridia, heterochromia, rings around the eye, conjunctivitis, strabismus)
	2. Look at the ears (if young enough)
		1. Check if less-formed, if there is recoil or not, discharge or obvious redness
	3. Look at the nose
		1. Check for polyps, discharge, look at nasal turbinates if necessary
		2. MENTION IF NASAL FLARING IS PRESENT OR NOT
	4. Look at their lips and into the mouth
		1. Check for angular stomatitis, chapping, dryness (should be wet), central cyanosis under the tongue, ulcers, comment on teeth if young enough
		2. If pharangitis or URT symptoms are involved, you should check the back of the mouth
	5. Feel for lymph nodes in the head and neck
	6. Look at the hands for pallor, cyanosis, clubbing, koilonychias, osler nodes, … So many things to look for, just be relevant to the case
		1. CHECK FOR CAPILLARY REFILL (should be < 2 seconds)
	7. If he is an older kid, you would check for axillary lymph nodes
	8. Look at the chest and note any discoloration or deformities or dilated veins and SIGNS OF RESPIRATORY DISTRESS
	9. Look at the abdomen and note any abnormalities, quickly check the skin turgor
	10. Feel for the femoral pulses
	11. Look at the lower limbs
		1. Check for edema and press on the ankle and hold
	12. If you can, look at the back