OUTLINE FOR PEDIATRIC HISTORY & PHYSICAL EXAM

HISTORY

Introductory Statement

This is the (1st, 2nd, 3rd) admission for this age, sex, with a chief complaint (in the parent’s or child’s own words) of duration.

History of Present Illness

Information in this section is of greatest importance. Remember that this percentage data to support the diagnosis is found in the history. All of the significant information that supports the differential diagnosis should be found in the HPI. List here all the pertinent, positive and negative direct answers to your questions. The information should be listed chronologically and should list the initial symptom and then the subsequent symptoms. It should be further noted that the portions of past history that would be pertinent to the present illness should be included in the information of the HPI. The HPI should have a lot of important details but these details should be written precisely, concisely, and orderly.

Past History

**Perinatal and Neonatal Information:** More emphasis will be placed on this information especially when it pertains to an infant patient. The information in this section might include birth date, hospital, city, weight, and length. The type of delivery, for example, spontaneous and the type of presentation; vertex or breech. Apgar scores, age of mother, length of gestation, exposures to infectious diseases, and medications, drugs, or alcohol including tobacco used during pregnancy should be recorded if pertinent to the case. Information regarding the newborn, might include hypoglycemia, cyanosis, pallor, seizures, jaundice, skin lesions, muscle skeletal deformities, respiratory distress or feeding problems.

**Previous Illnesses:** Age, severity, complications, and sequeli.

- Serious childhood illnesses
- Surgical procedures, approximate dates, and complications
- Injuries and fractures
- Hospitalizations

**Nutrition:** Questions regarding nutrition should be appropriate for the child’s age. For example, infants – breast or bottle fed, if formula is used which type, vitamin supplementation, and growth information.
Developmental History: Record information regarding a child’s current developmental status with regard to each of the four following areas: gross motor, fine motor, social and language skills. When children are of school age also include information regarding academics and physical activities such as sports.

Habits and Personality:
- Sleep
- Issues with regard to behavior

Immunization: Indicate sources of information, dates immunizations given, and which type of immunization was provided. Also include if any TB testing has been performed.

Medication/Allergies

Current Medications: Including name of medication, dose, route, frequency and indication for the medication.

Family/Genetic History

Record all known significant diseases in first degree relatives (parents, grandparents, aunts, uncles and siblings). Record all deaths in these first degree relatives. Examples that might be included in this section would be diabetes, cancer, epilepsy, allergies, hereditary blood dyscrasia, early coronary artery disease, hyperlipodemia, mental retardation, dystrophies, congenital anomalies, degenerative diseases, cystic fibrosis, and celiac disease.

Social History

- Living circumstances: place and nature of dwelling, sleeping arrangements, daycare arrangements.
- Economic circumstances
- Parents occupations and marital status
- Household pets
- Potential exposures to toxins in home, for example, cigarette smoke exposure
- Age of home of children less that 3 years of age (possible lead exposure)
- Water source

Review of Systems

Review each of the following systems and include all positive answers to questions.

- HEENT
- Respiratory
- Cardiac
- Gastrointestinal
PHYSICAL EXAMINATION

All positive physical findings should be recorded and pertinent negative findings to that specific differential diagnosis should also be included in the physical examination. The following list of physical findings are examples of those things that might be included.

**Vital Sign:** A successful pediatric examination varies with the age of the patient. Very young infants and neonates are often easiest to examine on the examining table. From several months to preschool age it is often more effective to have the patient lie or sit on the mother’s lap. It may be best to interview and examine adolescents without the parents present. If a parent is not present during the examination a student should have a nurse or the attending physician present at the time of examination or have parental permission to examine the child.

Observe the child under ideal circumstances, for example, while in mother’s lap and leave the more painful and uncomfortable parts of the examination until last, for example, throat and ears.

Record vital signs which include temperature, pulse, respiratory rate, and blood pressure (arm and legs). Weight, height, and head circumference should be measured, preferably using the metric system, and should include percentiles. Plot these parameters on a growth chart if not previously done. Record O₂ saturations and the amount of oxygen delivered if appropriate.

**General Appearance:** For example any obvious deformities, size appropriate for age, respiratory distress or pain, and hydration and general nutrition status.

**Head:** Normal or abnormal facies and normal or abnormal cepholy. Fontonelle size if open.

**Eyes:** Include all positive findings on eye examination and include proptosis, sclerae, conjunctivae, strabismus, photophobia, and fundoscopic exam.

**Ears:** Hearing, discharge, tympanic membrane appearance.

**Nose:** Air movement, mucosa, septim, turbinate appearance, teeth-number and caries, gum – color and hypertrophy ,epiglottis – appearance, tonsils – size and appearance.

**Neck:** Flexibility, masses. Thyroid – size.
Lymph node: If abnormal is size or texture record location, consistency, tenderness, size in centimeters.

Spine: Scoliosis, mobility, tenderness.

Thorax: Appearance and contour, respiratory rate and effort, regularity of breathing, symmetrical chest movement, character of respirations such as retractions.

Cardiovascular:
- Inspection, precordial bulge, apical heave, auscultation, rhythm, character and quality of sounds.
- Palpation: PMI, thrills, heaves.
- Auscultation: quality and intensity of heart sounds, murmurs, for example, timing, duration, intensity, location, radiation
- Pulses: radial and femoral pulses, rate and rhythm.

Abdomen:
- Inspection, contour, umbilicus, distention, veins, visible peristalsis, hernia.
- Percussion: fluid wave, shifting dullness, tympany, liver size, spleen size, CVA tenderness, abnormal masses.
- Palpation: tenderness, rebound, guarding, masses.

Genitalia:
Record Tanner Stage
- Female: external genitalia, appearance of vulva, clitoris, hymen.

Breasts: Tanner Stage

Rectal: Fissures, hemorrhoids, prolapse, sphincter tone, stool in ampulla, abnormal masses.

Skin: Texture, color, turgor, temperature, moisture, icterus, cyanosis, eruptions, lesions, scars, ecchymoses, petechiae, spider nevi, desquamation, hemangiomata, Mongolian spots, nevi.

Extremities: Tone, color, warmth, clubbing, cyanosis, mobility, Ortalami and Barlows maneuvers in newborns and infants, deformities, joint swelling or tenderness.
Neurologic:
- Mental status: affect, level of consciousness, speech.
- Motor: gait, stances, muscle power, tone, tics, ataxia.
- Cranial nerves: testing 1-12
- Deep tendon reflexes: 2+ is average when recording.
  - Record if Babinski present.
  - Infants, for example grasp, suck, moro, rooting, stepping, placing.
- Abnormal sensory findings.
- Meningeal signs

OBJECTIVE DATA
For example, chest x-ray report information if known should be reported and recorded.

PROBLEM LIST

DIFFERENTIAL DIAGNOSIS with discussion of pros/cons of each alternative diagnosis.

CLINICAL IMPRESSION based on your thoughts regarding the differential diagnosis.

MANAGEMENT PLAN: write this by system to allow you the opportunity to plan for all components of patient care: ie: Fluids/Electrolytes/Nutrition
  Respiratory
  Cardiovascular
  Heme
  Neuro
  ID etc.
  Your plan should directly support your assessment

DISCUSSION: Pick a topic pertinent to your case. Using the primary literature and other sources if necessary, write 1-3 paragraphs about your topic of interest.