Guide for Taking History in Pediatrics

Before starting the history, remember the following:

1. Introduce yourself to the patient and to the patient's relatives.
2. You have to be gentle and kind with the patient as much as possible.
3. Do not interrupt the patient's speech, unless it is getting away from the complaint description.
4. Present your history in a story-like fashion, and arrange it in a scientific way.
5. Avoid using medical terms as much as possible & try to present your history in pt's language, but in a logical way.
6. During history taking, observe the patient in general for any obvious sings that may help you to reach the diagnosis like abnormal speech, abnormal position or movement…etc.
7. When you present your history, you should be confident and comfortable and try not to repeat the information more than one time and try to concentrate on the important information that is related to the main problem.
8. It is better to bring some small toys or sweets to the child to make friendship with the child.
9. Remember to stand on right side of patient during history & clinical exam unless you are left-handed

1) Identification Data:

1. Name 2. Age 3. Sex 4. Occupation 5. Address 6. Nationality 7. Religion 8. Next of Kin 9. Date of Admission 10. Date of Examination

Note:

- Make your presentation in a story-like fashion, for e.g. Ahmad Kawa Muhammad, 5 years old, male, living in Sulaimani-Rzgari, Kurdish, Muslim, and his next of kin is his mother living at the same address, admitted on the 21st of April 2013, examined on the 23rd of October 2013.
- Sometimes you should ignore some questions according to the situation, for example it is not logical to ask about the occupation of a 5 year old child!

2) Chief Complaint and Duration:

- Try to mention one complaint (the main problem that brought the patient to the hospital)
- Avoid using medical terms as much as possible.
- Duration: the duration of the complaint before hospitalization.
- E.g. Chief complaint: frequent bowel motions of three days duration prior to admission to the hospital.

3) History of Present Illness:

This is the most important part in the history, it is better to obtain the information in the following sequences:

1. How the condition started? The onset; is it sudden, gradual, insidious or preceded by other complaint.
2. Full description of the symptoms in its sequence for e.g. if the complaint is frequent bowel motions (diarrhea) so we should mention the frequency, amount, odor, color, contents...etc.
3. Full description of the associated symptoms and related system(s) for e.g. in frequent bowel motions we have to make full description of the associated symptoms like vomiting and we have to make full description of the related system which is GIT by mentioning the important positive and then the important negative symptoms. In some complaints we have to make description to more than one system for e.g. fever maybe related to respiratory problem, GIT problem, CNS problem or renal problem…etc.
4. Try to avoid using medical terms as much as possible & try to make your description organized in a scientific way.
5. Mention how the patient was admitted to the hospital (from the outpatient clinic or private clinic…etc.) and what investigations were done there and what treatment was received and also after hospitalization what are the events in the hospital. Note: no need to mention the name of the investigations or treatments precisely. For example just mention: investigation done for the patient in form of blood, urine and stool examinations and treatment received in form of syrup, IV fluid and IM injections.
6. Patient's condition during hospitalization.
7. Lastly how is the patient's condition now? Is it better, same or deteriorated? And child activity, is it returned to normal or slightly better? etc.

- Remember that history of present illness is an important part in the history in general, so try to put big efforts in making it organized and logical as much as possible.

4) Review of systems:

- In this part of the history, you have to ask about the symptoms and signs of all systems, starting from the system(s) which is (are) related to the complaint (but do NOT repeat the information that you have mentioned previously in the history of present illness). So just say for e.g. "GIT system as mentioned in the history of present illness".
- It is better to mention the important symptoms which are related to the problem in the history of present illness rather than in review of systems, leaving the non-related symptoms in the review of systems.
- Your questions should be organized according to the age of the patient for e.g. it is not logical to ask about vertigo or palpitation in a one year old child.
- Start mentioning the positive and then the negative symptoms.
- Make your description in the review of systems in brief.
- The following are the list of questions that you should ask about in the review of systems.

A) GIT

- Feeding pattern, appetite, nausea, anorexia, vomiting, diarrhea, abdominal pain, epigastric pain, heart burn, hematemesis, hematochesia, melena or rectal bleeding, constipation, urgency, tenesmus, excessive thirst, weight loss, jaundice, urine output (in case of dehydration).

B) Respiratory

- Cough, sputum, dyspnea, wheeze, stridor, cyanosis, chest pain, hemoptysis, tachypnea, discharges from the nose or ears or eyes, post-tussive vomiting and whoop.

C) Cardiovascular

- Dyspnea, tachypnea, cyanosis, chest pain, palpitation, syncope, breathlessness on feeding, failure to thrive, weight loss, recurrent chest infections and leg edema.

D) Renal

- Dysuria, frequency, amount of urine, oliguria, polyuria, polydipsia, anuria, changes in urinary habits, color of urine, odor of urine, enuresis (nocturnal or diurnal), pyuria, hematuria, urgency, incontinence, loin pain, suprapubic pain and in adolescence ask about genital ulcer or discharges.

E) CNS

- Headache, dizziness, disturbance of consciousness, vertigo, drowsiness, convulsion, vision, hearing, speech, sphincter control, weakness, paresthesia, floppiness, numbness, tremor, ataxia and change in mood.

F) Musculoskeletal

- Limb abnormalities, arthralgia, arthritis, bone, pain, stiffness and joint swelling.

G) Skin

- Skin rash, itching, change in color, increase or decrease in pigmentation, bleeding spots (purpura, ecchymosis…) dermatitis, increase or decrease in growth of hair (general or local).

H) General

- These questions may be included or could be inserted into other systems: general activity, sleep, weight loss, fever, failure to thrive, pallor and easy fatigability.

5) Past History

Includes: 1. Prenatal 2. Natal 3. Postnatal 4. Past Medical 5. Past Surgical

Prenatal

- It means health of the mother and fetus during pregnancy. So ask about antenatal care visits (ANC), diseases during pregnancy, diseases induced by pregnancy like pregnancy induced HTN and gestational diabetes, history of bleeding during pregnancy (mention at which trimester), history of fever, skin rash, or any infectious problems during pregnancy (especially for those diseases that are responsible for congenital infections = TORCH), also ask about history of any medications during pregnancy, history of surgery, history of radiation exposure and any obstetric complications that occur during pregnancy and before delivery.

Natal

- It is the history of delivery. Ask about gestational age, mode of delivery, place of delivery, medical care level (obstetrician, physician, nurse, midwife), medications given during labor (oxytocin, narcotic…etc.), surgical interference, instrumental interference, and also ask about condition of the newborn after delivery (cry immediately or not, history of resuscitation, cyanosis, dyspnea, apnea, jaundice, obvious congenital anomalies…etc., admission to NICU and birth weight of the newborn).

Postnatal

- It is the history of the neonate. Ask about cyanosis, dyspnea, apnea, jaundice, convulsion, fever, infections, any medical or surgical problem, mode of feeding, feeding difficulty, and time of the first urination and defecation (passage of meconium).

Past Medical History

Ask for the following:

1. Previous illnesses (especially childhood illnesses) like measles, chicken pox, mumps, whooping cough, malnutrition…etc.
2. Chronic diseases like DM, asthma, congenital heart diseases…etc.
3. History of hospitalizations (mention something about time of hospitalization, duration, diagnosis and condition after discharge from the hospital).
4. History of transfusions (blood, plasma, factors…etc.).
5. History of contact with infectious diseases and history of travelling to endemic areas.

Past Surgical History

- History of surgical procedures (mention type of surgery, time, duration of hospitalization after surgery and complications of surgery if present).

Drug and Allergy

- History of long term medications like anti-hypertensive, steroids, NSAID, bronchodilators…etc. And history of allergy to drugs or other substances.

6) Nutritional History

- Questions depend on the age of the patient.
- In infants & young children the first question should be about type of feeding (bottle, breast or mixed feeding?). In breast-fed infants ask about: whether feeding on demand or special schedule, frequency of feedings per day, duration of each feeding, hygiene, condition of the child after feeding or signs of adequacy of feeding (2-4 hrs, good urine output, gaining weight), any problems associated with breast feeding (problems related to the mum like mastitis, retracted nipple…etc. or problems related to infants like poor sucking, regurgitation, vomiting, GER, cleft lip & palate…etc.), also ask about any added foods & if there are any problems associated with these foods.
- In bottle fed infants ask about whether on demand or special schedule, name of the formula, type and number of the formula, number of bottles available, frequency of feeding per day, duration of each feeding, hygiene (ask about the methods of sterilization), ask about the way of preparation (concentration of the formula), condition of the infant after feeding (signs of adequate milk supply), any problems associated with feeding (as mentioned previously), any added foods, and problems with added foods.
- Ask about age of weaning, time of introduction of gluten-containing diets, feeding habits & history of food allergy.
- In mixed feeding you have to ask about history of both (breast feeding and bottle feeding).
- In older children ask if the child is fed on ordinary family diet or on special type of diet and about feeding habits.
- If the main problem of the patient is related to nutrition for example malnutrition or failure to thrive, so feeding history should be taken in details from the beginning regardless of the child age.

7) Immunization History

- The questions depend on the age of the child and on the country schedule. Ask about vaccines received till the time of history taking, any missed vaccines, any history of delay in receiving vaccination and the reason behind it (for example febrile illness at the time of vaccination), any history of vaccines contraindications, side effects after vaccination whether it is local or general side effects. Any special vaccines received, and for what reason? (Like pneumococcal vaccine). Note: Do not forget to look for BCG scar in the left deltoid.

8) Developmental History

- The questions can be arranged according to the age of the child, for example in school age child ask about school performance, but in infants, children and patients with developmental delay you have to ask about all the questions in developmental history starting from the beginning. You can divide developmental history into:

  1. Gross motor 2. Fine motor 3. Hearing, vision and speech 4. Social

In general these are examples of the common questions in developmental history:

First social smile (in response to the mother's face) = normally develops at age of 6-8 weeks.

Head steady in sitting position = 3-4 months
Grasp a rattle = 3-4 months
Reaches for an object = 4 months
Transfer an object = 5 months
Sit with support = 6 months
Inhibit to no = 7 months
Sit without support = 8 months
Pincer grasp = 9 months
Stand with support = 10-11 months
Walks = 12 months

First real word = 12 months
Scribble = 13 months
Build tower of two cubes = 13 months
Saying 4-6 words = 15 months
Build tower of 6 cubes = 15-17 months
Run = 16-18 months
Draw a circle = 3.5-4 years
Draw a square = 4 years
Ride a tricycle = 3 years
Draw a triangle = 4 years

- These are averages and ranges of developmental milestones in children which differ from one nation to another.
- The child is considered to have developmental delay if he/she passes the upper limit for the development of specific milestone for example if the child cannot sit with support till the age of 8 months, it is considered as normal (range is 6-8 months) but after 8 months it is considered as abnormal or delayed.

9) Family History

- In family history you have to ask about the following questions: consanguinity of the parents, blood group of both parents, number of the family, the place of the child in the family (1st one or 2nd one), family history of diseases in maternal and paternal sides like family history of DM, asthma, congenital heart diseases, bleeding tendency, hemoglobinopathies, HT, allergic diseases, congenital anomalies, any history of childhood death and the reason…etc. Also family history of diseases in the siblings, history of stillbirth, abortion, congenital anomalies. If possible draw the family pedigree.

10) Socioeconomic History

- Ask about the following:
- Housing condition (owned or rented house), number of rooms in the house, number of persons in the house (crowding index=number of persons/number of rooms), water and electrical supply, sewage disposal, domestic animals, economic status (salary and total monthly income or you can only mention poor, medium or high economic status), education status of the parents, job of the parents, number of working persons in the same house, any history of smoking, alcohol consumption or drug abusers in the house.