PEDIATRIC HISOTRY AND EXAM

BE SURE TO INDIVIDUALIZE ALL INFORMATION TO THE CHILD YOU ARE SEEING, REMENBER THE SIGNIFICANCE OF THE CHILD'S AGE, Health history for the child is similar to the adult, with the additions of prenatal care, growth and development, and behavioural and school status histories. More detail about each system will be covered in class. Students are expected to incorporate this information incrementally.

Introduction (Identifying Data)

Name and age of client, name of parents(s) or caregiver. Whether acutely or chronically ill. Source of referral (school, parents, hospital).

History

Chief complaint

History of present illness

(Most important part of history). As for adults, a detailed, chronological account of each symptom and related events. Determine if the concerns are that of the parents, client, or third party (school, teacher, CHR). Include activities/behaviors in relation to the client's age and stage development.

Past history

P/N history of mother, birth history, gestation, & wt, neonatal Hx (Apgar score), congenital infections/defects. Omit in child over 2 unless contributory to present presentation.
Milestones (physical and social)
Allergies and reactions
Feeding/diet history
Parental response to problems
Medications
Screening (hearing, vision, mantoux, neonatal).
Ask specifically about any history of atopic disease/asthma, heart problems, jaundice, infections, seizures
Communicable diseases, other illness/injuries
Hospitalizations, operations

Family history

Medical problems in the family which are of significance to the child's current problem. Is there a family history of problems similar to that of the patient? Any history of birth defects in the family?

Social history Similar to adults, with a particular focus on the following:

Who lives at home? Who cares for the child? Babysitters, day care, etc. parents employed? Family support systems?
Stresses, concerns in the family
Socioeconomic circumstances that influences the care if the child and acceptance of therapies. Parental readiness, knowledge, attitude, and expectations.
Try to get a sense of family dynamics: evaluate for possible / potential abuse.
Consanguinity? Substance/solvent abuse?
Smocking in household?
Other safety issues i.e. where does the child sleep, heat source etc.

Review of System (functional inquiry)

(Symptoms at present, not past history). Similar to he ROS in adults with the following additions and variations. ADJUST TO CHILD'S AGE

General:	Change in activity, behaviour or eating problem, not gaining weight or weight loss.
Nutrition:	24 hour recall Breast or formula, frequency, **amount taken.** If formula, also note type and how it is prepared Regurgitation (describe) Intro of solids/traditional foods, type and amount Intake of non – food items (erasers, dirt, paper) Daily intake and type of milk Eating habits (likes/dislikes) Use of vitamin supplements
Eyes:	Vision (screening at school?), crossed eyes, reading difficulty. (maternal vaginal infection present if newborn?)
Ears:	Earache, multiple infections Drainage (describe) Frequent swimming? Perception of hearing (language skill for age, school performance, listen to commands at home?)
Nose:	Congestion, nasal flaring
Mouth/oropharynx:	Dentition = eruption of first teeth, caries, toothaches, tooth brushing pattern Sore throat (tonsils present?) Mouth sores
Breast:	Preadolescence ask re: developmental changes and perception of the same

Resp:	Cough (explore: ?worse @ night, ?present between colds, atopic skin disease) Noisy breathing, wheeze Fast breathing, indrawing apnea, snoring Bottle propping? Chocking episodes (inappropriate foods for age, eg. Peanuts, awareness of emergency measures to take for chocking)
Cardiac:	Ever told of any problems with heart Cyanosis/tachypnea with feeding or exertion Sweating with feeds, prolonged feeding times Can they keep up with the other children? Squatting?
GI:	Intake (diet history as above <u>including juice intake</u>) Vomiting/regurgitation Abdominal pain Stool pattern Diarrhea/ constipation (all need exploring of present)
GU:	Δ in voiding pattern/cry with voiding? Frequency (number of diapers changed if infant) Dysuria, abdominal pain Hygiene rituals Toilet training status Bed wetting (new onset? Explore fluid intake, stressors) Rashes Development of genitalia Onset of Menstruation, screen for sexual activity/abuse
Musculoskeletal:	Gait ability (limp?) Pain, heat, swelling Any loss of, or change in function Curvature of the spine
Neuro:	Question re: behaviors expected from infantile reflexes Recent fall, trauma, febrile illness Seizures, staring spells inattention (school or home) Passing out episodes Balance problems, muscle weakness (up/down stairs, getting up from lying) Achieving developmental milestones similar to siblings? Headaches Any loss of function, change in behaviour Speech-language delay, stuttering Learning difficulties

Endocrine:	Precocious or delayed puberty Growth delay Diabetes symptoms (start screening by age 8)
Skin:	Rashes, eczema Infections, lice Hygiene regime Report of jaundice

Pediatric Exam

Tailor to developmental level and history obtained. Similar to the adult exam with the following additions and variations. The P/E exam of adolescents age 13 through 18 is conducted essentially like that of an adult. Exam is performed out of sequence for infants, but is reported from head to toe.

Comment on general appearance.

Vital signs. Include BP routinely by age 3, and with younger infants if clinically indicated, good to count respirations for a full minute in infants as rate can normally be irregular.

Growth percentiles. Height, weight, head circumference (up to 24 months). Report in relation to percentiles (above, below or between), and **plot** on growth chart at each visit. Do not report measurements (except possibly in neonates).

Head:	**Inspection:** size and shape (moulding, haematomas), hair **Palpation:** Posterior and anterior fontanel (opened, closed, depressed or bulging
Neck:	**Inspection:** ROM, head control, skin folds **Palpation:** palpate clavicles in newborns
Eyes:	**Inspection:** alignment and position, corneal light reflex, red reflex, presence of nystagmus, color of sclera (jaundice). Vision screening for preschoolers
Ears:	**Inspection:** Alignment and position (low set?)
Nose:	**Inspection:** Symmetry, discharge, patent nares, bridge of nose (jaundice) **Palpation:** Sinuses (frontal sinus developed fully by age 8)
Mouth/: Oropharynx	**Inspection:** Hygiene, soft and hard palates (closed?) Buccal mucosa (color, hydration, lesions) Salivation Teeth Tonsils (redness, exudate, obstruction. Size of tonsils is usually of no significance. Maximum size b/w 2 to 6 years of age.

Chest:	Infant and toddler = Inspection (nasal flaring & indrawing, cyanosis, thoracic or abdominal breathing, strider, grunting, breast enlargement, chest wall deformity) & auscultation Older child=inspection, palpation, percussion, auscultation
Breast:	Examination should be done, however no significant findings are generally noted until puberty. Note in newborns +/- presence of enlarged breasts & discharge (N is milky/watery)
Lymphatics:	As in adults.
Heart:	Inspection: color (?central cyanosis, pallor, dyspnea position, precordium, nail beds) Palpation: PMI, heave, thrills (femoral pulses & liver in infants) Auscultation: Heart sounds, murmur (describe if present)
Abdomen:	Inspection: (umbilicus-hernia, cord hygiene, diastasis rectus muscles) Auscultation Percussion Palpation: normal liver boarder varies with age, rectal patency (verify by parent history stool passes without difficulty) **Rectal:** in newborns inspect area for sinuses, hair tufts, and gently stroke the anal area noting quick contraction of the sphincter i.e. "winking, to assess for lower spinal deformity (also a useful tool for checking for abuse in children). Internal rectal examination performed on all age groups, but **only** if GI symptoms reported in history include blood in the stool, or indicate a surgical abdomen.
Genitalia:	***Female Inspection:*** Frog leg position. Exam limited to **external** evaluation in infancy and childhood. Visualize perineal area, urethra, clitoris, hymen and vaginal opening. Sphincter/anal tone. Secondary sex characteristics (see Tanner's staging) Male Inspection: ?circumcised, scrotal/inguinal swelling, position of urethral meatus, discharge, secondary sex characteristics Palpation: Foreskin completely retractable by age 4-6, retract only to point of tightness before this age. Prepuce (? Paraphimosis). Both testes descended? Hydroceles? (Try transillumination) Hernias? (Try reduction). Sphincter/anal tone. Prostate unpalpable & undeveloped until puberty

MSK:

Spine/Back:	Inspection: movement in/out fetal position, abnormal posturing, and hair tufts, dimples, sinuses, Mongolian spots. Teenagers scoliosis/posture
Hips:	Inspection: (check if appropriate age), skin fold symmetry Palpation: Barlow-Ortolari's sign until mobile
Feet:	Inspection: Heel creases, clubfoot
Extremities:	Inspection: fusion of fingers/toes, # digits, symmetry, deformity, swelling redness, position, ROM, gait (if applicable)
Neurological:	Infantile reflexes (age appropriate) a) Position &movement Moro Tonic neck Plantar grasp Palmar grasp Babinski Step in place Clonus b) Feeding reflexes Rooting Sucking
Inspection:	requires careful observation of the child during spontaneous activity, since the child may not cooperate with requests as a teenager or adult would. Note the following: Alert and oriented (?), response to environment, tone, motor abnormality, coordination/symmetry of movements, loss of function, cranial nerves, cry (tone), consolable (?), scissoring of legs, rashes, jaundice. Use the DDST for fine-motor coordination for children under age 6. Sensory function is not normally tested before age 5

Skin:

Inspection:	Hygiene, pigmentation (Mongolian spot, haemangiomas, Port wine stain, Café au Lait spot etc in newborns), rashes, bruises (old or new?), jaundice, skin tags.
Palpation:	Texture and lesions (milia & erythema toxicum in newborns), turgor (tenting?)

Developmental Assessment

Milestones
Denver Developmental Screening Test at 2mo, 4mo, 6mo, 1 year, 18mo, & preschool.
If abnormalities, consult re: ↑ frequency of assessments.
School performance for children 5 and older.

Summary / Conclusions

Positive and any negative findings from both history and exam

Problem list/risk profile

Management plan within the context of a northern First National community, including education, anticipatory guidance, follow up, and evaluation.

Adapted from the following texts:

Bickley, L.S. (1999). *Bates' Guide to Physical Exam and History Taking (7th ed.)* Philadelphia, PA: Lippincott, Williams & Wilkins

Thompson, J.M. & Wilson, S.F. (1996). *Health Assessment for Nursing Practice* (1st ed.) St. Louis MI: Mosby-Year Book, Inc.

Swartz, M. (2002). *Textbook of Physical Diagnosis: History and examination* (4th ed.). Toronto, ON: W.B. Saunders Co.