History taking in paediatrics

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Paediatric history taking- Introduction

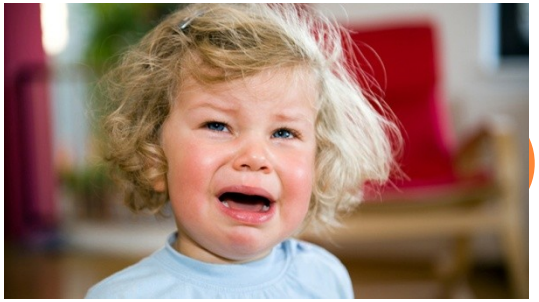
- Obtaining an accurate history is the critical first step in determining the etiology of a patient's problem
- A large percentage of the time, you will actually be able to make a diagnosis based on the history alone
- The value of the history will depend on your ability to elicit relevant information
- Successful interviewing is for the most part dependent upon your already well developed communication skills

Paediatric history taking- Introduction

- Observe the child at play in the waiting area and observe their appearance, behaviour and gait as they come into the clinic room

The continued observation of the child during the whole interview may provide important clues to the diagnosis and management

- When you welcome the child, parents and siblings, check that you know the child's first name and gender



Paediatric history taking- Introduction

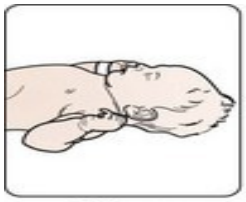
- Introduce yourself
- Determine the relationship of the adults to the child
- Establish eye contact and rapport with the family. Infants and some toddlers are most secure in parents' arms or laps. Young children may need some time to get to know you
- Ensure that the interview environment is as welcoming and unthreatening as possible. Avoid having desks or beds between you and the family, but keep a comfortable distance

Paediatric history taking- Introduction

- Have toys available, observe how the child separates, plays and interacts with any siblings present
- Do not forget to address questions to the child, when appropriate

Paediatric history taking- the history must be adapted to the child's age

- Birth history and impact of children's growth and development
- Often distracted by presence of the child
- Need to be flexible
- Maintain a sense of humour



Infant

Neonate (<4 weeks) Infant (<1 year)

Toddler

Approx 1–2 years

Preschool

Young child (2–5 years)

School-age

Older child

Teenager

Adolescent

Whenever you consider a paediatric problem, whether medical, developmental or behavioural, first ask, 'What is the child's age?'

Paediatric history taking- the history must be adapted to the child's age
older children &teenagers

- There will be occasions when the parents will not want the child present or when the child should be seen alone
- This is usually to avoid embarrassing older children or teenagers or to impart sensitive information
- This must be handled tactfully, often by negotiating to talk separately to each in turn.

Opening the consultation-*These questions may need to be addressed at the patient's parents, depending on their age, so adjust as appropriate.*

- **Introduce yourself – *name / role***
- **Confirm patient details – *name / DOB***
- **Explain the need to take a history**
- **Gain consent to take a history**
- **Ensure the patient is comfortable**

Presenting complaint

- Give the patient time to explain the problem/symptoms they've been experiencing
- A paediatric history often relies on collateral information from the parents
- It's important to use open questioning to elicit the patient's or parent's presenting complaint

"So what's brought your child in today?" or "What's brought you in today?"

- This can sometimes be difficult when talking to children and you may need to adopt an approach involving more direct questioning. So instead of saying *"Tell me about the pain" you may need to ask a series of* questions requiring only yes or no answers.

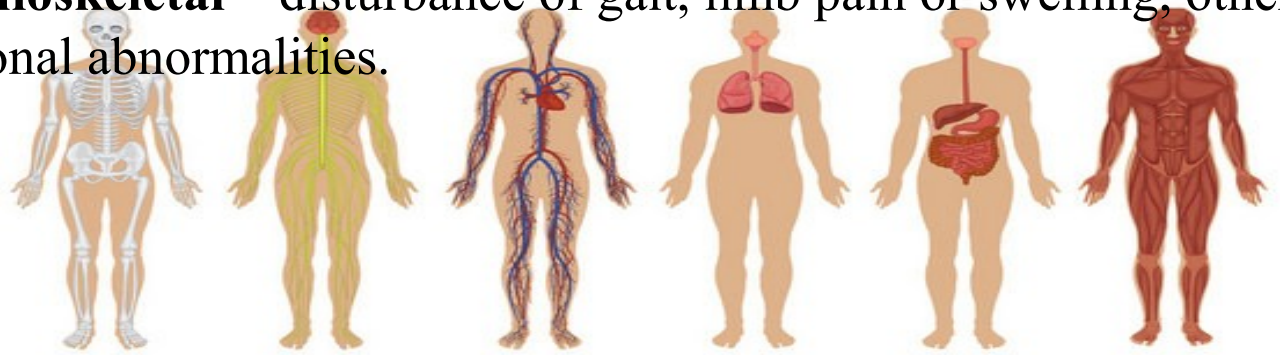
General enquiry

- General health – how active and lively?
- Normal growth
- Pubertal development (if appropriate)
- Feeding/drinking/appetite
- Any recent change in behaviour or personality.

Systems review

Make sure that you and the parent or child mean the same thing when describing a problem

- **General** rashes, fever (if measured)
- **Respiratory** – cough, wheeze, breathing problems
- **ENT** – throat infections, snoring, noisy breathing (stridor)
- **Cardiovascular** – heart murmur, cyanosis, exercise tolerance
- **Gastrointestinal** – vomiting, diarrhoea/constipation, abdominal pain
- **Genitourinary** – dysuria, frequency, wetting, toilet-trained
- **Neurological** – seizures, headaches, abnormal movements
- **Musculoskeletal** – disturbance of gait, limb pain or swelling, other functional abnormalities.



History of presenting complaint

- **Onset** – *when did the symptom start? / was the onset acute or gradual?*
- **Duration** – *minutes / hours / days / weeks / months / years*
- **Severity** – *e.g. if symptom is shortness of breath – are they able to talk in full sentences?*
- **Course** – *is the symptom worsening, improving, or continuing to fluctuate?*
- **Intermittent or continuous**? – *is the symptom always present or does it come and go?*
- **Precipitating factors** – *are there any obvious triggers for the symptom?*
- **Relieving factors** – *does anything appear to improve the symptoms, e.g. an inhaler*
- **Associated features** – *are there other symptoms that appear associated*

  e.g. fever / malaise
- **Previous episodes** – *has the patient experienced*

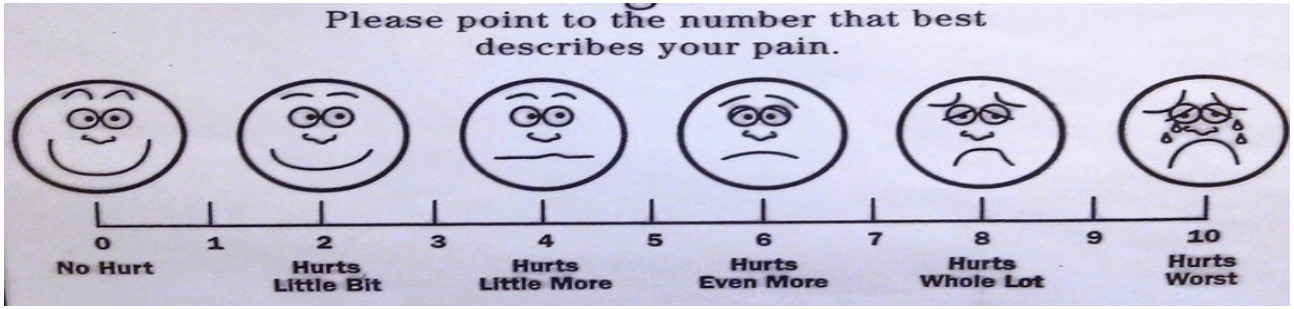
  this symptoms previously?

Key paediatric questions

- **Feeding** – *volume of intake / frequency of feeding*
- **Vomiting** – *frequency / volume / timing – projectile? / bilious? / blood?*
- **Fever** – *confirmed using thermometer vs subjectively feeling hot?*
- **Wet nappies / urine output** – *number of wet nappies a day – ↓ in dehydration*
- **Stools** – *consistency / steatorrhoea? (biliary obstruction) / red currant jelly (intussusception)*
- **Rash** – *any obvious trigger? / distribution? / blanching?*
- **Behaviour** – *irritability / less responsive*
- **Cough** – *productive? / associated increased work of breathing?*
- **Rhinorrhoea** – *often associated with viral upper respiratory disease*
- **Weight** gain or loss – *check baby book if the parent has it with them*
- **Sleeping pattern** – *more sleepy than usual?*
- **Unwell contacts** – *often children become infected from unwell siblings*

Pain – *if pain is a symptom, clarify the details of the pain using SOCRATES*

- **Site** – *where exactly is the pain / where is the pain worst*
- **Onset** – *when did it start? / did it come on suddenly or gradually?*
- **Character** – *what does it feel like? (sharp stabbing / dull ache / burning?)*
- **Radiation** – *does the pain move anywhere else?*
- **Associations** – *any other symptoms associated with the pain*
- **Time** course – *does the pain have a pattern (e.g. worse in the mornings)*
- **Exacerbating / relieving factors** – *anything make it particularly worse or better?*
- **Severity** – *on a scale of 0-10, with 0 being no pain and 10 being the worst pain you've ever felt*



Ideas, Concerns and Expectations – *often addressed to parents*

- **Ideas** – *what are the patient's / parent's thoughts regarding their symptoms?*
- **Concerns** – *explore any worries the patient / parent may have regarding the symptoms*
- **Expectations** – *gain an understanding of what the patient / parent is hoping to achieve from the consultation*

Summarising

- **Summarise what the patient / parent has told you about the presenting complaint.**
- This allows you to **check your understanding regarding everything the patient/parent has told you.**
- It also allows the patient/parent to **correct any inaccurate information and expand further on certain aspects.**
- Once you have **summarised, ask the patient/parent if there's anything else that you've overlooked.**
- Continue to **periodically summarise as you move through the rest of the history.**

Past medical history

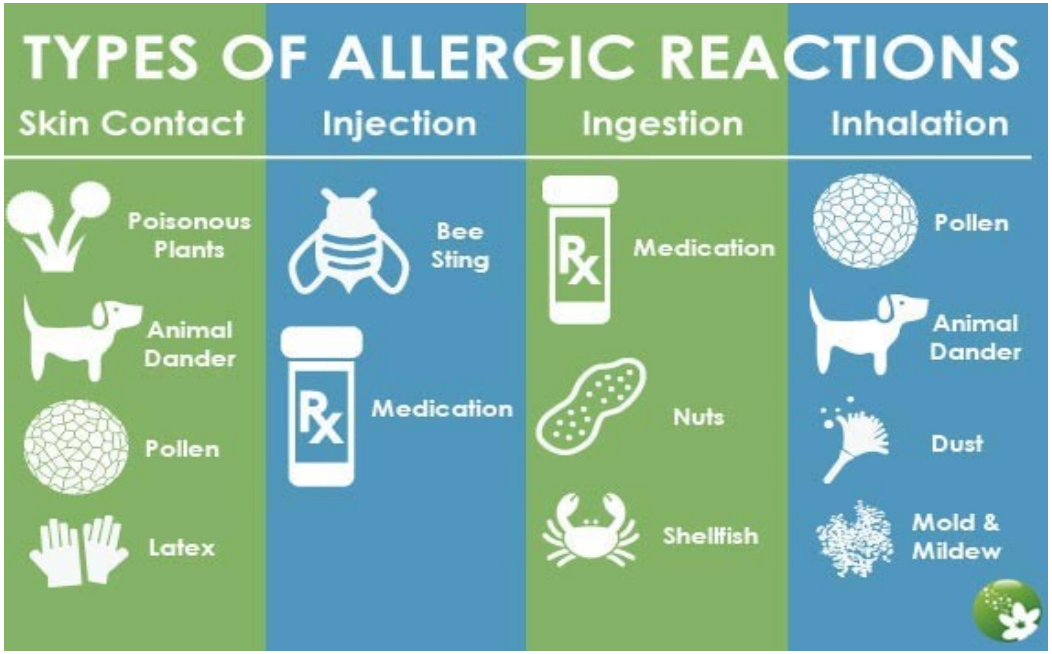
- **Antenatal period** – *illnesses or complications during gestation – e.g. rubella*
- **Birth** – *delivery complications / prematurity / birth weight*
- **Neonatal period** – *illness /admission to special care baby unit (SCBU)?*
- **Medical conditions**
- **Previous hospitalisation** – *when and why?*
- **Previous surgery**
- **Accidents and injuries** – *remain vigilant for signs of non-accidental injury*

Drug history

- **Regular medication – *e.g. inhalers for asthma***
- **Over the counter medication**

ALLERGIES

- Known allergies

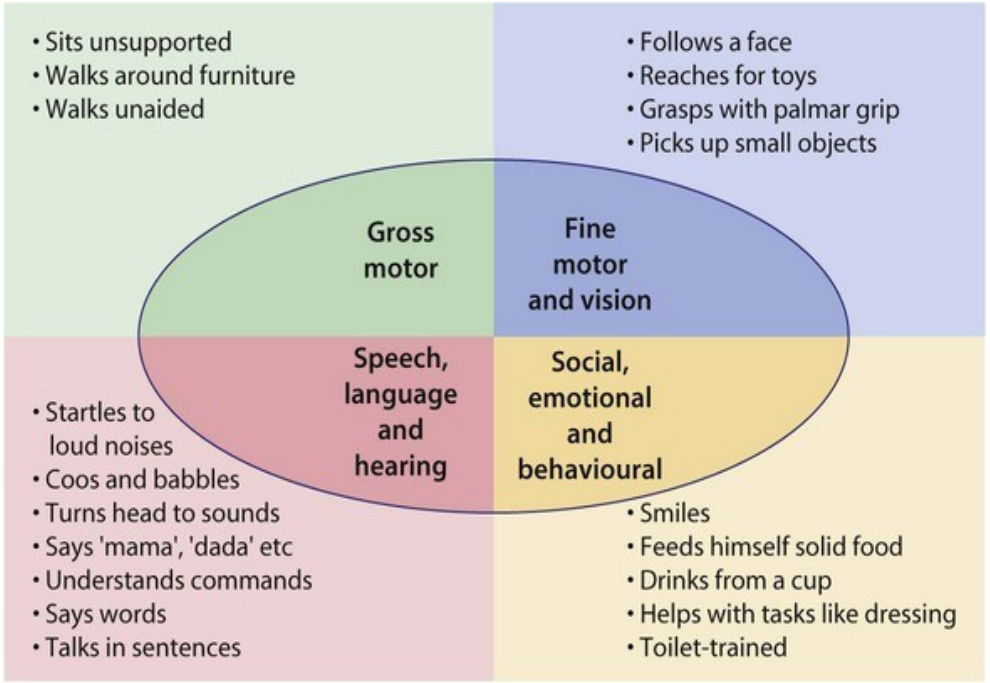


Developmental history

- **Current weight and height – *weight is required to calculate drug doses***
- **Developmental milestones *(are they on track for their given age?):***

e.g. sitting up, crawling, walking, talking, toilet training, reading

Some key developmental milestones in infants and young children

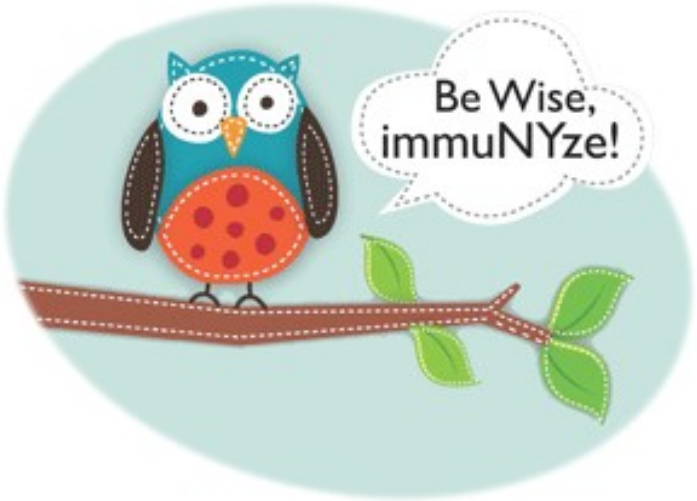


Developmental history

- Parental worries about vision, hearing, development
- Previous child health surveillance developmental checks
- Bladder and bowel control
- Child's temperament, behaviour
- Sleeping problems
- Concerns and progress at nursery/school.

Immunisations

- **Is the child up to date with their immunisations?**

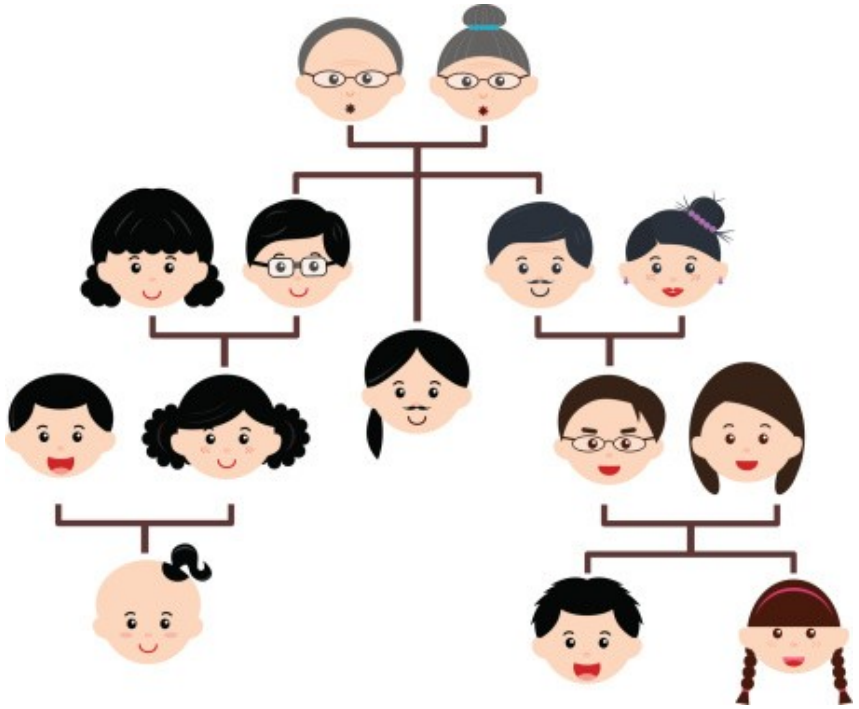


Dietary history

- **Type of food?** – *formula / breast milk / solids*
- **Intake –** *e.g. how many ounces of milk?*
- **Frequency of feeding** – *reduced or increased?*
- **Special dietary requirements? –** *cow's milk intolerance / coeliac disease*

Family history

- **Family history of disease** – *e.g. coeliac*
- **Genetic conditions** – *e.g. cystic fibrosis*
- **Family tree** – *useful to draw out if considering genetic disease*



Social history

- **Living situation** – *accommodation / main carer / who lives with child?*
- **Second hand smoke exposure –** *risk factor for otitis media / asthma*
- **Parent's occupation**
- **Pets** – *important when considering allergies / asthma triggers*
- **Schooling –** *stage of learning / any issues?*
- **Foreign travel** – *may be important when considering certain diagnoses e.g. TB*

Closing the consultation

- **Thank patient**
- **Summarise the history**