Junior Pediatric Clerkship

LSUHSC - Shreveport, Department of Pediatrics
HISTORY AND PHYSICAL GUIDE 2010-11

I **CHIEF COMPLAINT:** This is the patient/parent's own words in quotes (ex. "fever and vomiting x 5 days")
Informant & reliability - (ex. mother, grandmother, appears to be a reliable historian)

II **HISTORY OF PRESENT ILLNESS**:
State patient's age, race, sex, and any pertinent disease or diagnosis that they have, along with the reason that they presented to the doctor. Answer all "OLD CARTS" questions. Include pertinent negative and positive points about their history and the symptoms and/or lack of symptoms that they exhibit. **Discuss the history in logical, chronological order and include precise time reference to illness onset in your history.** Use complete sentences and only use hospital approved abbreviations. (Ex. The patient is a 5 year old black male with sickle cell disease who was in his usual state of good health until 2 days prior to admission when he developed fever up to 102º F and began vomiting 3 times a day.)

III **PAST MEDICAL HISTORY:**

A. Birth history: gestational age in weeks if known, full term (≥ 37 weeks GA) or premature infant (< 37 weeks GA), birth weight, vaginal delivery or C-section (ask why C-section?), age and parity of mother, duration of labor, rupture of membranes, complications of pregnancy, if any prenatal care (or not), infant APGAR scores if known, neonatal course (oxygen requirements, fever, treated for any infections, jaundice, feeding problems, length of nursery stay (normal newborn nursery versus NICU)

Maternal history: smoking history, drug use, alcohol use, presence of risk factors for HIV in mother and father (IV drug use, blood transfusion, multiple sexual partners) and testing for HIV during pregnancy, any illness during pregnancy (and at what GA), gestational diabetes, hypertension, vaginal bleeding, UTI's, yeast infections, history of STD's and treatment for them (syphilis, gonorrhea, chlamydia, herpes simplex virus, hepatitis B, hepatitis C, HIV, genital warts)

List mother's other pregnancies if any, in chronological order. Include date of birth, weight, sex, mode of delivery, health of child.

B. Immunizations: **See Recommended Childhood Immunization Schedule for US, below.** Is the child up to date on his shots? If not, why? If so, what does this include? Received where? Next due?

C. Previous hospitalizations: List dates if known, where hospitalized, approximate age, and reason for hospitalization.

D. Previous operations: List dates and type of surgery
(Ex. PE tubes for recurrent otitis media, circumcision, tonsillectomy, splenectomy)

E. Current medications: Prescription and over-the-counter with total dose, dose per kilogram, how often, duration, time of last dose, and indication for each (ex. Children's Tylenol 1 ½ tsps.= 10 mg/kg PO every 4-6 hours for 3 days, last dose 2 hours ago for fever).

F. Allergies: List drug, food, and environmental allergies and patient's reaction to them. (ex. Amoxil causes skin rash, peanuts cause anaphylaxis), any history of dermatitis, eczema, urticaria, hay fever, allergic rhinitis, asthma, allergy shots

G. Nutrition history:
Infants: breast or bottle fed, type of formula, # of ounces fed and how often (ex. 2-3 oz every 3- 4 hours), calories per kilogram per day (ex. 110 Kcal/kg/day). Has he had changes in his formula and why? Solid foods started at what age?
Older children: types of foods they eat, assess appetite, juice intake, milk intake (ex. likes chicken, potatoes, drinks 4 oz of juice and 2-3 8 oz glasses of milk a day). Is patient able to eat by mouth, or is he fed via gastrostomy tube, nasogastric feeding, or TPN? (given IV). If one of these modes, what nutrition is he on and how much? (Ex. takes Pediasure 1 can through gastrostomy tube 4 times a day and then receives continuous feeding with Pediasure at 15 cc/hr over 12 hours at night from 8pm to 8am)

H. Developmental history: **Refer to Development Tables A & B**; list all current developmental milestones for the patient; is the patient developmentally delayed/advanced? what is the patient's current developmental age?

IV FAMILY HISTORY:

1. Father's age, health status
2. Mother's age, health status
3. Caretaker's age and health status
4. Presence or absence of familial diseases and who has them, (including diabetes mellitus, cancer, hypertension, kidney disease, liver disease, congenital heart disease, collagen vascular disease (rheumatoid arthritis, lupus, juvenile rheumatoid arthritis), anemia, (sickle cell anemia or trait), immunodeficiencies (AIDS, Wiskott-Aldrich, IgA deficiency), genetic disorders (Down's syndrome, Turner's syndrome, cystic fibrosis), etc.

V. SOCIAL HISTORY:

1. Where was child born? Where does child live and with whom? Primary caretaker?
2. Apartment, trailer, institutional setting or in a home? How long at this address?
3. In the country or in city?
4. City water and sewage or well water and septic tank?
5. Lives with biological parents, foster parents, adoptive parents, or relative?
6. Employment of parents or primary caretaker and what they do? Marital status of parents? Legal custody of child?
7. Financial status: self pay with own private insurance, military insurance or medicaid, food stamps, receives checks from SSI or aid to dependent children?
8. Smokers in the home?
9. Pets: (ask about dogs, cats, birds, ferrets, turtles, snakes, iguanas, hamsters, gerbils, birds). Do the pets live inside the home or outside? Ask about recent bites or scratches inflicted by pets.
10. List everyone who lives with or has contact with the child.
11. Does child attend daycare? Babysitter?
12. Travel history (particularly to foreign countries)? What country and for how long?
13. Name of primary care physician.

VI. **ADOLESCENT HISTORY/ISSUES (See HEEADSSS below)**

1. What grade are you in and what type of grades do you make? Have you had to repeat a grade or have you ever been suspended from or dropped out of school?

2. Are you planning to graduate from high school? Go to college?

3. Do you have a job and if so what type of work and how many hours a week?

4. Who do you live with? Have you ever lived in foster care or institution? Have you ever run away from home? If so, why?

5. Have you ever had any thoughts about harming yourself (suicide) or others (homicide)?

6. Do you ever have feelings of sadness or depression for more than 3 days in a row?

7. Have you lost or gained weight in the past year? If yes, how much weight have you lost or gained in lbs and over what period of time.

8. Do you drink alcohol and how much? Do you smoke or chew tobacco and how much? Have you smoked marijuana, or used drugs (heroin, cocaine, speed, acid, etc)

9. Does anyone in your family have a drug or alcohol abuse problem?

10. Have you ever had sexual intercourse? At what age? How many different partners? Do you use birth control and what do you use? (Birth control pills, condoms)

11. Have you ever had a sexually transmitted disease? (GC, syphilis, herpes simplex, genital warts, chlamydia, HIV) If yes, were you treated?

12. For sexually active males: Do you know how to properly use a condom? Have you had any problems with penile discharge or lesions? Have you fathered a child?

13. For females: Have you started your period? And at what age did you start?
What date did your last menstrual period start?
Are your periods regular? (once a month?)
Have you ever had a vaginal infection?
Do you have painful or excessively heavy periods or bleed in between periods?
Do you think you may be pregnant? Have you ever been pregnant?

14. Do you use a seat belt?
Do you ride in a car when the driver is drunk or "high"?
Do you feel safe at home? At school? Have you ever been hit by a parent, relative, friend, including boyfriend / girlfriend?
Does your mother or caregiver ever get hit by his / her significant other?
Are you bullied at school, at home, or on cyberspace?
Has your date ever raped you?

VII REVIEW OF SYSTEMS: 2-3 questions concerning each system

*******If the information is pertinent to the HPI, place it there.*******
*******If the information is already in the HPI, do not repeat it here…just write "See HPI".*******

A. **General Health:** fatigue, weight loss, weight gain, appetite, physical activity level (Typically, all of this information belongs in the HPI to show how the current illness has changed the child from baseline.)

B. **HEENT:** headaches, trauma, vision or hearing impairment, blurry or double vision, need for glasses/contacts, eye or ear infections, sore throat, runny nose, nosebleeds, sinus infections, strabismus

C. **Cardiovascular:** heart murmurs, congenital heart defects (ASD, VSD, coarctation, ToF, etc), abnormal heart rate (sinus tachycardia, bradycardia, palpitations), chest pain, hypertension

D. **Hematological**: Any excessive bruising, clotting disorders (history of blood clots or hypercoagulability), excessive bleeding with or without surgery, history of anemia, history of sickle cell disease or trait, history of Thalassemia, leukemia, or other white blood cell abnormalities, history of tumors.

E. **Breasts:** development, trauma, lumps, pain, nipple discharge, gynecomastia

F. **Respiratory**: shortness of breath, wheezing, dyspnea, coughing, orthopnea, hemoptysis, night sweats, chest pain, pneumonia, asthma, bronchitis, TB

G. **GI:** appetite, dysphagia, nausea, vomiting, (ex. vomiting 3 x/day about ½ cupful for past 2 days, blood-tinged, non-bilious, usually 30 minutes after eating), diarrhea (describe stool color, consistency, frequency, bloody or not) constipation, abdominal pain, gas, melena, hematochezia, jaundice, problems gaining weight or problems with excessive weight gain

H. **GU:** dysuria, polyuria, oliguria, bedwetting, incontinence, hematuria, hesitancy, frequency, decreased urinary stream, urgency, UTI history, kidney stones, kidney disease, hypospadias, circumcision.

I. **Neurologic:** seizures, motor tics, cerebral palsy, muscular dystrophy, normal or abnormal gait, disturbances of smell, vision, hearing, speech, developmental delay, performance in school

J. **Musculoskeletal:** trauma, fractures, arthritis, muscle weakness or atrophy, flexor contractures, scoliosis, club feet, deformities

K. **Skin:** color, pigmentation, scaling, bruising, dry skin, rashes, pruritus, skin lesions, eczema, psoriasis, atopic dermatitis, abnormal loss or growth of hair, nail changes

VIII. PHYSICAL EXAMINATION:

Vital signs: Temperature :___(☐C or ☐F, how taken: oral, axillary, rectal, tympanic)
BP:___(use appropriate size cuff according to age/size of child)
Is BP normal, high normal, or hypertensive (for age, sex, height or weight of child or adolescent)
Pulse:___(count for 1 minute); is this normal for the age of the child?
Respiratory rate:___ (count for 1 minute); is this normal for the age of the child?

Note: Growth parameters should be plotted on age/sex appropriate growth chart and placed on EVERY patient's chart. Also, attach a copy of completed growth chart to your write-up that is turned in to your attending.
Weight: ____ (kg) , percentile for age _____
Height/length: ____(cm), percentile for age _____
(length is lying measurement-usually <2 years old, height is standing measurement)
BMI: _____, percentile for age _____
Head circumference: _____ (cm), percentile for age (mainly on infants)

General appearance: State of health and nutrition (ex. well-developed, well-nourished infant in no acute distress; malnourished child in moderate distress due to pain)

1. Skin: note color, skin turgor, presence of lesions, or rashes. Describe any rashes (ex. generalized, erythematous maculopapular rash with few discrete 2-3 mm papules noted over chest and back)

2. Head: fontanelles in infants (soft/flat versus firm/bulging), shape (normal, microcephalic, macrocephalic, dolicocephalic (flattened on sides), hydrocephalic. Note if cranial sutures are closed, any scalp lesions, seborrhea, hair loss.

   Eyes: red reflex bilaterally, pupil size, pupils equal and reactive to light, extraocular movements, conjunctivae clear, red, or icteric. Any strabismus, nystagmus, cataracts, presence of sty, excessive tearing, exudate, eyelid edema or erythema surrounding eye

   Ears: normal shape and placement or low set, appearance of tympanic membranes (describe color, mobility, light reflex, presence of normal landmarks, PE tubes, evidence of middle ear effusion, perforation of ear drum), external ear canal (any edema, erythema, drainage)

   Nose: nares patent, any drainage, nose bleeds, nasal polyps, nasal flaring (sign of respiratory distress)

Mouth: moist or dry mucous membranes, condition of teeth, any mucosal lesions noted, erythema or exudate of posterior pharynx, normal or enlarged tonsils, exudate of tonsils, uvula midline or not, arched palate, palatal petechiae, appearance of gingiva, oral thrush

Throat/neck: cervical adenopathy (note location, size in cm, freely moveable or fixed to underlying tissue, firm or fluctuant, tender or nontender, overlying skin discoloration, increased warmth to touch, pain on palpation, single node or several nodes matted); neck supple or signs of meningismus (positive Kernig's or Brudzinski's sign); check for neck masses, enlarged thyroid gland

3. Thorax: external appearance, pectus excavatum or carinatum, barrel chest

   Lungs: describe what you hear and where you hear it - wheezes (inspiratory vs expiratory or both), rales, rhonchi, crackles, or clear and equal breath sounds; note diminished or absent breath sounds and where located; suprasternal or intercostal retractions (sign of respiratory distress)

   Heart: inspection, palpation for thrills and PMI, percussion, auscultation, assess rate, rhythm, splitting of S_2 with inspiration, murmurs (characterize whether systolic, or diastolic and where it's loudest), gallops, pericardial friction rubs. Check peripheral pulses (radial, brachial, femoral, dorsalis pedis)

   Breasts: Tanner stage (see Figures A & B), symmetrical, skin lesions, nipple discharge, palpate for masses or tenderness, gynecomastia

4. Abdomen: soft or distended, normal or hypo or hyperactive bowel sounds, guarding, rebound or referred tenderness, presence of any masses and location, condition of umbilicus, hepatosplenomegaly (How many centimeters below the right costal margin is the liver if it's enlarged? How many centimeters below the left costal margin is spleen or is only the tip palpable?), presence of umbilical or inguinal hernia (note size in cm; easily reducible or incarcerated?); palpate inguinal area for femoral pulse and for presence of lymphadenopathy.

5. Genitalia: external appearance; note any lesions. In males: note if circumcised or not, foreskin easily retractable or not, hypospadias, palpate for descended testes bilaterally, presence of inguinal hernias. In females: note if erythema of external genitalia, presence of vaginal discharge. In infants: note diaper rash and describe the rash. For adolescent: **note Tanner Stage of puberty.**

6. Anus: appearance of mucosa, note any rectal fissures or tears (Describe location according to face of a clock, i.e. rectal fissure seen at 1 o'clock). If rectal exam indicated, describe sphincter tone, tenderness, presence and character of stool in vault, heme positive or negative on guaiac.

7. Extremities: note any digital clubbing, cyanosis, edema; deformities of limbs, digits, or nails; extra or missing digits; range of motion of all joints; motor strength

8. Neurologic/reflexes: mental status, cranial nerves, test deep tendon reflexes, presence or absence of primitive reflexes in infants **See Table C**, sensation, cerebellar function, etc.

IX. LABS, XRAYS, OTHER DIAGNOSTIC/THERAPEUTIC TESTS

List all of these and explain what the results mean.

X. ASSESSMENT/IMPRESSION:

Include differential diagnosis for each problem. Based on the history, clinical signs and symptoms, lab results and x-ray findings, describe why you are considering or discarding each diagnosis.

XI. PLAN:

List all diagnostic and therapeutic maneuvers specifically related to each problem listed in your assessment. Explain the reason for each.

Ex. For a patient with pneumonia and 10% dehydration:

1. 20 cc/kg NS bolus x 1 for resuscitation fluids and then IV fluid hydration with D_5 ½ NS + 20 meq KCL/L at a rate of 75 cc/hr. to replace the rest of the deficit over 24 hours.
2. IV Rocephin at 250 mg IV q 12 hours empirically pending blood culture results to cover most likely pathogens for pneumonia (ie *Streptococcus pneumoniae*)
3. Supplemental oxygen for pulse ox $\leq$ 94%. Check pulse ox q 6 hours.
4. Repeat CXR in am to assess the progression/regression of the pneumonia.