

Below is a template for writing a complete paediatric patient record. In a consultation, begin with the concerns of the parent(s) and end with the most disliked part of the examination.

Keep focused. Be detailed *when relevant*. There must be a *logical sequence* in your record. **The record is a legal document** that must describe your thinking and action with the precision and completeness necessary in a courtroom.

Present history -> background history -> status praesens -> supplementary investigations -> interpretation/diagnosis -> management

In the history: Use dates or “x many days ago”, not weekdays.

In the status praesens: Describe what you observe, not your interpretation of it!

History:

First, note how you got the information. Who's present? Direct interview? Telephone? Interpreter?

Reason for admission: Why is the patient admitted this time?

Social History:

Age and sex of the patient. Ethnic background, birthplace, language-understanding level of parent(s).

Siblings and home environment (smoking, pets, carpeting).

The child's level of care is important to note, including the number of caretakers, the work situation of the parent(s) including occupation (important to give information at the right level), childcare while parent(s) are at work (child day-care centre, school, after-school program – friends/hobbies?).

Family History:

Disease in the family, parents, siblings or other close relatives. Death of a sibling due to unknown cause.

Past Medical History / Hospital Admissions:

Pregnancy, birth and neonatal period, including birthweight and gestation. **Growth. Percentiles.**

Nutritional state (length of breastfeeding). Health centre check-ups and immunization status (reasons if not vaccinated). Progression of key developmental milestones (time of rolling over, sitting, walking, talking in sentences). These elements must be noted in detail when deviation from the norm or a neurological disorder is suspected.

Previous illness, hospital admissions, health problems in childhood, exposure to risk of infection, allergies and non-tolerable foods.

Present situation:

Reason for consultation. Initiation of symptoms (gradual or sudden start). Description of symptoms, specific symptoms (cough, laboured breathing, vomiting, diarrhoea, pain, etc).

It is important to obtain detailed and specific information and to note the order with which the symptoms presented themselves. Describe the chronicity of each symptom independently.

Be open and listen to the parent(s)! It is very important to note the concerns of the parent(s).

Vegetative functions: (do not write “normal”)

Urination – describe if possible (number of wet diapers etc), colour if appropriate

Defecation – describe frequency, consistency/colour (Bristol Stool scale)

Appetite – describe

Sleep – describe

Medications:

Any use of medications, including dosage.

Allergy:

Obligatory when assessing e.g. obstructive airways disease

Include any adverse reactions to medications.

Status praesens; date and time:

*Describe what you observe, **not** your interpretation of it!*

X-month/year-old boy/girl. Generally good health/ill-health. Well/thin/emaciated.
Hollow eyes, sunken fontanelle, reduced turgor?
Degree of contact. Movement. Cooperation during the examination.
Oedema (seldom seen in children). Rash. Cyanosis. Jaundice. Petechiae.
Nuchal and back rigidity. Enlarged lymph nodes – **where have you checked?**
Respiratory distress? (tachypnoea, laboured breathing/ease of respiration, chest wall recession, use of accessory muscles of respiration, nasal flaring). Respiratory stable? Circulatory stable – cold/warm dry/extremities?

Height (**percentile**) Weight (**percentile**) Head circumference (**percentile, children younger than 2 years old**). If weight & height/length have not been done – you will have to do it! Excellent learning opportunity. Look up the percentiles for growth, pulse, RF and BP for age, ex: height 99 cm (50-75 centile). Weight 22 kg (2 kg above the 97th centile)
Pulse (**high, low, normal for the age**) ex: Pulse/HR: 100 bpm (80-120) – normal for age
Respiratory frequency (RF: XX/min (**high, low, normal for the age**))
Blood pressure (**high, low, normal for the age**)
Temperature
Capillary refill time in seconds (**central/peripheral, high, low**)

Caput:

Separation of the sutures. Shape, symmetry.

ENT:

Examination of the ears with an otoscope and examination of the throat should be made at the end of the consultation, but noted in the “anatomical order” in the patient record.

Neck:

Slightly enlarged glands are not uncommon. Describe enlarged glands (where, size, soft/hard, tender...)

Thorax:

Inspection of the chest: Anatomical variation (pectus excavatum et carinatum), status after major surgery

Cor:

Inspection (voissure)
Palpation (ventricular heave, displaced ictus, thrill)
Auscultation (heart sounds, systolic/diastolic murmurs)
Percussion (rarely helpful in children).

Pulm:

Auscultation (abnormal breath sounds: Stridor, crackles, wheeze, decreased breath sounds, expiratory grunting). Prolonged expiration?
Assisted, forced respiration
Percussion (comparing sides)

Abdomen:

Inspection, auscultation, palpation and percussion. Palpation should be done tenderly.

Femoral pulses.

Genitalia:

Scrotum – often appropriate if abdominal pain

If the child has a diaper – always open and check genitalia (normal feminine/masculine?) + look for diaper rash etc.

Rectal examination:

Not part of the routine examination. When performed, the little finger should be used with young children.

Reflexes:

Checking for primitive reflexes during the first months. These reflexes gradually disappear after three months of age, and should be absent after 6 months, with the exception of the plantar grasping reflex, which is gone by the 9th month. Deep tendon reflexes can be examined from the 6th month.

Neurological screening:

A brief neurological overview should be performed in all children (contact, muscle tone and patterns of movement), while a more detailed neurological examination is only done when indicated.

Supplementary investigations:

List investigations performed or planned with date/time relevance to the present complaint

Imaging (x-ray, ultrasound, CT, MRI, scintigraphy ex. ++)

Blood chemistry

EEG, ECG, urinary test, fecal sampling, nasopharynx aspirate ++

Include all results as possible! If results will not be available until after 1-2 days or later, you can write this, otherwise, all results must be listed. If not possible – comment your reasons for not doing it.

Summary and interpretation (including tentative diagnosis):

Patient record ends with a short summary of the patient history and examination findings. This should **not include new information**, but rather the **essential** points of the patient history and examination.

An interpretation of the symptoms and findings, leading to a conclusion with a *tentative diagnosis* should be clearly separated from the history and status. Are vital signs (pulse, RR, BP...) normal for age?

Management plan:

Hospitalization? Treatment initiated? No actions necessary?

At note!

Some of the learning this semester is for you to become confident examining children and skilled at history taking. Both history taking and examination differs between children and adult patients. You must have done it all to write a medical record.

It could be that parents will ask you not to perform an examination such as looking in the mouth or the ears, if a GP/emergency room and a doctor at Barnemottaket has already done it. That is ok, but generally, you should do most of it yourself.

The nurses have not always done all the readings, such as blood pressure, weight/height if they do not see the necessity in just this case. You should at least get vitals (RF, pulse, saturation and temperature) and weight, length and head circumference if the child is less than two years. If done, it can easily be seen on a PEVS – form, which you can bring into the room or copy before entering. **If the values divide from the norm you must comment; for instance caused by unrest, crying etc.**