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History taking in paediatrics

-and how does it differ from adults?

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Patient record

- The patient record is a legal document!
- Present history -> background history -> status presens -> supplementary investigations -> summary -> interpretation (including diagnosis) -> management
  - Complete logical sequence
- In the status presens: *Describe what you observe, not your interpretation of it!*
- Be detailed *when relevant*

Listening to mothers/ parents

- The most important attribute of any good doctor is to be a good listner!
- Mother and/or the father has right until proved otherwise
  - Mothers are, by and large, excellent observers of their offspring
  - They make good interpreters of the problems their children have when they are ill

Aims in history taking

How can it helps you to:

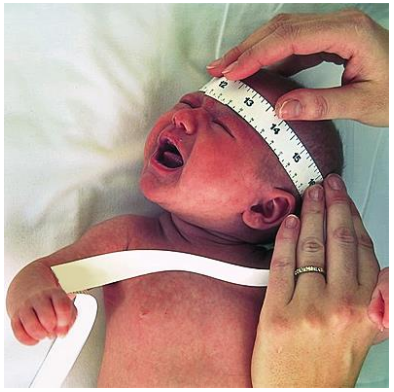
- Reaching a correct diagnosis
- Establish a good relationship with the child and the family
- Get an overview of previous and current health status - identify problems that are not immediately apparent

Before entering the room

- Prepare if possible:
  - Read medical notes/ referral letter
  - Learn and remember the name
  - What is the child's age
    - Make up Your mine about the developmental stage of the child

Approach: Depends on the age of the child

Neonate < 4 weeks



Toddler 1-2 years

Adolescents

Developomental approach to assessment - 1

- **Preterm Infants and Newborns**
  - Initialy swaddled in the parent`s arms or on the examining table to maintain body temprature
- **Infants up to 6 months of age**
  - Most effectively assessed on the examination table
    - Support the infant`s head during the pysical exam
- **Children from 6 months to 2 years of age**
  - From 7 – 9 months of age, a progressive approach to stranger anxiety happens
  - Once the infant is able to sit stably, the examination can proceed in the partens lap to decrease fear and starnger anxiety

Cont. developomental approach to assessment - 2

- **Young Children, 3 – 6 y**
  1. By 3 years of age they are able to make eye contact and they can be separated from the parents
  2. If the child is confident it should be examined sitting at the examination table
     1. Young children enjoy play, drawing and role - playing the physical examination with puppets or stuffed animals

- **Children 6 – 12 y**
  1. They benefit most from talk-through approach to the physical exam
  2. They are interested in learning about their bodies

Cont. developomental approach to assessment - 3

- **Adolescents**
  1. The approach should be based on the developmental stage rather than the age
  2. Respect and confidentiality are essential components
  3. Adolescents should be interviewed and examined separately from the parent or peers

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Observation of parent-child

Quality of relationship

Parental guilt

Nonverbal communication

Family dynamics

The child`s presenting problem may not always be the biggest problem – and sometimes the child is not the real patient

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Observation of parent-child

Or: the presenting problem of the child
is minor as compared to the parents concern
Try to disclose why!

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Approach

- Greet the child first
  - By name
  - Appreciation of the child`s individuality

- Always be seated during the consultation
- Make sure you use phrasings that parents and the child understand
  - Avoid medical terms
  - Confirm mutual understanding of words with parents

Occupy the child

- Children easily get bored during history taking
- Have toys available; may give valuable insight into
  - Awareness
  - Developmental skills
  - Behavior
- Sometimes: Split consultation into two sessions

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Outline- paediatric history

1. Current problem
   - History of current illness
   - Past medical history
2. Pregnancy and birth history
3. Family and social history
4. Developmental history
   - Immunization record
5. Natural functions
6. Allergy
7. Medications

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1. History taking

- Presenting problem
  - ”What brought You to the hospital?”
- Difficult – but let the parents/child complete their opening statement without interrupting!
  - Include the child if appropriate
- Establish sequence and evolution of symptoms
- Use open questions

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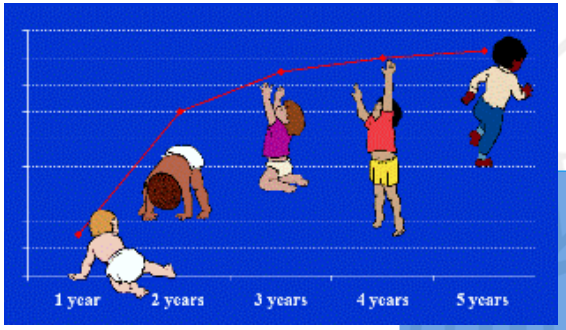
2. Pregnancy and birth history

- Maternal illness or problems during pregnancy
- Mode and difficulties during delivery
- Gestational age
- Birthweight
- Length
- Head circumference
- Neonatal periode
  - Feeding history if appropriate

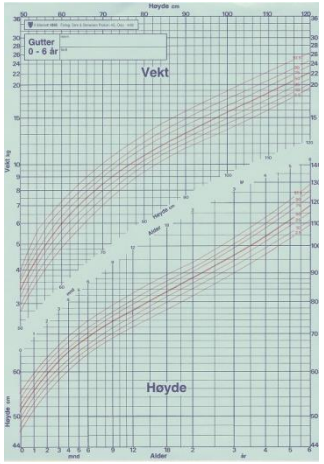
3. Family history-social

- Family structure/occupations:
  - Hole family?
  - Married, samboere, divorced, only a mother/father
  - Siblings, which number in the order
- Day care
  - Kindergarten, school?
- Are there any diseases in the family?
  - Consanguinity

4. History of development - appropriate for age?



- Major milestones
  - Compared to siblings and friends
  - Older children school performance, behavior
- Growth
  - Infants: proper weight gain?
  - Head circumference
  - Older children: length/weight assessment
- Immunization
  - Followed the Norwegian vaccination program?
    - If not, why not?



5. ”Vegetative functions”

- Appetite
  - Weight loss or gain?
- Urination
  - Number and wetness of diapers
- Defecation
  - Pattern of feeding, bowel movements
  - Normal stool items, frequency, consistency, nocturnal, striving to get it out, etc.
  - Describe it if is illness
- Sleeping cycle, alertness and activity