

PEDIATRIC HISTORY AND PHYSICAL EXAM TEMPLATE*

IDENTIFYING DATA

Patient's, Parent's or Guardian's Initials: (do NOT use patient's name - this is potentially a HIPAA violation)

Informant:

Primary Care Physician:

Referring Physician (if not Primary Care Physician):

CLINICAL HISTORY

Chief Complaint: Including the patient's name, age, ethnic origin, sex, and reason for admission.

Present Illness: Elicit the facts of the illness, particularly the time and nature of the onset. Arrange these facts in a chronological order and relate them in a narrative fashion, tracing the course of events up to the time of the visit. What was done for the child; what drugs were given and what were the results of such treatment? Pay special attention to recording "pertinent negative" data as well as positive information. This includes physical exams, laboratory evaluations and treatments which occurred before the present admission. How has the illness affected the patient's lifestyle? The HPI should conclude with a description of the visit to clinic or emergency department which resulted in the present admission.

Past History:

Prenatal/Perinatal: Duration of pregnancy, maternal illness prior or during pregnancy, maternal conditions during pregnancy. Details of labor and delivery. Condition of infant at birth. APGAR scores (if available). Gestational age. Drugs taken during pregnancy.

Birth and Neonatal Period: Condition and vigor of infant at birth. Birth weight, postnatal problems such as neonatal cyanosis, jaundice, convulsions, skin eruptions, initial feedings, etc.

Feeding History: Initial feeding, breast or bottle, what kind of feedings. Tolerance for feeds. Weaning. Addition of solid foods. Current dietary intake, balance, and child's attitude toward eating. Vitamin supplements. Usually discussed in detail when patient less than 2-3 years old.

Growth and Development: Birth weight, length and head circumference. History of dentition. When did anterior fontanelle close. Weight at different ages (if known to informant.) Developmental landmarks: First smile, held head erect, rolled over, recognized people, sat alone, stood with support, stood alone, crawled, walked, used

* N.B. Not all of the information listed below will need to be obtained on every patient. Your assessment should serve as a guide to determine which pieces of information are pertinent and should be included.

words and sentences. If the child is greater than 4-5 years, a global statement such as “the developmental history is normal” is acceptable.

Past Illnesses/Review of Systems:

Infectious disease (measles, rubella, mumps, chicken pox, pertussis diphtheria, poliomyelitis, scarlet fever), details of onset, severity and complications or residuals.

Respiratory system: Functional status. Details of otitis media, tonsillitis, repeated URI's, allergy, bronchitis, pneumonia, cervical adenitis, chronic cough, croup, mouth breathing, persistent fevers, sleeping patterns.

Gastrointestinal system: History of early feeding difficulties, diarrhea, constipation, stool abnormalities, vomiting in relation to infections and emotional difficulties.

Cardiovascular system: Inquire about cyanosis, dyspnea, excessive sweating in infancy, fatigability, syncope, joint pains and epistaxis.

Genitourinary system: Significant items are infections of urinary tract, hematuria, dysuria, frequency, urgency, dribbling, enuresis, edema oliguria. Repeated bouts of unexplained fever.

Nervous system: Inquire about convulsions (get details if they have occurred), tics, habit spasms, emotional lability, tremors and incoordination.

Psychological: Inquire (appropriate to age) for restlessness, tantrums, night terrors, tics. How does child get along with his associate at play, in nursery school, in school. Some indication of the parent's attitude toward the child can be obtained from these and other questions.

Surgical History: Dates, nature of and complications from any operations.

Accidents/Injuries: Date, nature of and complications of any injuries. Mention only if relevant to the present illness or serious in nature.

Immunizations: tabulate dates of all immunizations and tests for immunity. This may be summarized as: “immunizations are up-to-date.”

Current Medications: Name, dosage form, dose, frequency, and how long patient has taken it if germane to presenting problem.

Family History: Age, physical condition and state of health of each parent and sibling. List mother's pregnancies in chronological order, giving details and outcome of each. If siblings have died, give the nature of the condition leading to the death and the results of postmortem or other examinations.

Recent acute illnesses in the family need to be described. Chronic illnesses among members of the family need to be noted. If the CC and PI suggest the possibility of a heritable condition, explore the family for the pattern of similar conditions within the immediate family and forbears. Check for parental consanguinity. Mention only if clearly relevant to the current admitting problem.

Social History: Explore the living conditions for the family to obtain a knowledge of the environment in which the patient lives in order to appreciate the chance for exposure to specific infections, poisons and toxic substance, as well as to appreciate pertinent psychological and emotional factors which might be involved in the present illness.

PHYSICAL EXAMINATION

General information: for example: “in general the patient was a health appearing, chubby infant no acute distress.”

Vital signs:

Weight and Height: Record for this patient and give percentiles from comparison against normal range for age.

Head Circumference: Record for this patient and give percentiles from comparison against normal range for age. Mention in any child less than 2-3 years old.

Temperature (when taken)

Pulse rate

Respiratory Rate

Blood Pressure (what extremity and in what position: sitting, supine, etc.)

SpO₂ (when applicable)

General Inspection: Habitus, Choice of posture. Type and amount of spontaneous movement. Restless, irritable, calm, apprehensive, drowsy, apathetic, stuporous, comatose. Signs of pain. Nature and quality of breathing. Color of skin and lips (Cyanotic, pale, flushed) Nature of cry (short catchy cry of pneumonia, hoarse cry of laryngitis, sharp painful cry of acute inflammatory process of fracture when body or bed is touched.)

Head: Sutures and fontanel; open or closed. Craniotables. Scalp (lesions, edema, hair distribution, parasites). Shape normal or abnormal.

Eyes: Condition of conjunctivae and lids. Ptosis, strabismus, other paralysis. Pupillary reactions and asymmetry. Corneal ulcers or opacities. Scleral appearance (jaundice, blue, inflamed). Gross visual acuity in older children.

Ears: Examine external canals for lesions and infection, tympanic membrane for inflammation, bulging, retraction, perforation, serous fluid behind drum, mobility.

Nose: Appearance of mucous membranes and presence of foreign bodies, purulent or serous drainage, blood-tinged drainage. Nasal flaring.

Mouth: Appearance of mucous membranes of lips, gums and buccal areas. Number of teeth, presence of caries. Look for enanthemata. Condition of tonsils, soft and

hard palate, posterior oropharynx. Presence of exudates, membranes, petechiae or vesicular or ulcerous lesions.

Neck: Mobility, head tilt, limitation of motion, nuchal spasm or rigidity. Position of trachea. Presence of masses or swellings.

Chest: Shape and symmetry in relation to patient's age. Symmetry of movements with respiration. Supersternal, infrasternal or intercostals retractions.

Lungs: Quality of breathing, breath sounds, voice sounds should be described. Variations of symmetry of transmission or quality of these sounds should be described. Presence of adventitious sounds such as crackles, wheezes or rubs.

Heart: Description of rate, rhythm, quality of heart sounds, location of PMI, presence and location of murmurs, description of murmurs (intensity, quality, transmission) sometimes the heart is examined first in apprehensive infants.

Abdomen: Symmetry. Status of umbilicus. Presence or absence of palpable organs or masses. Tenderness. Distention. Presence of signs of ascites. Percussion note. Quality of bowel sounds.

Genitalia:

Males: phimosis, paraphimosis, meatal stenosis, hypospadias descent of testes, inguinal hernia, hydrocele.

Females: Perforate hymen, normal location of urethra, vaginal discharge (nature and quantity).

Presence of any dermatitis. Position, tone and appearance of anus.

Trunk and Spine: Symmetry, presence of spinal curvature (describe)

Extremities: Look for clubbing, cyanosis, venous engorgement, nail abnormalities, lesions of skin, palms and soles, edema, hemorrhage, and contusion. Check for asymmetry or deformities. Check for presence and strength of central and peripheral pulses. Check for capillary refill.

Skin: Rashes, turgor, edema, erythema, cyanosis, pallor

Superficial Lymph Nodes: Cervical, axillary, inguinal, and epitrochlear. Size, consistency, tenderness (measure with tape).

Neurological: Status of cranial nerves. Check DTR's, clonus, Babinski response, abdominal and cremasteric reflexes. Check for touch and pain sensation. Mental status (orientation). Cranial nerves II thru XII. Motor. Sensory (pain, light touch). Reflexes. Coordination and gait. Infants: the primitive reflexes, including Moro. Tonic neck, Parachute, etc.

ASSESSMENT

List pertinent diagnoses or problems in order of importance beginning with problem that most directly resulted in the patient's admission. Include the appropriate ICD-9 code for each. For each problem, list your differential diagnoses beginning with most likely one.

Example:

1) Wheezing (786.07) Differential diagnosis: asthma, bronchiolitis, cystic fibrosis, or gastroesophageal reflux disease

2) Allergic rhinitis (477.5)

OR

1) Status asthmaticus (493.9)

2) Acute respiratory failure (518.81)

3) Influenza virus infections (??)

PLAN

List your treatment plan as you would if you were writing orders to admit this patient.

DISCUSSION

Give a brief one-paragraph rationale for your differential diagnosis and selection of most likely diagnosis. List pertinent clinical questions that remain regarding diagnosis and plan for treatment.

Diagnostic Studies are traditionally mentioned after the physical exam, however, some attendings may prefer a discussion of the assessment and plan prior to mentioning lab results. Remember that if lab results are obtained prior to patient's arrival at the current hospital, they are appropriately mentioned in the HPI.