Paediatric history taking: few important points

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INTRODUCTION

National children policy of Bangladesh and Child Act-2010, as well as the United Nations convention on the rights of the child, define a child as any person under 18 years of age.

Child is not a mini adult. Its body physiology, homeostasis, immune response, illness or disease pattern, its basic and nutritional needs etc. are different from that of adults. It grows up passing through different ages of life. History taking is really an art. In children, it depends on variety of factors e.g. child may be well, distressed or ill and the parents may be extremely anxious. A competent Paediatrician should be able to relieve the anxieties of parents. Most paediatric histories are taken in general practice in a chamber or in out-patient department of a hospital or in the emergency room. Such histories are brief and focused in necessity. Detailed histories are considered to be taken, if required or after admission in the inpatient department by the attending doctor; Paediatrician must be careful about the privacy, dignity and confidentiality of the patient.

Learning objectives

- To understand the content differences in a Paediatric history taking in comparison to an adult.
- To understand how the age of the child has an impact on obtaining an appropriate medical history.
- To understand all the complaints illustrated by the parent as historian.
- To understand appropriate wording for open ended or direct question.
- To develop awareness about the appropriate settings to obtain a complete medical history compared to a more limited focused history.

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Components of paediatric history

Varies in different age group e.g. <1 year, 1-5 years, >5 years and adolescent

Content differences are

a) Pre-natal, natal, post-natal history
b) Developmental history
c) Immunization history
d) Social history of family
e) Environmental risks

Parent as historian

a) Parents interpreting symptoms and signs. Some children above 4 years age are able to say some of their own complaints.
b) Reliability of parents' observation and wording varies e.g, ask when symptom like pain abdomen was noticed instead of asking when pain abdomen was started.
c) Observation of parent child interaction.
d) Quality of relationship e.g. parents attitude towards his/her child

History taking

Remember that the manner, physical position, body language of the consulting paediatrician will contribute the outcome of the consultation. Be relaxed and smile to the patient, greet the parents as well as the patient, which will provide confidence to the baby to cooperate. Listen to the parent or patient carefully, when they describe their complaints, avoiding writing or noting at that time. Open questions are encouraged, avoid leading question unless it is very much required. Acutely ill children pose a challenge for a busy paediatrician. Illness can span the spectrum from simple viral infection to life threatening emergencies. The initial approach must focus on the general evaluation and stabilization of the acutely ill infant and child. The attending Paediatrician has to distinguish between patients who can be managed with close follow-up and those that need to

be transported to a high level care. Children of all ages can present with similar symptoms but the etiology of the illness can be age dependent.

A thorough history is paramount to arrive to a correct diagnosis. History should be opened with patients name, age, sex, ethnic origin and the chief complaints. Children may not be able to completely define or localize their symptoms. On the basis of chief complaints, the paediatrician must ask question that help to distinguish between common and potentially life threatening entities.

History of present illness

Reason for visiting paediatrician – which should include all positive historical findings, as well as, pertinent negatives. Begin the present illness with the statement that "the patient was in good health until" or if the patient has a "chronic illness". Remember that physical examination, laboratory evaluation, assessment and treatment, which occurred before the present illness are a part of the present history, specially, for chronic illness. It is useful to know description of each symptom which includes:

- When the symptom first occurred
- Type of onset (sudden or gradual)
- Frequency of occurrence (daily, weekly, monthly)
- Precipitating factors like emotional stress, exercise etc.
- Associated symptoms like nausea, vomiting, headache
- For pain: location, radiation and severity

Present illness should include family's life style, school environment, school performance; current medication should always be mentioned including indication and dosage. In the paediatric present history, general items to be asked about feeding and fluids, sleep, bowel and bladder function, vision and hearing (age appropriate). Enquire about child's diet; detail nutrition history is important in some cases.

Past history

Past history of infant and child differ from adult past history. Exactly how much past history to include is a matter of judgement and no firm guidance can be set. This may include pre-natal, natal and post-natal, past-medical and surgical history, as required or relevant. Feeding history to be taken when patient is under 2 to 3 years of age or has a history of feeding problem. Ask about weaning age or any problem to introduce solid food, specially in case of failure to thrive patients. History of food allergy is to be taken.

Growth and development

If relevant to the patient, if there is any question of developmental problem, a more complete developmental history must be taken (Denver developmental screening test as a guide).

Immunization history

Immunization history is important and to be mentioned.

Previous illness, accident, hospitalization should be mentioned, if relevant to the present illness or if they were of serious nature.

Many Paediatrician prefer that all information from the past history might be relevant to the present problem, can be discussed as that part of the present illness, but one should avoid too much description of the past history under the present illness.

Family and social history

Family history should be described if clearly relevant to the present illness. History of consanguinity is important in relation to disease pattern. It is important to include a brief social history including members of the household, occupation, education, significant family stress and any problem of the child relating to his/her family, peers and school. A detailed discussion will be required only if relevant.

Physical examination

There is no real demarcation between history and examination. It is said that mostly diagnosis are made on history, 5 to 10% on physical examination and the remainder on investigation.

Observation as a part of physical examination is important in the evaluation of a child. Considerable information can be gained by observing the child before starting with the actual examination which can provide valuable clues in arriving at diagnosis – e.g. appearance, status of hydration, respiration, chest indrawing etc.

To get co-operation, patient should be kept on parents lap or close to the parents. Older child may be seated on the examination table. Approach the patient with a friendly attitude and with simple conversation to make him/her relaxed and calm. In paediatric physical examination, it is less likely to complete a "head to toe" examination. Order of examination should be from least

distressing to most distressing part. The best general rule in paediatric physical examination is flexible. Heart and lungs can be auscaltated when he child is in most comfortable position and calm. Always one should start physical examination with appearance of the child such as baby is thin, chubby, happy etc. depending on age of the child.

Next, vital signs should be recorded including OFC, height and weight and those are of age related. The components of physical examination those are more bothersome to the child to be completed last; like examination of ears, throat and oral cavity. Examination of eye is a routine part of the paediatric assessment beginning in the newborn period. Newborn and children should be examined by an ophthalmologist whenever significant ocular abnormality or vision defect is noted or suspected. Pre-school vision screening is a mean of reducing preventable vision loss.

For systemic examination there should be protocol for each system and attending doctor should have competence in examination of all systems. The complaint related to the system by the patient or attendant should be examined thoroughly and then the related system, if pertinent.

Some special examination like Tanner staging in adolescents, rectal and pelvic examinations are not done routinely, unless there are special indications.

Conclusion

During writing history, do not use those abbreviations which are not readily recognized by the doctors. Be careful while talking about prognosis or breaking any bad news. Do not ask any question that can hurt the child or the parents. At the end of the history taking discuss with the parents or summarize the problem and try to answer his/her query.

FURTHER READINGS

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