Pediatric history 

Patient profile

Name _____ Age _____ Female/male _____ lives in ___ ____
The patient was admitted via _____ on (day) _____ at (time) _____.
History was taken from the _____ by _____ a 5th/6th year medical student on (day) _____ at (time) _____.

Chief complaint

The patient is complaining from _____ for _____ duration.

History of presenting illness

Try to clarify as much as you can :)

The patient was doing well/reltively doing well until she/he started to complain from:

- Site.
- Onset.
- Character & pattern (constant or progressive).
- Radiation.
- Timing (continuous or intermittent).
- Exacerbating / relieving factors.
- Severity (affect the sleep, feeding & activity).

Constitutional symptoms

☐ Fever:
- Documented or not & Amplitude: _____
- Rout (oral, rectal, axillary):_____
- Pattern (continuous or intermittent): _____
- Number of spikes (frequency):_____
- Duration of attack: _____
- Triggers/Special times: _____
- Relieving factors (antipyretics, cold compressors): _____

☐ Chills, rigor, night sweats: _____
☐ Convulsions: _____
☐ Sick contact: _____

- [ ] Recent weight changes: _____
- [ ] Feeding (baseline & any changes) & Appetite: _____
- [ ] Activity (lethargy, excessive sleep, social interaction): _____
- [ ] Excessive crying, irritability (infants): _____

Notes

Review of systems

Head

- Injuries, headache, hair loss, signs of scalp infections (redness, itching, scaling)

Eyes

- Vision problems, use of glasses, history of discharge, abnormal tearing, eye injuries.

Ears

- Hearing problems, history of otitis, ear pain, ear discharge.

Oral cavity & throat

- Sore throat, dental problems, bleeding gum, oral ulcers.

Nose & respiratory system

- Runny nose, nasal bleeding.
- Cough (dry or wet, day or night, contionous or intermittent, triggers, relieving factors) & hemoptysis.

- Rapid breathing, difficult breathing, noisy breathing (stridor, wheeze, grunting, snoring), laboured breathing.
- History of recent URTI.

Cardiac system

- Chest pain, palpitation, history of murmurs, tachypnea, orthopnea.
- Exercise tolerance (fatigue after feeding [sucking] or activity).
- Excessive sweating after feeding [sucking] or activity.
- Cyanosis, pallor, cold extremities & edema (in the face or extremities).
- History of rheumatic fever in patient & family.

Gastrointestinal system

- Abdominal pain, abdominal distention, dysphagia, odynophagia.
- Diarrhea, constipation, stool color, stool consistency, blood in stool.
- Nausea, vomiting, hematemesis.
- Jaundice.

Genitourinary system

- Urination baseline (number of wet diapers per day).
- Urine color & smell.
- Frequency, polyuria, oliguria, incontinence, bed wetting, poor urine stream, hematuria, foamy urine, dysuria.
- Flank pain & periorbital swelling.
- History of UTI.
- Urethral or vaginal discharge.
- Age of menarche.

Extremities

- Joint or muscle pain, swelling, muscle strength, any limitation of movement.

Neurologic system

- Seizures, abnormal movements, tremor, weakness.
- Headache, altered consciousness, dizziness, syncope.

Skin

- Rashes & bruising.

Past medical & surgical history

- Previous history of similar complaint: _____
- Medical illnesses: _____
- Surgical history: _____
- History of trauma: _____
- Previous hospitalizations & ER visits: _____
- Medications (bame, dose, frequency, rout, how long): _____

  _____
- Vaccinations (type & date): _____
- Allergy (if so, clarify their reaction): _____
- Blood transfusions: _____

Antenatal history

- Mother age: _____
- Number of pregnancies: _____
- Any abortions: _____
- Maternal diseases: _____
- Maternal health during pregnancy:

1. Complications during the pregnancy (HTN, DM, bleeding, trauma, recurrent UTI, fever, anemia): _____
2. Drug use: _____
3. Smoking and alcohol:_____
4. Diet: _____
5. Vitamin deficiencies: _____
6. Radiation exposure: _____
7. Abnormal antenatal scans and screening tests: _____

Birth & neonatal history

In some cases you need to put this part & feeding in the HPI especially in infants

- Gestational age at delivery: _____
- Mode of delivery (vaginal or cesarean): _____
- Duration of labor: _____
- Interventions (induction of labor, anesthesia, forceps, vacuum): _____
- Birth weight: _____
- Head circumference & length (if known): _____
- APGAR score (if known): _____
- Health concerns at birth (respiratory distress, oxygen therapy, jaundice, anemia, birth injuries, feeding concerns, congenital anomalies): _____
- Length of stay: _____
- Admission to NICU (Why? & length of stay):_____

Feeding or nutritional history

Infant (0-1 year)

- Breast fed or bottle-fed? _____
- Formula or breast milk (type of formula, frequency, duration, amount, reasons for any changes in the formula): _____
- Problems related to feeding (vomiting, regurgitation, baby colic, diarrhea):

Children (2–12 years)

- Age at weaning and introduction of soild foods
- Supplementation with vitamins or fluoride.
- Ask the parents to describe what the child typically eats for breakfast, lunch, snacks, and dinner to assess whether the child is receiving adequate nutrition.

Adolescents (13-17 years)

- Ask the patient to describe what they traditionally eat for breakfast, lunch, snacks, and dinner to assess whether the individual is receiving adequate nutrition.

- Eating disorders.

Developmental history

- Developmental milestones.
- The mnemonic **SHADSS** can help structure the interview with a **school-age children**:
  - **S**chool: Grades.
  - **H**ome: Relationship with family.
  - **A**ctivities: Friends & hobbies.
  - **D**epression: Emotions, confidants, thoughts & acts.
  - **S**ubstance abuse: Exposure or use of drugs, tobacco & alcohol.
  - **S**afety: Violence (at home or school) and access to weapons :(

Family history

- Age of parents and siblings: _____
- Family history of illnesses: _____
- Deaths in family: _____
- Family member with similar complaint: _____

Social history

- Who lives with the child? _____
- Parent's employment _____
- Insurance _____
- Pets _____
- Smoking status of anyone living with the child _____

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