History Taking 3rd year Lecture

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Objectives

- To understand that the parent / guardian is the historian
- Build a rapport with parent/guardian as well as older children
- To understand the appropriateness of open ended questions
- Content differences between paediatric and adult histories

Parent as a historian

- Depend on parent to interpret symptoms of the child
- Look through referral letters and health passport books
- Observe child and parent / guardian interactions

Rapport

- Importance

  Allows you to gain trust of the parent/guardian as well as the older child

- To build a rapport
  - Always introduce yourself
  - Avoid an interrogation
  - Look interested and smile
  - Maintain eye contact with the child & guardian
  - Avoid scribbling in notes while you or the parent is talking

Open Ended Questions

- Do not lead the guardian on
- It allows you to keep your differentials open

- Example:

"When did you notice that Mary was limping?"

Instead of , " When did Mary's hip begin to hurt?"

"When did Grace start convulsing?" instead of "When did Grace develop meningitis?"

Content differences between paediatric and adult histories

- Prenatal and birth histories
- Developmental history
- Social history of the family – environmental risks
- Immunization history

Outline of paediatric history

- Background information
- Presenting Complaint
- History of presenting Complaint
- Review of systems
- Past medical history
- Pregnancy and birth history
- Developmental history
- Family history
- Social history

Background information

- Patient's name
- Date of birth
- Age
- Sex
- HIV status
- Source of history (relationship of child & informant very important)
- Referral source (include reason for referral & working diagnosis)

Presenting Complaint (s)

- Main reason (s) for coming to hospital e.g

  vomiting, cough, diarrhea

- Duration of symptoms e.g. cough 1/52, vomiting 3/7

  Be systematic, start with the earliest symptoms, it helps in organizing your history of presenting complaint.

- In cases of long histories, still ask the reason for seeking health care services at that time

History of presenting complaint (s)

- Tell a story
- Include details of the presenting complaints in chronological order. E.g. the child was well until 2 wks prior to admission …… (explaining how it started)
- Use patient or guardian's own words (no medical terms) e.g. "mum noted that the child was pale" instead of "mum noted that the child was anaemic"
- Include progression of symptoms, aggravating and relieving factors

History of presenting complaint (s)

- Associated symptoms, relevant positives and negatives (relevant systemic review)
- Medical attention sought, medications given, over what period and their curative effects
- Patient’s general state during the illness, e.g. appetite, school performance, sleep

Systemic Review

- Get information about complaints from systems not represented in the history of the presenting complaints
- Serves as a checklist for pertinent information that might have been omitted
- Do not do a systemic review of a system that has already been discussed in the history of presenting complaint

Systemic Review

- Neuro
  - Headaches , Visual disturbances , Speech
  - Fits, faints , dizziness , floppiness
  - Abnormal posture, gait
  - Involuntary movements , numbness
  - Changes in mood, activity or behaviour

- Respiratory
  - Discharge from nose, ear, eyes
  - Sore throat , hoarseness
  - Cough , coughing blood (haemoptysis) , whistling sound when breathing (Wheeze) , Snoring
  - Breathlessness (Dyspnea)

Systemic Review

- Cardiovascular
  - Breathlessness , Exercise intolerance , Tiredness and lethargy
  - feeding difficulties – associated breathlessness / sweating
  - Pallor and cyanosis – intermittent (blue episodes)/persistent, associated with crying or straining
  - Dizzy spells or fainting (may be confused with fits)
  - Chest pains or palpitations
  - Oedema

- Gastrointestinal
  - Appetite and feed tolerance , difficulties in swallowing ,Thirst
  - Nausea , Vomiting (amount , colour , blood / bile- stained

Systemic Review

- Genitourinary
  - Incontinence or bedwetting
  - Increased urinary frequency
  - Painful urination (Dysuria) , blood in urine (haematuria)
  - Change in character of urinary stream or appearance of urine
  - Urethral / vaginal discharge
  - Menstrual history
  - Sexually- active
  - Sexual abuse

Systemic Review

- Musculoskeletal
  - Trauma , Joint swelling , Painful limbs
  - Weakness , Deformities
  - Difficulty in walking / moving extremities
  - Muscle pains or cramps
  - Weight loss

- Skin
  - Rashes , itching ,
  - colour change & distribution , hair & nail growth
  - bruises or bleeds easily
  - Night sweats

Past medical history

- All previous hospital admissions with dates, diagnoses and prognoses
- Major surgical illnesses
- HIV status , blood transfusions
- Chronic illnesses eg TB .
- Drugs and allergies

Pregnancy and Birth history

- Mother's health during pregnancy – HIV status, PMTCT, any other drugs , vaccinations
- Gestational age at birth
- Labour and delivery – length of labour, place and mode of delivery, presentation
- Neonatal period- birth weight, whether child cried soon after birth , admissions to nursery (reasons)
- If neonatal , genetic or developmental case, more detail is required e.g. miscarriages, terminations, stillbirths, neonatal deaths

Developmental history

- Ask age at which major milestones were achieved - smiling , sitting alone , crawl, walking , run, first word, toilet training

- Cover all areas of development :
  - Gross & fine motor- head control, sitting independently, crawling, walking , reaching for objects
  - Hearing & vision - turning to sound , obeying commands , fixing and following
  - Speech & language - age at first spoken word
  - Social - smiling responsively

- Deviations from normal because of illness.
- Developmental concerns

Nutrition and immunization history

- A nutritional history can be included at this point :
  - Bottle or breastfed and for how long
  - Timing of introduction of solids/cereals
  - Current dietary intake if relevant to complaint of an older child

- Know the current immunisation schedule & ascertain that the child is immunised fully to date :
  - BCG and polio at birth
  - DPT Polio Hib HepB at 6 weeks
  - DPT Polio Hib HepB at 10 weeks
  - DPT Polio Hib HepB at 14 weeks

Family History

- Ages of parents and what they both do
- Marital status and how long married
- Consanguinity
- Number of siblings , sex & age of each
- Family history of diabetes, atopy / allergy , epilepsy, Tuberculosis

Social History

- Housing: type of accommodation, rented or owned, number of bedrooms, toilet facilities
- Source of water
- Usual meal composition , how may times a day ?
- Any pets at home.
- Usage of mosquito nets?