Paediatrics History

History taking is an important aspect in Paediatrics as it posses an excellent challenge to learners in terms of collection, correlation and corroboration of information, which is from a legion list of sources. History forms the most important single factor in making proper assessment.

The general consideration will be:

- Interpretation of history
    - Take special interpretation of the complains given
    - Guide the process to the productive phase of the interview
- Source of history
    - Think of important and informative sources
- Direction of questioning
    - Should be methodical and exhaustive
    - Be three dimensional
    - Should not be prying
- Recorded history
    - Be detailed
    - Clear
    - Chronological
    - Contain significant information
    - Include the parents' interpretation of the situation
- Psychotherapeutic effects

General Outline of History

1. Identification data
2. Presenting complain
3. Present illness
4. Previous health
    i. Antenatal
    ii. Natal
    iii. Neonatal

5. Development – milestones

6. Nutrition
    - Breast feeding
    - Weaning
    - Solid foods
    - Supplements

7. Immunization

8. Past medical history
    - Illnesses
    - Operations
    - Accidents/injuries

9. Habits
    - Eating
    - Sleeping
    - Exercise and play
    - Urinary
    - Bowel
    - Disturbances

10. Family history
    - Health of parents
    - Marital relationships
    - Siblings
    - Stillbirths
    - Diseases
    - Health of contacts

11. Personality history

- Relations with other children
- School progress

12. Social history

- ❑ Family
- ❑ School

Obstetric History

A. Past Obstetric history

i. Menarche
ii. Menstrual cycle – duration. Flow
iii. Gravidity
iv. Abortions/miscarriage
v. Live children – number and sate of health
vi. Still births
vii. Child deaths
viii. Previous pregnancies - get detailed information

B. Current pregnancy

i. Contraceptives – type, duration of use and date of discontinuation
ii. Last menstrual period (LMP)
iii. Previous menstrual history (PMP) to establish whether the menses were regular
iv. Symptoms since LMP
    1. Nausea, vomiting, indigestion
    2. Constipation
    3. Vaginal discharge
    4. Vaginal bleeding
    5. Abdominal pain
    6. Infections
    7. Radiological examination
    8. Medications being taken presently and any other time during the current pregnancy

9. Others

C. Past medical history

i. Vascular disorders
ii. Viral infections
iii. Heart disease & Rheumatic heart disease
iv. Hypertension
v. Diabetes
vi. Jaundice
vii. Ant blood transfusions
viii. Bladder and kidney disease
ix. Thyroid disease
x. STI's – syphilis, HIV/AIDS
xi. Accidents and any surgical operations e.g. #pelvis
xii. Others

D. Family history

i. Diabetes
ii. Hypertension
iii. Cancer
iv. Health of infant's father
v. Inherited abnormalities
vi. Twins/multiple pregnancies
vii. Sickle cell disease
viii. Others

E. Personal habits

i. Smoking
ii. Alcohol intake
iii. Drug abuse
iv. Drug addiction

F. History of previous pregnancies

i. The year/date when the child was delivered

ii. Abortion/miscarriage

1. Date
2. Trimester
3. Any medical intervention e.g. evacuation
4. Elective or spontaneous abortion

iii. Complications during pregnancy

1. Blood pressure
2. Blood sugar
3. Vaginal bleeding
4. Infections
5. Others

iv. Delivery

1. Where child was born – home or hospital
2. Hours in labour
3. Type of delivery
    a. Vaginal
        i. Spontaneous
        ii. Induced (state reason for induction)
        iii. Assisted (state reason for assistance)
    b. Caesarean section (state reason for the operation)
        i. Elective

ii. Emergency

4. Anaesthesia given
    a. Epidural
    b. General
    c. Local
    d. Inhaled
5. Maternal complications
    a. Sepsis
    b. Psychosis
    c. Bleeding
        i. Antepartum heamorrhage (APH)
        ii. Postpartum heamorrhage (PPH)
6. The baby
    a. Birth weight
    b. Sex
    c. Estimated weeks of gestation
    d. Neonatal complications
        i. Hypoglycaemia
        ii. Asphyxia
        iii. Neonatal sepsis
        iv. Opthalmia neonatoram
    e. Was the baby breast-fed or bottle-fed?
    f. The child's present age
    g. Child's present health
    h. Associated problem such as: -
        i. Anaemia
        ii. Allergy
        iii. Infections
        iv. Deficiency disorders
        v. Others

Gynaecological History

1. Parity

2. Problems during pregnancy
    a. Diseases
    b. Complications during labour
    c. Puerperal period – complications and infections

3. Abortions
    a. Stage or gestation
    b. Any underlying factor
        i. Infection
        ii. Stress
        iii. Trauma
    c. Any termination of pregnancy (method and reason)
    d. Infertility (primary or secondary)
    e. Family planning methods

4. Menstrual cycle
    a. Menarche (10 – 16 years)
    b. How long it took to become regular
    c. Regularity
    d. Duration of the cycle (21 – 35 days in Britain and 21 – 30 days in America)
    e. Duration of flow (3 – 7 days)

5. Past Medical History - Previous disease, operations and dates

6. Family History
    a. Related disease
    b. Chronic diseases
        i. Tuberculosis
        ii. Cardiac disease

iii. Allergies

iv. Psychiatric history

7. Chief complains

8. History of presenting illness
    a. Pain
    b. Bleeding pattern
        i. Flow
        ii. Watery
        iii. Clotted
        iv. Duration
    c. Per vaginal discharge (PV)
        i. Timing
        ii. Duration
        iii. Colour
            1. Yellow purulent – vaginitis and cervicitis
            2. Whitish, cream (curdy) – candida infection)
            3. Blood stained – CaCx, Ca vulva
            4. Greenish – trichomoniasis