Professionalism
Procedure Clerkship.d

OUTLINE FOR PEDIATRIC HISTORY & PHYSICAL EXAM

HISTORY

Introductory Statement

This is the (1st, 2nd, 3rd) admission for this age, sex, with a reason for admission.

Chief Complaint (CC) in parents' or child's own words.

History of Present Illness

Information in this section is of greatest importance. Remember that 90% of pediatric diagnoses are made with the history. All of the significant information that supports the differential diagnosis should be found in the HPI. List here all the pertinent, positive and negative direct answers to your questions. The information should be listed chronologically and should include the initial symptom and then the subsequent symptoms. The portions of past history that would be pertinent to the present illness should be included in the information of the HPI. The HPI should contain a number of important details, but these details should be written precisely, concisely, and orderly. Include objective data in your narrative (e.g., x-ray reports and labs obtained in other hospitals) gathered prior to admission that pertain to the patient's need for admission. Information that reflects the severity of illness, for example how the current symptoms affect routine activities is valuable. It is important also to report in the HPI that which reflects the parents' understanding of the problem and their fears and concerns. Finally, note the reason in which the referring physician feels the child actually requires admission rather than treating problem as an outpatient.

Past History

Perinatal and Neonatal Information: More emphasis will be placed on this information especially when it pertains to an infant patient. The information in this section might include birth date, hospital, city, weight, and length and the type of delivery, for example, spontaneous and the type of presentation; vertex or breech. Apgar scores, age of mother, length of gestation, exposures to infectious diseases, and medications, drugs, or alcohol including tobacco used during pregnancy should be recorded if pertinent to the case. Information regarding the newborn, might include hypoglycemia, cyanosis, pallor, seizures, jaundice, skin lesions, muscle skeletal deformities, respiratory distress or feeding problems.

Nutrition: Questions regarding nutrition should be appropriate for the child's age.

For example, infants - breast or bottle fed, and if formula is used which type. Also note vitamin supplementation, water source and WIC participation.

Developmental History: Record information regarding a child's current developmental status with regard to each of the four following areas: gross motor, fine motor, social, and language skills. When children are of school age include information regarding academics and physical activities such as sports.

Immunization: Indicate sources of information, dates immunizations given, and which type of immunization was provided. Also include TB testing results and dates if performed. Remember that parents often wrongly assume that their children are" up to date on shots" and it is always best to review vaccine record yourself.

Habits and Personality:

- Sleep
- Issues with regard to behavior

Previous Illnesses: Age, severity, complications, and sequelae. Report as a list and include dates. Serious childhood illnesses, injuries and fractures, and hospitalizations must be reported.

Surgical Procedures: List with approximate dates, and complications

Allergies (Medication and Others)

-Type of reaction

Current Medications: Create numbered list, including name of medication, dose, route, frequency and indication for the medication.

Family/Genetic History

Record all known significant diseases in first degree relatives (parents, grandparents, aunts, uncles, and siblings). Record all deaths in these first degree relatives. Examples that might be included in this section would be diabetes, cancer, epilepsy, allergies, hereditary blood dyscrasia, early coronary artery disease, hyperlipidemia, mental retardation, dystrophies, congenital anomalies, degenerative diseases, cystic fibrosis, and celiac disease. Report the condition in relationship to the patient (for example: maternal uncle has glycogen storage disease type 1.)

Social History

- Living circumstances: place and nature of dwelling, sleeping arrangements, daycare arrangements.
- Economic circumstances
- Parents occupations and marital status
- Household pets
- Potential exposures to toxins in home, for example, cigarette smoke exposure
- Age of home of children less than 3 (possible lead exposure)

Review of Systems

Review each of the following systems and include all positive answers to questions. (Remember that this is a review of systems and not review of symptoms. Do not repeat HPI information in this section). Include at least one item in each system and be sure not to use the short-cut of "negative" or "unremarkable."

- General
    - HEENT
    - Respiratory
    - Cardiovascular
    - Gastrointestinal
    - Genitourinary
    - Skin
    - Muscle/Skeletal
    - Hematologic/Lymphoid
    - Endocrine & Growth
- Neurologic
- Psychiatric

PHYSICAL EXAMINATION

All positive physical findings should be recorded and pertinent negative findings to that specific differential diagnosis should also be included in the physical examination. The following list of physical findings contains examples of those things that might be included.

A successful pediatric examination varies with the age of the patient. Very young infants and neonates are often easiest to examine on the examining table. From several months to preschool age it is often more effective to have the patients lie or sit on the mother's lap. It may be best to interview and examine adolescents without the parents present. If a parent is not present during the examination a student should have a nurse or the attending physician present at the time of examination or have parental permission to examine the child.

Observe the child under ideal circumstances, for example, while in mother's lap and leave the more painful and uncomfortable parts of the examination until last, for example, throat and ears.

Vital Signs: Record vital signs which include temperature, pulse, respiratory rate, and blood pressure (arm and legs). Weight, height, and head circumference should be measured, preferably using the metric system, and should include percentiles. Record BMI and percentile for all children 2 years and older. Plot these parameters on a growth chart if not previously done. Record O_2 saturations and the amount of oxygen delivered if appropriate.

General Appearance: For example any obvious deformities, size appropriate for age, respiratory distress or pain, and hydration and general nutrition status.

Head: Normal or abnormal facies and normal or abnormal head shape. Fontanel size if open (anterior and posterior).

Eyes: Include all positive findings on eye examination and include proptosis, sclerae, conjunctivae, strabismus, photophobia, and funduscopic exam.

Ears: Hearing, external canal, discharge, tympanic membrane appearance.

Nose: Air movement, mucosa, septum, turbinate appearance, perinasal sinus tenderness.

Mouth and Throat: Color, dryness, fissure; appearance, teeth – number, presence of caries, gum - color and hypertrophy, epiglottis - appearance, tonsils - size and appearance.

Neck: Flexibility, masses. Thyroid - size.

Lymph node: If abnormal in size or texture record location, consistency, tenderness, size in centimeters.

Spine: Scoliosis, mobility, tenderness.

Thorax: Appearance and contour, respiratory rate and effort, regularity of breathing, symmetrical chest movement, character of respirations such as retractions.

Lungs: Percussion, palpation, fremitus, auscultation.

Cardiovascular:

- Inspection, precordial bulge, apical heave, auscultation, rhythm, character and quality of sounds.
- Palpation: PMI, thrills, heaves.
- Auscultation: quality and intensity of heart sounds, murmurs, for example, timing, duration, intensity, location, radiation.
- Pulses: radial and femoral pulses, rate and rhythm.

Abdomen:

- Inspection, contour, umbilicus, distention, veins, visible peristalsis, hernia.
- Percussion: fluid wave, shifting dullness, tympany, liver size, spleen size, Costovertebral angle tenderness, abnormal masses.
- Palpation: tenderness, rebound, guarding, masses.

Genitalia:

Record Tanner Stage
- Male: circumcised, testes - appearance and size, hydrocele - presence hernia.
- Female: external genitalia, appearance of vulva, clitoris, hymen.

Breasts:

Tanner Stage

Rectal (only if indicated):

Fissures, hemorrhoids, prolapse, sphincter tone, stool in ampulla, abnormal masses.

Skin:

Texture, color, turgor, temperature, moisture, icterus, cyanosis, eruptions, lesions, scars, ecchymoses, petechiae, spider nevi, desquamation, hemangiomata, mongolian spots, nevi.

Extremities:

Tone, color, warmth, clubbing, cyanosis, mobility, Ortalani and Barlow maneuvers in newborns and infants, deformities, joint swelling or tenderness.

Neurologic:

- Mental status: affect, level of consciousness, speech.
- Motor: station and gait, muscle strength, tone, tics, ataxia.
- Cranial nerves: testing 2-12

- Deep tendon reflexes: 2+ is average when recording.
    - Record if Babinski present.
    - Infants note premature reflexes such as grasp, suck, Moro, rooting, stepping, placing.
- Abnormal sensory findings.
- Meningeal signs

CLINICAL DECISION MAKING

Problem list

Create a comprehensive list of problems on admission for your patient, such as dehydration and pneumonia. Be as specific as possible. Include some information about the severity or seriousness of each problem. Don't forgot problems like incomplete vaccination status or obesity that could be addressed after discharge.

Summary Statement

Write one or two sentences concisely summarizing pertinent historical and objective information. The first half should include the key historical information and the second half focusing on the objective findings (exam and lab). The summary statement should balance being complete and concise from which a differential diagnosis is created.

Differential Diagnosis

Using your summary statement (not just each problem in your problem list) as your point of origin, develop a differential diagnosis for your patient. Ideally there would be 4-6 items to consider in your differential. If the diagnosis is known on admission, consider other possibilities as well. For a known infection, like bronchiolitis, consider not only other pathologic processes (like heart disease, airway abnormalities) or which infectious agents could be the culprit (RSV, adenovirus, pertussis, etc.)

Clinical Impression

Which of your possible diagnoses do you think is most likely and which are less likely? Show your clinical reasoning and be convincing.

MANAGEMENT

Management Plan

Use your problem list to generate your plan to be sure you cover everything that is important for your patient. Use specific doses of medications, including mg/kg if applicable. For IV fluids, include the composition and rate. For labs and radiology, include specific tests and what you hope to learn from the results. Patient and family education goals prior to discharge should be considered part of the plan A outstanding plan includes contingency planning (if-then, when to

escalate work up or care) and could refer to a clinical guideline applicable to your patient.

Addendum

Pertinent subsequent lab results or change in patient status after your admission H and P that you may desire to report.

LEARNING ISSUE

Write a short, one to two paragraphs in your own words on something you found interesting about your patient that you wanted to learn more about. Report on a specific medical topic that pertains to this patient. This might be from the differential diagnoses or problem list. Use evidence-based literature to support your information and document your references.

FEEDBACK NOTES

Attending evaluation

In addition to meeting the clerkship requirements for professionalism, a part of your preceptor evaluation will be based on how well you do with your write ups. You will be asked to complete at least 2 full inpatient write ups. You may be asked to complete a third write up if needed to demonstrate competency in this area. We are looking for completeness, evidence of clinical reasoning, and ability to incorporate feedback into improvement.

PHAPPEE rubic

The clerkship uses the PHAPPEE rubric for evaluation. This rubric was developed and validated by the national group of pediatric clerkship educators and is similar to the oral case presentation evaluation form used for Professor Rounds. The scale goes from 1-5 (5 being the highest) with the goal of being at a level of 3 by the end of third year.

Due dates

H&Ps are due before 11:59 pm two days before our scheduled time for the Written Case Presentation Session. That will give me enough time to review them and generate meaningful feedback for you. On the Fargo campus, email your write-ups to both chris.tiongson@sanfordhealth.org and brianne.melicher@und.edu . For the other campuses, please turn them in to your campus clerkship directors.