



History Taking Form

Pediatric History
 MED40 at Taibah University
 By: Abdullah K. Aljohani

- Check that you know the child or young person's first name and gender. - Introduce yourself. - Determine the relationship of the adults to the child or young person. - Explain your role - Obtain Consent - Clarify Confidentiality

◇ Personal Data				
◇ Name: ◇ Age: ◇ Sex:				
◇ Source of history (Mother- Father - Others):				
◇ Residency: ◇ Nationality:				
◇ Chief Complaint (The stated reason for seeking care at the present time - The main symptom that brought the patient to the hospital) (Use their own words, The parents may tell you the diagnosis)				
◇ Chief Complaint:				
◇ Route of admission (<input type="checkbox"/> Emergency <input type="checkbox"/> Outpatient department <input type="checkbox"/> Referral from) ◇ Date of admission: (/ /)				
◇ The duration, for how long?.....				
◆ History of Presenting Illness (HPI) (Obtain a complete chronological sequence of events)				
◇ 1- SOCCRATES				
Site				
Onset	<input type="checkbox"/> Sudden <input type="checkbox"/> Acute <input type="checkbox"/> Gradual			
Character	<input type="checkbox"/> Pricking <input type="checkbox"/> Cutting <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Throbbing <input type="checkbox"/> Colicky <input type="checkbox"/>			
Course	<input type="checkbox"/> Constant (Stationary) <input type="checkbox"/> Continuous: Improve or worsen with time?			
	<input type="checkbox"/> Intermittent: How many times? Each one last for how long? <input type="checkbox"/> Progressive <input type="checkbox"/> Regressive			
Radiation				
Alleviating factors				
Time	When did it Start? Increase at a specific time in the day?			
Exacerbating factors				
Severity	Scoring: (1 - 2- 3- 4 - 5- 6 -7 -8 -9 -10) <table border="0" style="float: right;"> <tr> <td>Interfering with:</td> <td><input type="checkbox"/> Daily activities</td> <td><input type="checkbox"/> Sleep (Awake from sleep)</td> </tr> </table>	Interfering with:	<input type="checkbox"/> Daily activities	<input type="checkbox"/> Sleep (Awake from sleep)
Interfering with:	<input type="checkbox"/> Daily activities	<input type="checkbox"/> Sleep (Awake from sleep)		
Straw & Fears	What is the final straw that brought you to seek help?			
◇ 2- Associated symptoms related to the relevant systems				
◇ 3- Specific questions - Risk factors - Complications				
Findings from specific questions?				
Risk factors related to the CC, or to possible DDx:				
Complications?				
◇ 4- General Enquiry FAST				
Feeding:				
- Feed per day? Amount per feed..... Weaning				
Activity:				
How active is the child usually? Is that changed? <input type="checkbox"/> Yes <input type="checkbox"/> No				



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Sleeping:

Any difficulties? Waking up?.....

Temperament:

Has the child changed at all? School changes?,

Teachers notes?

-

◇ 5- Review of involved system/s (The chief complaint could be involved in more than one system) See the check list below

CAGED SUN

Cardio:

Cyanosis - Chest pain - Palpitation - Exercise intolerance - Orthopnea - Paroxysmal Nocturnal Dyspnea -
Edema of ankle - History of rheumatic fever - SOB - Sweaty on feeding

Airway:

Cough - Sputum (Quantity, Color Relation to position) - Dyspnea - Chest pain -
Wheezing - Breathing problems (Snoring) - Runny nose

GIT:

Vomiting - Regurgitations - Hematemesis - Diarrhea - Constipation - Abdominal pain - Abdominal
distension - Change of appetite - Change of weight - Abnormal taste and swallowing - Heartburn - Abnormal
bowel habit - Nature of stool - Rectal bleeding - Melena - Jaundice

ENT, Eye, Endocrine:

ENT: Hearing problem - Snoring - Stridor - Throat infection - Rhinitis - Dental caries

Eye: Pain - Redness - Excessive tearing - Double vision - Blurred vision - Itching or dryness - Eye glass
or contact lenses

Endocrine:

Heat or cold intolerance - Change in hair distribution - Voice change - Polydipsia - Polyurea - Exophthalmos
- Discoloration of skin

Derma:

Rashes - Itching - Change in hair or nails - Pale or dry skin

Skeletomuscular:

Joint pain / Stiffness - Swelling - Muscle (Limb) pain or weakness - Gait problem.

Urinary:

Polyurea - Oliguria - Dysuria - Hematuria - Urgency - Buring micturition - Passing stones - Toilet
training - Wetting

Neuro:

Fainting - Fits - Chronic headache - Local weakness - Paralysis - Sensory disturbance - Tremor -
 Memory loss- Irritability - Drowsiness

◇ 6- Constitutional symptoms

Fever

Documented, or no? reading?

The way of measuring? By whom?



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	Associated with Chills and rigors? Antipyretic medication use?		
Fatigue			
Weight change	Intentional, or no? How many Kilos? Duration?		
Night sweating			
Appetite change			
◇ 7- Hospital course (What happened since you arrived? History of the same episode before?)			
◇ Past Medical History (You can ask quickly about the past by HOPD Hospital admission, Operations, Previous illnesses/ allergies, Drug Hx)			
Previous similar attack	<input type="checkbox"/> Yes	How many times?	What's the time of each one?
	<input type="checkbox"/> No	When did the last time happen?	What's the time BETWEEN each one?
Chronic disease?	<input type="checkbox"/> ADHD <input type="checkbox"/> DM <input type="checkbox"/> Asthma <input type="checkbox"/> G6PD <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Autism <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Other:		Under control, or not?
	Other disease?		
Hx. Of Hospitalization	<input type="checkbox"/> Yes, Why?	Duration?	Investigations?
	<input type="checkbox"/> No		
Hx. Of Trauma/ Accident			
◇ Immunization			
Appropriate for age?		Unwanted reactions?	
Non-routine vaccines were given? (Influenza, Pneumococcal, Covid-19)?			
MMR vaccine?			
◇ Past Surgical History			
Any previous surgery?	What (Type)?	Why?	When? Where? Complication?
◇ Past Drug History			
Drug	For what?	Dose	Route Frequency and duration
<input type="checkbox"/> Antibiotics <input type="checkbox"/> OCP <input type="checkbox"/> NSAIDs <input type="checkbox"/> CCB <input type="checkbox"/> ACEi <input type="checkbox"/> ARBs <input type="checkbox"/> Herbal			
Side effects?			
◇ Allergy From (Food - Drug - Environments)			
<input type="checkbox"/> Yes, For What?	When?	How was the reaction?	How was it managed?



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No Say "No Known Allergy" (NKA)

♦ Blood transfusion			
Why?	When?	How many units?	Any complication?

♦ Obstetric History

- 1- Prenatal:
- Antenatal Care (ANC) at And was Regularly Irregularly Attendant. Folic Acid? Yes No
 - Uneventful pregnancy? Yes No
 - History of Maternal infections (TORCH infection) such as Fever, Skin rash, swellings, discharges? Yes No
 - History of Maternal DM, HTN? Yes No
 - Exposure to radiation or medications? Yes No
 - Physical or psychological trauma? Yes No
- 2- Natal
- Duration of pregnancy: Full term, Pre term, Post term
 - Mode of delivery SVD, Cesarean Section, Duration?
 - Complications during delivery?
 - Cried immediately? Yes No History of resuscitation? Yes No
 - Birth weight?
 - Congenital anomalies or birth injuries?
 - Discharge from nursery after?
- 3- Immediate Postnatal
- NICU admission? Yes No If yes. Why?

♦ Family History

Age of parents: Father: Mother:	Consanguinity? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hx of abortion? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hx of premature delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hx of stillbirth? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hx of childhood deaths? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hx of similar conditions in the family? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hx of DM, HTN, Heart disease, Bronchial asthma, Blood disorders, Epilepsy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Who?, Controlled? And How?			
Number of siblings and age of each one?			
Inherited or Genetic diseases? <input type="checkbox"/> Yes <input type="checkbox"/> No , if yes mention What?			
Family pedigree -> See below			

♦ Social History

Occupation: Father: Mother:	Housing - Type of accommodation? (Rented or owned, house of flat, number of bedrooms, washing and toilet facilities, air conditions and heaters)	Socioeconomic status?
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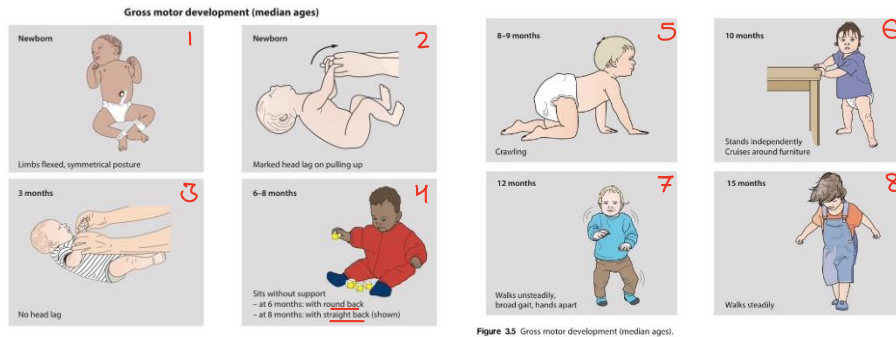
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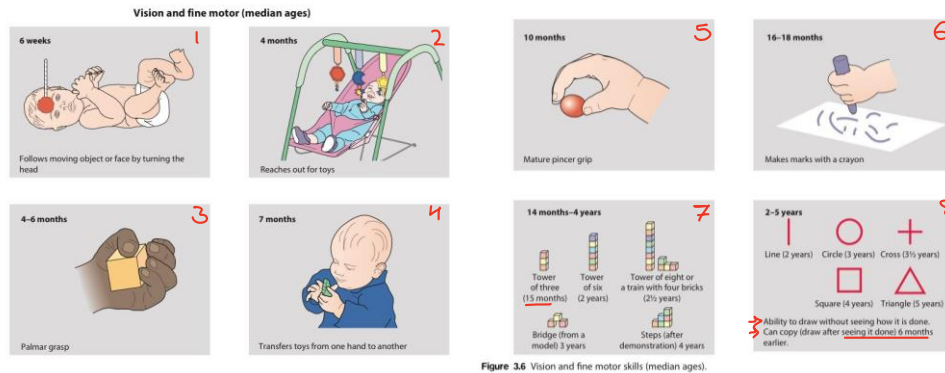
Parental conflict?	Smoking, drugs, drinking?	Life at school and home?
Activity?		Sports?

Developmental history (Gross Motor, Fine Motor, Hearing and Speaking, Social skills, Visual, Schooling level and performance) N.B. If the mother has other children compare his or her development with his or her other siblings.

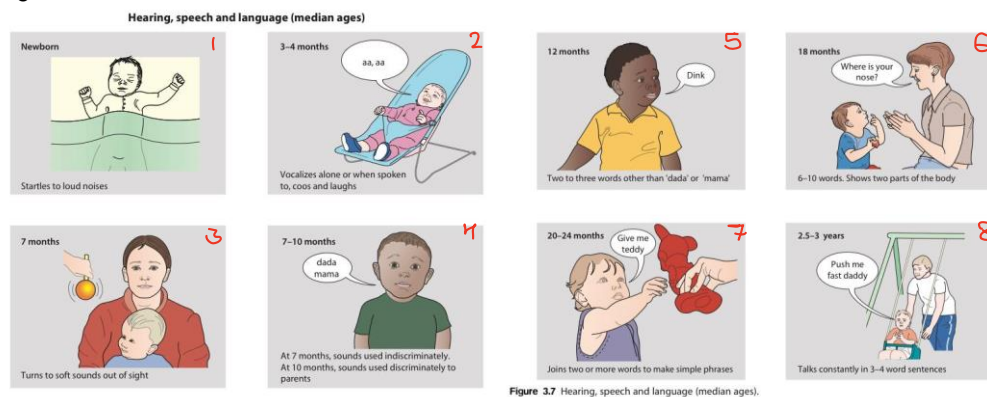
1- Gross motor:



2- Vision and fine motor:



3- Hearing and speaking:





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4- Social skills

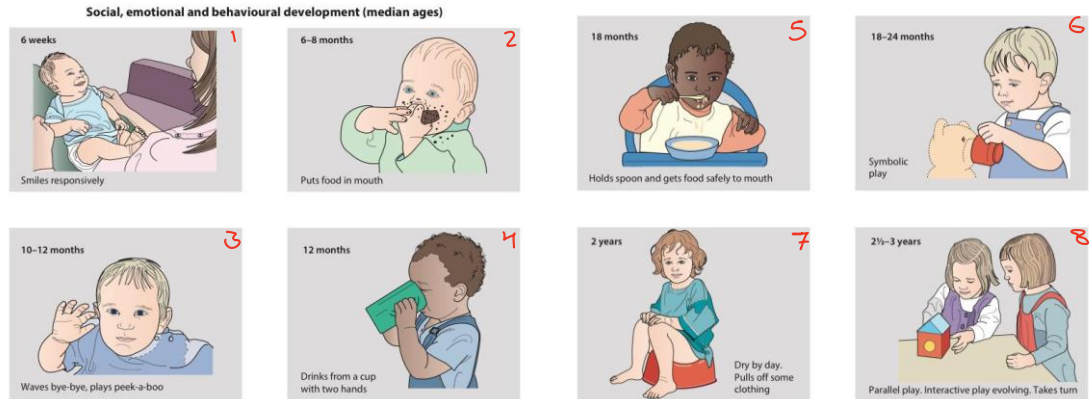


Figure 3.8 Social, emotional and behavioural development (median ages).

Does his or her development consider as normal compared to his or her siblings? Yes No

Dose his or her development age go with her chronological age? Yes No

Age of bowel control?

Age of bladder control?

◇ Nutritional history

Breast feeding for?.....

Bottle started at age of due to

..... ml/day or /feed and everyhrs.

Which formula did she/ he receive?.....

How was it prepared?

How long did she/he take it?

Frequency of feeds?

Total daily intake?

Solid food was introduced at the age of In form of

Vitamins or iron supplements?

How is the appetite?

ICE (I: Ideas, C: Concerns, E: Expectations)

I:

C:

E:

◇ Summary (Brief summary)

Blank space for writing the summary.



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Don't forget RULE:

In case of **Fever** don't forget to ask about:

Documented or no , How was it measured?, History of TB - Rheumatic fever - Recent travel
Animal contact - Contacted with infected patient - Ingestion of raw milk - Recent eating from outside - Chills or rigors - Skin rash - IV drugs

In case of **Asthma** don't forget to ask about:

Inhaled allergen (Animal in home, Moles, Cockroaches or rodent) - Exercise (Typically develop 5 to 15 minutes after exertion) - Tree, grass or cold weather (Seasonal symptoms) - Smoking (or any one smoke in the house) - Indoor or outdoor pollutant & irritant (Fumes, Wood-burning painting) - Work place (Does the patient have the symptoms during but not during the weekend) - Symptoms of rhinitis - Respiratory infection - GERD - Medication use (Aspirin, NSAID, Beta blocker)

In case of **Chronic Diarrhea** don't forget to ask about:

Amount - Smell - Color - Presence of mucus or blood - Watery or floating over the toilet bowl

In case of **Weakness** don't forget to ask about:

Site (Proximal - Distal) (Arm - Hand - Leg - Foot - Thigh - Whole limb)
Symmetry (Unilateral - Bilateral) Timing (Diurnal variation)

In case of **Anemia** don't forget to ask about:

Diet (Vegetarian - Poor diet) Color of stool and urine - Bleeding from (Nose - Mouth - Piles) - Drug (NSAID - Aspirin) - Jaundice - Pale - Diffuse pain - Mouth ulcers - Joints pain - Loss of hair - Lethargy - Syncope - Palpitation - Drowsiness - Headache - Dizziness - Exclude G6PD (Fava beans etc ...)

In case of **Seizure** don't forget to ask about:

Describe the seizures? (e.g., movements, duration, frequency), Is there a loss of consciousness during seizures?
Has the child experienced any head injuries or brain-related illnesses? Is it symmetrical in both half of the body?
Is there a family history of seizures or epilepsy? Triggering factors (TV, Flash of light, Sleep deprivation) Fever?

Pre-Seizure (Aura) Symptoms:

2. Aura Description:

- Can you describe any unusual behaviors, signs, or sensations your child exhibits just before a seizure occurs?

3. Changes in Behavior:

- Does your child show any sudden shifts in mood or behavior before a seizure?

4. Visual or Auditory Changes:

- Has your child mentioned seeing or hearing things that are not present before a seizure?

5. Sensory or Physical Sensations:

- Does your child experience any strange or abnormal sensations in their body, like tingling, or numbness before a seizure?

6. Gastrointestinal Sensations:

- Have you noticed any changes in your child's appetite or any unusual stomach sensations before a seizure?



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Post-Seizure Symptoms:

1. Post-Seizure Behavior:
 - What behaviors or signs does your child display immediately after a seizure?
2. Confusion or Disorientation:
 - How long does it take for your child to become fully alert and oriented after a seizure?
3. Memory or Recall:
 - Does your child have any difficulty recalling events or experiences following a seizure?
4. Physical Symptoms:
 - What physical symptoms or complaints does your child express after a seizure (e.g., headache, muscle weakness, neck stiffness, tongue biting)?
5. Emotional State:
 - Does your child experience any mood changes or emotional shifts after a seizure?
6. Sleep or Fatigue:
 - Does your child feel excessively tired or experience changes in sleep patterns following a seizure?
7. Incontinence:
 - Does your child lose control over bladder or bowel functions during or after a seizure?

I looked at many resources, notes of doctors, previous students' works, and previous history files, so I created this file in the hope that it will benefit you. I wish you all the best.

Thank you,

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