HISTORY & EXAM FORMAT
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1- PERSONAL DATA: Age, sex & Hx source

2- C/O; parents wards & the duration of the symptoms

3-; HPI
A; Chronologically

B, Details of the major symptoms eg pain, vomiting….

1- WHEN: (onset, duration, frequency)
2 - WHAT characteristics
3 - WHERE, site & radiation
4 - WHAT FACTORS increase it or decrease it.(feed, drink, travel,,,)
5 - WHAT associations?
- **Fever, cold symptoms, contact with sick patient , animals, travel**
- **Abdomen, Nausea, Vomiting, Bowel movements, Urination**
- **Wt changes & appetite**
- **Rash, Joint**
- **Bruises, bleeding & Jaundice**

6- Severity; what is the effect of the symptom on sleep, school, social life, sports
7- Progression of the events (investigations if done in other hospital & management given, medications, procedures,,etc)

4- PREG Hx:
- **Mother age, planned pregnancy?**
- **Mother illness during pregnancy (fever, rash, joint pain), meds, smoking**
- **ANTENATAL FU (screens, US, Ix,, if relevant)**
- **LABOUR: Term, mode of delivery, resuscitation, Birth Wt**
- **NEONATAL: when discharged with mom, how he was doing in the first month of his life basically in regards of of (fever , Jundice, Seizures, sleep, colic, infections, respiratory Sx)**

5- NUTRITION; his current diet, restrictions, wt gain
if detailed required eg FTT:
- Br milk, formula (frequency, amount, latching, sucking, swallowing, chocking, cyanosis)
- solids; what, when introduced, amounts
- Supplementations; vitamin eg vit D

6- VACCNINATIONS: When the last vaccines?, if no vaccine was give ask why?

7- DEVELOPMENT: start with screen Qs:
- **IS IT NORMAL /COMPARE TO SIBILINGS**
- **Any regression, loosing skills at any time?**
- **How did U find him as an infant (for big kids?)**

THEN; GM, FMV, HREL, Communications with others (parents, siblings, strange adults, other kids, play.. for autism)

Self-care (feeding himself, dressing, undressing, toilet training)
Behaviors; mood (irritable, agitated, depressed, sad, happy + CAPS; Concentration, Activity, Play with others, Sleep)

GROSS M;
If parents not remembering the details just ask what can s/he do now?
- Head control when pulling to sit-down 3- 4 m
- Rolls from Front to back on 4 m (use the help of the hand).
- Rolls from Back to front on 5 m
- sit alone on 6m
- Crawl 7-8 m
- Pull to stand from 9-10m
- Cruise 10-11 m
- To walk alone 12 m (can be used as a start & move forward for big kids or if Parents are not remembering the initial milestones)
- runs by 18 m
- walk up & down the stairs (one step at a time on 2 y)
- Walk up stairs alternatively, ride tricycle on 3 yrs
- walk downstairs alternatively by 4 yrs, hops on one foot 4 yrs
- Skips- ride bicycle with no training wheels 5Yrs

FINE & VISION; Start with asking about vision?
- Open hand spontaneously (un-fisted > 50% of the time) ... 3m
- transfer objects to mouth 4 m
- Transfer objects from 1 hand to another ... 6- 7 m
- Pencil grip.... 9-12 m
- release objects on command...12 m
- drink from a cup...1yr
- **Is he printing/ drawing/ coloring? What can he does?** Scribble… 18 m, vertical & horizontal lines 2, circle 3, + 3.5, sq 4, triangle 5, rectangle 6
- 2 cubes..14 m
- 4 cubes.... 18 m
- 6 blocks... 2y
- Persons with 6 parts.... 5yrs
- Others: Train 2.6(30m), Bridge 3, gate 3, steps 6.

HEARING, Receptive & Expresive LANGUAGE, Communications & play;
Receptive: Do U feel that his hearing is normal? Was it assessed?
- turn head to sound 4m
- understand No… 12m
- understand commands.. 15 m (2 steps)
- identify body parts (18 m)
- ---------5 ---------- (2 yrs)
- Match colors …. 2.5 yrs
- Count to 10 … 5yrs

Expressive:
- babbles… 6ms
- say mom/dad specifically + other 3-4 word vocabulary... 12 m

- point to several body parts ... 16 m
- 50 words vocabulary/ 2 word sentences... 2 yrs
- 3 words sentences....3 yrs
- name colors… 4yrs

Communications & play (for autism)

PERSONAL-SOCIAL;(feed, dressing, toilet, play)
- Social smile spontaneously...3m
- discriminate social smile /show like and dislike...6m
- pat a cake, peek-a-boo 9m
- comes when called…. 1y
- mimic actions of other ...18m
- **play with others... 24 m**
- **engages in cooperative play... 4yrs**
- **Toilet trained … 3-4 yrs**
- **Feed from a spoon**.... 15-18m
- **Undress** himself / undo buttons …. 2 y
- dress himself / do up buttons …. 3yrs
- dress without assistance … 5y

8- PH;
- **CHRONIC DIS & its severity assessment**
- **Previous admissions, surgery, head trauma**
- **Meds & Allergy**

*** FOR CHRONIC ALLNESSES ASSESSMENT eg BA or Seizures**
DX; when, age, How (Sx & Ix)

A; details of the attacks;
- Frequency, last attack
- Severity (home/ER/hospitalization; frequency- duration)
- Between attacks & general

P; PPT/Trigger factors

D; drugs; doses,response, SE,compliance
Other Mx' (nutrition, alternative Tx, surgery)

P; Progress
- General course
- Home Mx
- Hosp frequency-duration-Rx
- Outpatient F/U; Where- frequency- IX-

COM ; complications (disease- medications)
Compliance

SR;
HEAD: HA, Sz,
EYE: vision, concerns,
EARS: pain, recurrent infections,
THYRIOD: swelling, feeling hot/cold/ sweaty (GAMES; growth, appetite, motion of the bowel, mood changes, skin & hair changes)
CHEST, CVS: SOB, wheezes, chest pain
ABDM: pain, V, BM,
LIVER; Jaundice, bruising, bleeding
GUS: Urinary Sx, change in color, smell, steam
MSK: joint pain, limping
SKIN: rash, itching

9- FH.;

- Parents ages & health status- consanguinity (DRAW FAMILY TREE)
- Occupation (financial status & whom take care of the kids when they at work)
- Hx of SNABLS (Same illness, Neonatal death, Abortions, Birth defects learning disability, Sz)

10- SH;

1-With whom is the child living? / Who is the primary caregiver? With whom is the child staying stay if parents work (day care, babysitter, servants, and grandparents)
2- Occupation
3 -impact & copping of chronic illness on the family: social lifestyle, having time for rest, marriage stability, depression/denial, financial support,
4- Stresses, new changes (move, new baby, divorce..)
5- **Physical home environment** eg for asthma; types of the house, smoking, pets, Plants, carpeted/ ceramic floor

11- ALLERGY HX
12- MEDICATION HX

PHYS EXM;
1- Wash hands
2- ASK the parents what is the best setting U think he will be more comfortable for exam (your lab, bed … esp for 2-3 years) also ASK to **EXPOSE** his upper body.

3- General Look; PAUSE TO OBSERVE & COMMENT VERBALLY ON:
1- Wellbeing & sickness / comfort ability
2- Nutrition status: well nourished, thin, good muscle bulk,,,
3- RD
4- Dehydration status
5- Colure: pale, pink, jaundice
6- Facial dysmorphic features & neuro-cutanous stigmata
7- His position, limbs movements (important for neuro patients)

MAKE COMMENT THAT U WILL CHECK YOUR OBSERVATIONS MORE WITH MORE SPECIF EXAMS.

5- Vital Signs: HR: RR: Temp: BP: O2 sats:
GP; Height___ % Weight___ % HC___%
BMI_____

6- Hand: clubbing, paleness, pulse,,,

7- HEEN :
Head: size, shape, fontanel & scalp
Eyes: pale, jaundice, nystigmus , squint … use the ophthalmoscope for red reflex & to assess the EOM.
Ears; otoscope (mention U want to do it at the end)
Nose & Mouth: dental status, palate, uvula, tonsils
Neck**;** thyroid , LAP

8- Resp:
- Inspection: RR- chest movements/ expansion – shape – scars
- Palpate trachea
- Auscultate : Air entry : compare sides & front/back
- Percuss if applicable: ----------

9 - CVS:
- Clubbing - priph pulses/ femorals – CRF
- palpate precorduim (Apex beat, PS heave)
- Auscultate : H sounds + murmurs (change positions , 4 areas & the back)

10- Abdomen: observe, auscultate and palpate as in adults. Children often have a palpable liver edge…always palpate from the pelvic brim up. Consider a rectal exam if applicable to presenting complaint.

11- GUT; for tanner stage , inguinal hernia
12- CNS; HMF, Cr N, TPR, Sensation, Prioception, Gait, spine if indicated
13- MSK
14- Skin; rash, bruises, birth marks

IMPRESSION

- In 2 to 3 sentences, provide a summary of the patient with main findings.
- For example: 1 year old previously healthy Caucasian boy presented to ER with complaint of cough and increased work of breathing. Neither Chest x-ray nor the physical exam showed any focality and the NPW is pending. He has been admitted for likely RSV bronchiolitis and is currently stable on 3 L of oxygen).

PROBLEM LIST
- List all of the acute and chronic problems using patient descriptions (cough, fever, difficulty breathing).

- Do not to list diagnosis as the problem i.e. asthma, pneumonia etc.
- List a differential diagnosis for each problem with reasons for and against each diagnosis.
- This list should be in order of significance.
- There may be problems that were elicited in history which were not part of the presenting symptoms.

FOLLOW UP NOTES: SOAP

S (Subjective):

- Information provided by parents / patients about their condition. Get details of the symptoms the patient was admitted with and if symptoms have improved.
- Example: if the child was admitted with diarrhea – has he had any more loose stools, change in number of stools, colour etc.
- Is the patient eating better? With an infant you might want to quantify the amount of milk / fluids taken as per mother. Passing urine stools.

O (Objective):

- The information gathered from the physical examination and from the tests.
- Begin with weight (if new weight available), vitals. If febrile, maximum temperature in last 24 hours.
- Total input and output – especially in a child admitted with dehydration or with a renal problem. Also important in children not gaining adequate weight due to any reason.
- Physical examination conducted on that day. Include all pertinent positives and negatives.
- New laboratory results and other tests done with results i.e, renal ultrasound – normal. Also mention tests already done with pending results.

A (Assessment):

- Assessment of the patient – what you consider the problems with the patient, with the most relevant problem listed first.
- It is also the summary of how the patient is doing and what has changed from previous day.

P (Plan):

- What are the plans for the patient according to each problem?
- Some people like to merge assessment and plan together.
- The most significant problem should be mentioned first.
- This section should include all the medications, lab tests to be ordered and to be followed, consults to be asked.
- It is very important to write the plan after the rounds as most of the decisions are made in the rounds.