History and Physical Examination
(Format for Students)

The medical record is the basis for medical care, and one should make every effort to include all pertinent information. The following guidelines help in organizing the history and physical examination data.

PART I: THE ELEMENTS OF A COMPLETE HISTORY

Approach for taking history:

Taking history from patients especially pediatric patients is an art. It is an art of communications, information gathering, asking questions and grasping and waiting for the appropriate answer. The interviewer has to have patience, reasonable humor, friendly attitudes and calming behaviour.

He/she must not be condescending, ridiculing, threatening or accusing. Occasionally the interviewer may be faced with patients who are difficult to stop talking or divert the topic. On the other hand, he may be faced with patients who are very difficult to get information from. In all situations, the interviewer needs to be the master of the scene with tactful, gentle and friendly approach. Children usually come with their parents or at least one of them. It is advisable that the history taker engages the child in the discussion or keeps him busy as the situation may demand. Often times the questions may lead the dialogue astray, so they need to be well directed problem oriented and mostly open-ended. Closed-ended question may be resorted to as the case may be.

The interviewer usually starts with a good introduction with greetings. He then asks about the patients demographic data such as name, age, sex and etc.

I. General Information:

A complete history includes the name, age and birth date, sex, admission date, referral source (e.g. a clinic or physician) and relation of informant to the child, including a statement of the reliability of the informant.

II. Chief Complaint (Presenting Complaint):

The chief complaint is a brief statement, in the informant's or patient's own words of the reason the child was brought to the hospital or clinic. The duration of the problem should be noted.

III. History of the Present Illness:

The history of the present illness is the portion that tells, in the chronologic sequence, the problem or problems for which the child is being seen. It should begin with a statement of the child's general status and onset of illness, such as "This is the first admission of this 3-year-old boy who was well until two days before admission." Each problem defined in the history should include the following information: