Pediatric Inpatient History and Physical Requirement

All students are expected to submit two H&Ps to your floor attending prior completion of the pediatric ward rotation. Your ward attending will grade your H & P and provide you with feedback. Please submit your H&Ps as you complete them so you may incorporate the feedback you receive on subsequent H&Ps.

The Pediatric H&P is very similar to what your have learned in the Introduction to the Practice of Medicine with some unique features.

Here are the requirements for the H&P.

History

CC: Age of pt and primary complaint/concern

HPI/ROS: Please be detailed. If it is a lengthy HPI – feel free to divide it into paragraphs for the ease of the reader. Include all pertinent positives and pertinent negatives that you think may be related to the chief complaint (this can include pertinent aspects of past medical history, ROS, family history, social history) and that may help you arrive at a final diagnosis. Specific things that we often ask about in pediatrics are: PO intake (normal & current – quantify), urine output (normal & current – quantify), level of activity, make sure you quantify vomiting/diarrhea if present, sick contacts.

PPI: This is an area that many of our students have difficulty .Explain the parent's and/or patient's point of view with respect to the illness, injury, chief complaint. Indicate what they think may be the cause, any fears that they have, any expectations that they have of the medical staff. Please explore beyond the fact that the parent(s), caretaker(s) are worried about their child being admitted to the hospital.

Birth Hx: Term vs. Preterm (age of gestation), method in which child delivered (NSVD vs. C/S – if C/S, why?). Problems with pregnancy, delivery, newborn period, prenatal history: (meds, etoh, tob, infections, serologies, GBBS status)

PMHx:
PSHx:
FHx –Congenital disorders, learning disorders; Psychiatric illnesses (for immediate family, i.e. parents, grandparents, and siblings).

Immunizations: whether or not the patient is up to date, also get the records – most parents have them readily available

SHx – Family constellation, ages of parents, marital status of parents. Who is the child's primary caretaker? Does the child attend daycare? Who lives at home? Pets? Smokers? Involvement with other children?

Diet/Intake
Elimination – hard stools, blood in stool, frequent urination

Development – Assess the level of development. What age did the child roll; sit up, first words, walking. If the child has been admitted for an injury, does the child's developmental abilities allow him/her to be injured in such a way? (i.e. hx that child rolled out of bed to floor causing closed head injury – can 2 month old infant roll and get injured this way?)

Meds – include OTC, herbal supplements, vitamins
Allergies –Medications, foods, environmental
ROS -

Physical exam
Always include *all* vitals – temp, HR, RR, BP, (pulse ox if done)
Always include weight, length, head circumference and their percentiles on the growth curve, *include weight for length if < 3y/o or BMI if >3y/o* and include a plotted growth chart (filling out both sides of the sheet)
Entire Exam including: Head, Eyes, Ears, Nose, Throat, Neck, Lungs, Heart (including pulses and capillary refill), Abdomen, GU, Extremities, Neuro, Lymph nodes and Skin

Labs
Imaging

Problem List

Assessment – Summarize the complaints and physical findings, and a general assessment of the clinical status of the child. (I.e. 22 month old male with febrile respiratory infection and dehydration – clinically stable)

Differential Diagnosis: Synthesize the problem list and rank the order of diagnoses beginning with what you feel is the most likely diagnosis. Discuss the findings (from history, physical, labs, imaging) that support or do not support each item on your differential.

Plan: Please write your plan in three parts as you have learned. – Diagnostic, treatment, and education (referring to patient education). Support each item on your plan

Always indicate you discussed the above with the team or with the attending.

Sign your name and pager number

Date and time your notes.