Paediatric History

History taking in children is likely to be compromised by a variety of factors, not least that the child may be distressed and ill and the parents extremely anxious. This is particularly true where most paediatric histories are taken - that is, in general practice and in accident and emergency departments. In general practice such histories will usually be gathered within consultations which are of necessity brief and focused. Wider aspects of the consultation are considered in the separate article Consultation Analysis.

It is intended that this account should inform about history taking and provide a framework and some important general points as well as some examples of more detailed, focused elements of history taking. However, it is understood that a comprehensive history may not be either achievable or appropriate when children or their parents consult with doctors.

See also separate article Paediatric Examination.

Taking a paediatric history

General points

- If the child or family does not speak your language, try to find an interpreter, or arrange one for a subsequent consultation, to clarify what has been discussed.¹, ²
- Specific skills and techniques need to be employed to take a good history of a child's illness.
  - In very young children who have no speech, or limited speech, you must take the history through the parent or parents and learn to interpret it. Consider:
    - The younger the child, the more reliant one is on their account.
    - A parent may be extremely anxious, tired or both. This can impair communication between doctor and parent.³
    - An empathetic approach is likely to improve communication and hence the history and accuracy of diagnosis.
  - With teenagers, it may be difficult to give appropriate autonomy without offending the parent(s). With older teenagers it may be necessary to invite the parent(s) to leave so that further history can be taken, or to achieve privacy by using the opportunity of the examination to separate the teenager from a parent or guardian. An experienced chaperone or practice nurse may also be used as a 'foil' to achieve privacy for the patient.
  - When dealing with older children and issues of confidentiality, if you are unsure of the legal and ethical implications of confidential medical information, seek the advice of a medico-legal advisor or consult General Medical Council (GMC) guidance on the subject.⁴ It may be appropriate to discuss difficulties with a medical indemnity or defence organisation.

- Unfortunately, some parents or carers very occasionally may not have a child's best interests at heart. They may attempt to conceal facts and keep secrets. In such a situation it is important to remember that your overriding duty is to the child. It can be very difficult to reach a conclusion about such matters without multidisciplinary or expert support.⁵ Where child protection issues are important:
  - Seek medico-legal advice from your medical indemnifier.
  - Consider current and relevant guidelines.⁶
  - Access local child protection teams for support and advice on procedure.
Privacy, dignity and confidentiality. Often difficult in busy paediatric wards or general practice/child health surgeries, where physical space is at a premium. During an average stay in hospital most patients and their relatives will overhear confidential exchanges, and only a few will ever recall being offered a room/screen to preserve privacy during history/examinations. Try to avoid such pitfalls and put yourself in the place of the child/parent(s) before taking histories/conducting examinations or discussing private/confidential information.

Aims of the paediatric history

The suggested aims of the paediatric history are to:

- Direct appropriate examination and investigation.
- Reach a correct diagnosis (or form a differential diagnosis).
- Establish the context of a child's illness (psychological, family and social context).
- Establish and maintain a good relationship with the child and parent(s). This helps child and parent(s) to accord with the advice given by the healthcare professional, especially where it might conflict with their own expectations or beliefs.
- Use the interaction with the child/parent(s) as part of the therapeutic process.
- Use the understanding and knowledge of context and background to tailor pragmatic, appropriate treatment strategies.
- Take an overview of the child's previous and current state of health to anticipate or identify any problems which may not be immediately apparent.

Presenting complaints

- Record the child's and parents' own words as faithfully as possible, using direct quotations if relevant.
- Where there are multiple symptoms set each one out separately with space to document the features of how it developed and the relationships between the symptoms.

Current illness

What to ask about the current illness

- When and how did it start?
- Was the child well before?
- Have there been any previous episodes of similar illness?
- How did it develop?
- What aggravates or relieves the symptom(s)?
- Any contact with similar illness in others/siblings, or infectious outbreaks?
- Any recent overseas travel?
- How has the illness affected the family?
- Have the symptoms kept the child from attending nursery/school?

In infants

- Pattern of feeding, bowel movements, and number and wetness of nappies.
- Sleeping/waking cycle, alertness and activity.
- Whether there has been weight loss or gain.

Further directed questioning

Having established these facts:

- Form hypotheses about the possible diagnoses/problem.
- Test the hypothesis with appropriate further enquiry.

Past history

Peri-conceptual history

- Establish whether there was any parental illness around the time of conception that may be relevant.
- Note whether the child was conceived naturally or by assisted reproduction.
- If relevant, establish whether the child is adopted (or in foster care) with due sensitivity to the child's awareness of the facts.
History of pregnancy
Any factors relevant to fetal well-being should be recorded. For example:

- Antenatal infections (for example, rubella).
- Rhesus incompatibility and haemolytic disease.
- Exposure to prescribed, recreational drugs or over-the-counter (OTC) medication.
- Any maternal illness or problems in pregnancy.

Perinatal history
Factors pertinent to the child’s health should be identified. For example:

- Gestation.
- Duration of labour.
- Mode of delivery.
- Birth weight.
- Resuscitation required.
- Birth injury.
- Congenital malformations identified.

Neonatal period
Relevant examples include:

- Jaundice.
- Fits.
- Febrile illnesses.
- Bleeding disorders.
- Feeding problems.

Other relevant past history
This will include:

- Any subsequent illnesses, surgery, accidents or trauma.
- Results and any concerns from screening tests at child health clinics or school.
- Immunisation record.
- Travel details.

Developmental history

- Parental recall of major milestones will usually give important information (such as sitting up, crawling, walking, talking, toilet training, reading).
- It may be useful to ask how the child’s progress and milestones compare with siblings and peers.
- Observations from other carers (school, nursery and extended family) may be helpful.
- See ‘Further reading & references’, below for a useful article on assessment of development.

Current medication

- Prescribed medication.
- OTC medication.
- Recreational drug or solvent use - in teenagers such information is much more likely to be forthcoming if the patient is seen alone and reassured that confidentiality will be maintained.
- Complementary formulations.

It is worth remembering that a parent’s memory of medication may not be accurate. Corroboration may need to be sought. Pharmacists, GP computerised practice records and health visitors may be useful sources of additional information.

Drug intolerances, adverse drug reactions and allergies
It is important to enquire further about any allergy. Minor adverse reactions can often be labelled inappropriately as allergies.
Family history

- Relevant history. For example:
  - Previous miscarriages or stillbirths
  - Diabetes mellitus
  - Hypertension
  - Renal disease
  - Seizures
  - Jaundice
  - Congenital malformations
  - Infections such as tuberculosis

- Note whether siblings and parents are all alive and well.
- Consider conditions which may have a genetic component (such as ischaemic heart disease and cerebrovascular disease). Occasionally it is appropriate to address risk factors (such as familial hypercholesterolaemia) during childhood.
- Consanguinity occurs more commonly in some cultures and may be relevant to inherited disease (particularly autosomal recessive conditions).
- It can be useful to present findings by using a two-generation family tree.

Social history

This is separate from family history but allied to it.

- Take care not to offend, when enquiring about the structure of the family unit, by making assumptions about who may or may not be present or 'involved'.
- Be prepared to allow information to come out gradually. Information may come from others (for example, nursing staff, play specialists, educationalists). Ask about:
  - Who lives at home (and any role in childcare)
  - Siblings (ages, health, problems)
  - Play
  - Eating and sleeping patterns
  - Schooling and any problems
  - Pets
  - Housing issues or problems
  - Childcare (if a parent works or both parents work)
  - Parental occupation(s)
  - Smoking in the home

- Child abuse is a common problem. Child abuse comes in many guises and harm is inflicted in many different ways. Any such concerns may emerge from the social and family history and any concerns should be shared with colleagues and Social Services.

Educational history

It may be appropriate to ask specific questions about a child's experience and attainments at school. This may include, for example, asking about ability to concentrate and to make progress with learning in reading, spelling and mathematics. Any fear or anxiety about school should be explored. Bullying is common and can interfere with learning. Reports from teachers can be enlightening and supplement the history.

Emotional history

Specific questions may be asked about mood, eating and sleeping habits, interests, hobbies and other activities. Life events and emotionally disturbing events can have a major effect on well-being and general development.

Systems review

- Consider further information about other organ systems.
- Ask questions pertinent to the diagnostic hypothesis and the age of the child.
- Consider general issues, particularly psychological factors which may have been overlooked.
Summarising

- At the end of the history-taking discussion it helps doctor and parent(s) to summarise understanding (including diagnosis, problems and any psychological factors).
- It is important to give the child and the parent(s) an opportunity to reveal omitted details and to ask questions.

Further reading & references

1. Das A; Medical Interpreters. BMJ Careers. 2009 June 17
2. Language interpretation (guidance on use of interpreters); Public Health England
4. 0-18 years guidance: Principles of confidentiality 0-18; General Medical Council
6. Protecting children and young people: The responsibilities of all doctors; General Medical Council

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