Pediatric Health History

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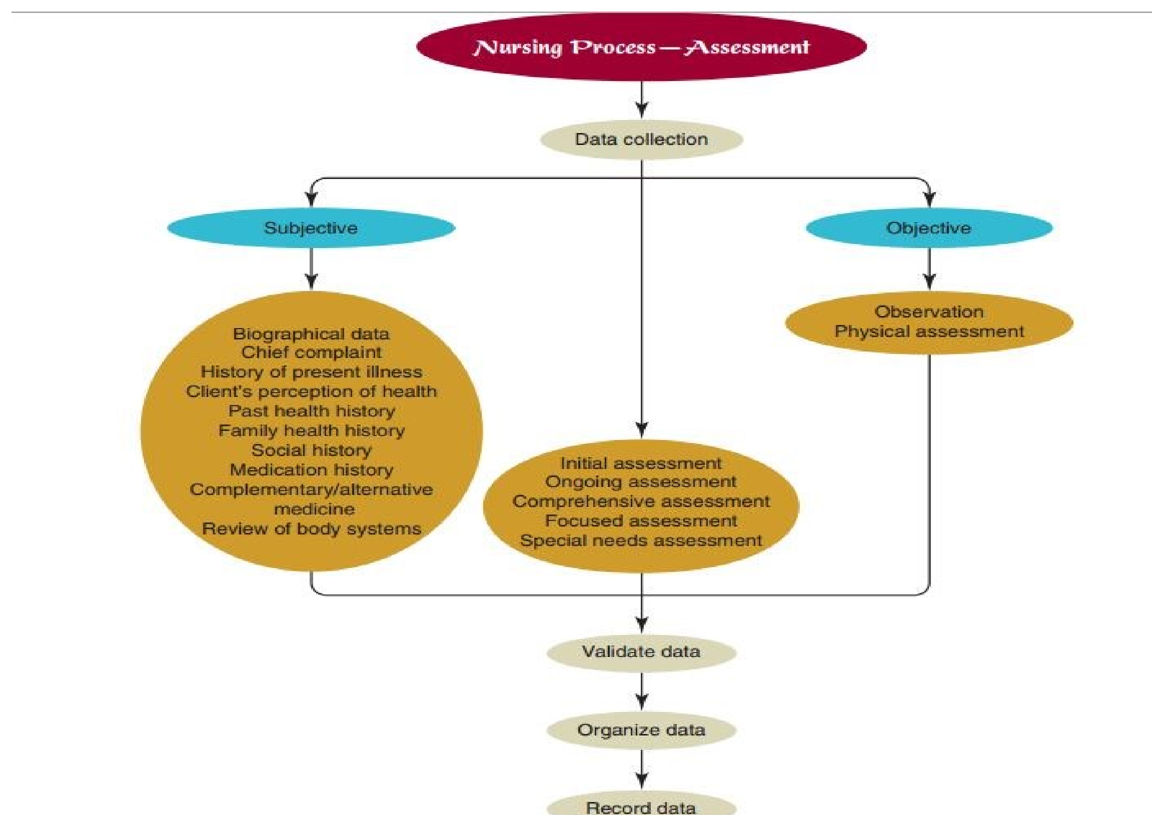
Objective

1. Define health history
2. Numerate and describe types of Pediatric Health Histories
3. Differentiate between objective and subjective data.
4. Describe Methods of Data Collection.
5. Identify How to Conduct a Pediatric History Interview.



The Health History

A health history is a collection of **subjective data** that provides a detailed profile of the patient's health status. Nurses use therapeutic communication skills and interviewing techniques during the health history to establish an effective nurse–patient relationship and to gather data to identify actual and potential health problems.

Types of Pediatric Health Histories (Chiocca, 2015)

1. **Initial (comprehensive) health history:**

   An initial health care visit requires a **comprehensive health history**, which creates a database of information for the child who is new to the provider's practice. The data collected in this history focus not just on past or current illnesses, but also on wellness, health patterns, health knowledge, and activities of daily living (ADL). The content of this history creates a baseline against which all future changes in the child's health status are measured.

2. **Interval (well-child) health history:**

   Subsequent well-child visits require an interval history; that is, a history that updates the patient's health status since the last office visit.

3. **Focused (episodic) health history:**

   This history is problem-centered, focusing on the present illness or problem. A focused health history is all that is necessary when the child presents with an acute problem or the exacerbation of a chronic condition.

4. **Follow-up health history:**

   When the child returns to the office after an illness or injury, a follow-up history is taken to assess whether the problem is the same, better, or worse.

5. **Emergency health history:**

   An emergency health history involves the quick collection of data in an acute situation. While this history resembles a focused history, it needs to be obtained rapidly, usually simultaneously with interventions, such as the administration of medications or respiratory treatments.

DATA COLLECTION (Taylor, Lillis, LeMone, & Lynn, 2011)

Two Types Of Data: Subjective and Objective.

1. **Subjective data** are information perceived only by the affected person; these data cannot be perceived or verified by another person. Examples of subjective data are feeling nervous, nauseated, or chilly and experiencing pain. Subjective data also are called **symptoms or covert data**.
2. **Objective data** are observable and measurable data that can be seen, heard, or felt by someone other than the person experiencing them. Objective data

observed by one person can be verified by another person observing the same patient. Examples of objective data are an elevated temperature reading (e.g., 101F), skin that is moist, and refusal to look at or eat food. Objective data also are called **signs** or **overt data**.

Methods of Data Collection

1-Observation is the conscious and deliberate use of the five senses to gather data (objective data).

2-Patient interview the nurse obtains a nursing history by interviewing the patient. (An **interview** is a planned communication)

3-Physical assessment (or *physical examination*) produces primarily **objective data** and makes use of the techniques of inspection (visual examination), palpation (touch), percussion (tapping a body surface), direct auscultation (listening with the unaided ear), and indirect auscultation (listening with a stethoscope).

How to Conduct a Pediatric History Interview (Chiocca, 2015)

Obtaining an accurate and complete pediatric health history is essential when providing health care to children. The pediatric health care provider must possess excellent **communication skills** when working with children and families in order to elicit the most accurate and complete health history while maintaining provider–patient trust.

Infants and Young Children

• For **infants** and preverbal children, the **primary source** of historical information is the parent or primary caregiver.

For older infants and **toddlers,** it is important that the parent remain within eyesight of the child to minimize stranger anxiety. Parents can then concentrate on answering questions rather than tending to a crying child.

Some **preschoolers** can answer questions during the history, depending on their language abilities, developmental level, and temperament. These questions may involve play, toys, likes, dislikes, friends, and school.

Young children who are very shy should not be forced to participate in the interview, and children should not be overwhelmed with too many questions. The health care provider should remember to use simple terms and avoid medical jargon.

School-Aged Children and Adolescents

• Children who are **school-aged and older** can provide their own health history with verification from the parent or caregiver as needed. Beginning the encounter with the parent in the room is important to make the child feel comfortable and secure.

Older school-aged children and adolescents have a heightened need for privacy. For this reason, the parent should be asked to leave the room for certain portions of the history, such as questions that deal with drug or alcohol use, sexual activity, depression, and risk-taking behaviors. The **preteen or adolescent** is more likely to give accurate answers without the parent present.

BOX 4-4 OUTLINE OF A PEDIATRIC HEALTH HISTORY

Identifying information

1. Name
2. Address
3. Telephone
4. Birth date and place
5. Race or ethnic group
6. Sex
7. Religion
8. Date of interview
9. Informant

Chief complaint (CC)—To establish the major specific reason for the child's and parents' seeking professional health attention

Present illness (PI)—To obtain all details related to the chief complaint

Past history (PH)—To elicit a profile of the child's previous illnesses, injuries, or operations

1. Birth history (pregnancy, labor and delivery, perinatal history)
2. Previous illnesses, injuries, or operations
3. Allergies
4. Current medications
5. Immunizations
6. Growth and development
7. Habits

Review of systems (ROS)—To elicit information concerning any potential health problem

1. General
2. Integument
3. Head
4. Eyes
5. Ears
6. Nose
7. Mouth
8. Throat
9. Neck
10. Chest
11. Respiratory
12. Cardiovascular
13. Gastrointestinal
14. Genitourinary
15. Gynecologic
16. Musculoskeletal
17. Neurologic
18. Endocrine

Family medical history—To identify genetic traits or diseases that have familial tendencies and to assess exposure to a communicable disease in a family member and family habits that may affect the child's health, such as smoking and chemical use

Psychosocial history—To elicit information about the child's self-concept

Sexual history—To elicit information concerning the child's sexual concerns or activities and any pertinent data regarding adults' sexual activity that influences the child

Family history—To develop an understanding of the child as an individual and as a member of a family and a community

1. Family composition
2. Home and community environment
3. Occupation and education of family members
4. Cultural and religious traditions
5. Family function and relationships

Nutritional assessment—To elicit information on the adequacy of the child's nutritional intake and needs

1. Dietary intake
2. Clinical examination

Review of systems:

General

Overall state of health; recent weight loss or gain (compare to growth charts); obesity; delays in physical, psychosocial, or language development; fatigue; weakness; malaise; difficulty performing activities of daily living; or chronic pain.

Integument

General skin texture, birthmarks, or pigmentation; skin color changes (jaundice, cyanosis, mottling, pallor, bruising, or petechiae); rashes or lesions (location and description); excessive skin dryness; pruritus; hives; atopic dermatitis; contact dermatitis; seborrhea; acne; changes in moles; changes in body hair (excessive hair growth or loss or hair color change); nail disorders; or pediculosis.

Head

Head size and shape (including fontanels), microcephaly, macrocephaly, head injuries, headaches, or dizziness.

Eyes

Visual problems (blurred vision, double vision, bumping into objects, sitting very close to the television or computer screen, inability to see blackboard, holding book very close to face, squinting, rubbing eyes, photophobia, use of glasses or contact lenses), date of last eye exam and results, strabismus, dizziness, eye drainage or infections, excessive tearing, or eyelid edema.

Ears

Ear infections (e.g., otitis media, otitis externa), ear pain, ear drainage, surgery (e.g., myringotomy with tympanostomy tubes), delayed speech, evidence of hearing loss, date of last hearing exam and result, or tinnitus

Nose

Frequent rhinorrhea, upper respiratory infections, sinusitis, allergic rhinitis, stuffy nose, nasal congestion, allergies, mouth breathing, snoring, obstructive sleep apnea, epistaxis, allergic salute, allergic crease, dark circles under eyes, or altered sense of smell

Mouth/throat

Pattern of tooth eruption or loss, number of teeth, teething (infants), dental care, use of fluoride, dental caries, age of first dental visit, date of last visit to dentist, frequency of dental visits, tooth pain, history of dental trauma, sores in mouth or tongue, history of oral candida infections, gum bleeding, mouth breathing, tonsillar enlargement or infections, history of tonsillectomy, postnasal drip, cleft lip or palate, sore throats, streptococcal infections, difficulty chewing or swallowing, hoarseness, or voice and cry irregularity.

Chest

Pain, newborn breast enlargement, male gynecomastia, breast lesions, discharge, or enlarged

Neck

Limitation of movement, pain, stiffness, torticollis, thyroid enlargement, or lymphadenopathy axillary nodes

Lymphatics

Frequent infections, fevers, pain, and swelling, tenderness of any lymph nodes, hepatosplenomegaly, chills, night sweats, or pallor.

Respiratory

Frequent respiratory infections, dyspnea (shortness of breath), apnea, stridor, croup, pneumonia, cystic fibrosis, asthma, wheezing, chronic cough, sputum production, reduced exercise tolerance, dyspnea at rest or on exertion, cyanosis, or tuberculosis; date of last chest radiograph and skin reaction from tuberculosis skin testing; or history of smoking or secondhand smoke exposure.

Cardiovascular

Murmurs, congenital heart defects, poor infant feeding, slow or decreased weight gain, chest pain, cyanosis, tachypnea, tachycardia, hypertension, edema, cold extremities, dizziness, palpitations, fainting spells, exercise intolerance, dyspnea on exertion, fatigue, diaphoresis, rheumatic fever, anemia, or recent blood transfusion

Gastrointestinal

Appetite, food intolerances, dietary history, abdominal pain, ulcers, nausea, vomiting, reflux, recent changes in bowel patterns, gastrointestinal infections, diarrhea, belching, flatulence, constipation, type and frequency of stools, use of laxatives, blood in stools, jaundice, anal itching, fissures, or pinworms

Genitourinary

Dysuria, frequency, urgency, burning, hesitancy, enuresis, urinary tract infections, discharge, polyuria, oliguria, hematuria, character of stream, or flank pain; history of epispadias or hypospadias and date of surgery; history of cryptorchidism (include age of child and if orchiopexy performed, include date of surgery); hernia, hydrocele, swelling of scrotum when crying, performance of testicular self-exam in adolescent males, sexually transmitted infections, or sexual activity.

Gynecologic

Age of menarche, date of last menstrual period, length of menses, frequency of cycle, dysmenorrhea, history of heavy menstrual bleeding, vaginal discharge, abnormal vaginal bleeding, sexual activity, type of contraception, date of last Pap smear, or obstetric history, if applicable

Musculoskeletal

Usual activity level, history of weakness, clumsiness, ataxia, lack of coordination, unusual movements, joint or muscle pain, cramps or inflammation; swelling, sprains, fractures, mobility problems, back or joint stiffness, abnormal gait, limps, or spinal curvatures

Neurologic

General affect and mood, ataxia, tremors, tics, dizziness, syncope, tingling, sensory changes, paresthesia, unusual movements, seizures, loss of consciousness, memory loss, headaches, aphasia or other speech problems, fears, nightmares, or unusual habits

Endocrine

Disturbances in growth, polyuria, polyphagia, polydipsia, thyroid disease, obesity, type 1 or 2 diabetes, excessive sweating, salty taste to skin, intolerance to temperature changes, signs of early or delayed puberty, or abnormal hair distribution.

Hematologic

Anemia, pallor, lymphadenopathy, bleeding disorders, bruising, petechiae, bleeding gums, blood transfusions, toxic drug exposure, radiation, or chemotherapy

Psychosocial development

Developmental delays, behavior changes, tantrums, breath-holding spells, bedwetting, school failure, social withdrawal, irritability, sleep pattern disturbances, depression, substance abuse, eating disorders, or psychiatric disorders. (Hockenberry & Wilson, 2015)

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