MEDICAL UNIVERSITY - PLEVEN
FACULTY OF MEDICINE

Department of pediatrics

Lecture № 1

Making Diagnosis in Pediatrics

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Pediatric History & Physical Examination

MAKING THE DIAGNOSIS IN PEDIATRICS

DIAGNOSTIC PROCESS

1. Taking the history of illness
2. Performing physical examination
3. Making pathologic syndromes
4. Making primary diagnosis
5. Differential diagnosis
6. Laboratory (laboratory and technical procedures)
7. Results of the illness duration and treatment
8. Final diagnosis
9. Writing Discharge summary

HISTORY OF ILLNESS

INTRODUCTION

- Specific features and rules in Pediatrics
- Aim – history to be complete and true
- The physician has to:
  - have ability to obtain every detail diplomatically
  - have ability to listen well when the parents tell their story
  - establish a friendly relationship with the child (words and toys)
  - show selfconfidence, introduce himself, keep his voice low
  - permit the child to sit in the mother's lap or to stand close to her side
  - look at the child from time to time (in this way he may learn much about the illness)
  - give an opportunities to parents to ask their questions

HISTORY OF ILLNESS

DISADVANTAGES

- Small children cannot describe their symptoms accurately
- There is negative attitude toward disease and possible hospitalization
- Some parents are uncooperative
- Few mothers can give an intelligent history

PEDIATRIC HISTORY

The details include information concerning:

1. **Personal data:**

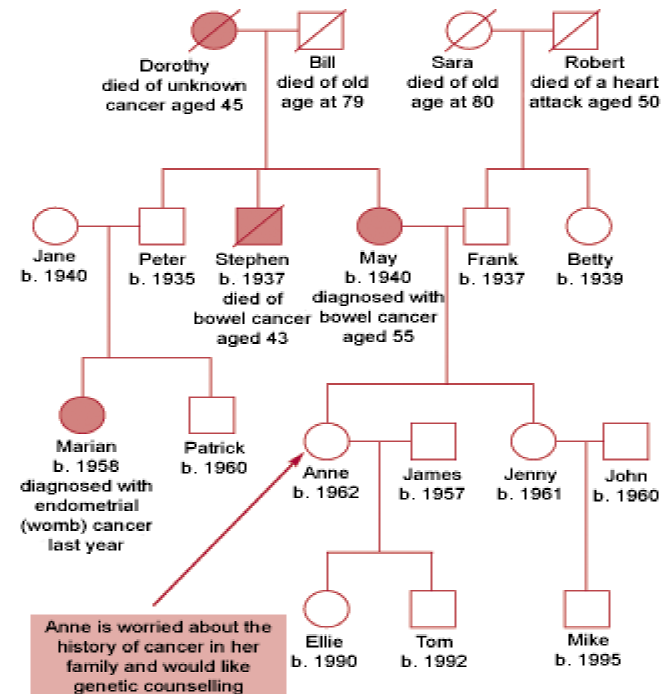
- Name of the child
- Address
- Age (date of birth)
- Parents (name, age, occupation)

2. History of present illness:

- When did the problem start? Duration?
- What is the first symptom?
- Other consequent symptoms and their chronology
- The chief complaint (the trouble symptom should be describe by parent's own words)
- Definition of the affected system in the body
- Review of systems – are there any symptoms related to head, eyes, lungs, heart, gastrointestinal system, genitourinary system, extremities, neurological system, skin (only important negatives)
- Information about sign of infection (fever)
- Definition – Acute or chronic process?
- Definition of the background of illness (normal or pathologic)

3. Family history

- Illness in: mother, father and siblings – seizures, asthma, allergies, CVD, cancer, metabolic diseases (diabetes, lipid disorders)
- Relatives – hereditary diseases, early death in the family (siblings, cousins)



4. Medical history (child development)

- Prenatal history – pregnancy, exposure to illness
- Birth history – birth weight and length, delivery (forceps, operation), duration of labor
- Neonatal history – jaundice, cyanosis, respiratory problems, seizures, metabolic disorders
- Growth and development – body weight and length, mental development, puberty, behavioral history (sleeping and eating habits)

- Diet and feeding history – breast milk, formulas, solid foods, cow's milk
- Immunizations and allergic diseases – tuberculosis, hepatitis B, diphtheria, tetanus, whooping cough, poliomyelitis, measles, rubella, mumps
- Prophylaxis of Rickets

5. Past medical history

- Frequency of infections
- Residual defects
- Previous operations
- Previous hospitalizations

6. Social history

- Marital status of the parents (single parent)
- Employment status
- Income of the family
- Hygiene in the house
- Health insurance status

7. Epidemical history

- Exposure to tuberculosis
- Contact with others who are ill