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CHAPTER 1

MEDICAL HISTORY

The history should be a detailed, clear and chronologic record of all the relevant information. In many cases the interview is the first stage in the psychotherapeutic management of the family. It is important to introduce oneself and recognize the importance aspects influencing doctor-patient communication.
A complete database entails the following:

Background and Information

Particulars in connection with the patient's name and address are supplied by the parent(s) and noted by the administrative officer.

1. Patient	• Name and surname • Age, date of birth • First name • Sex • Church affiliation, religion
2. Parents	• Name and surname • Address • Telephone numbers at home and work and cell phone numbers
3. Informant	• Name and relation to patient • If the informant is not the mother, reason?
4. Doctor who referred patient	• Family physician if patient is not a referral • Address
5.Place of consultation	• Consulting rooms • Outpatient department • Casualty department • Ward
6. Date and Time of consultation	

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Main complaint

The course of the main complaint must be documented in chronological order. If possible write down the information offered by the informant or patient in his/her own words. If the parent says the child is short of breath or finds it difficult to breathe, do not decide to write “dyspnoea”. Date the commencement of symptoms precisely and completely, e.g. started to cough on 3 March 2008 – that is 5 days ago.

The following information must be obtained if applicable

- Health status immediately prior to present illness.
- How long ago was the patient completely well?
- Disease course, sequence and period separating new symptoms.
- Factors aggravating or relieving symptoms.
- Treatment received and duration.
- Possible exposure to infectious diseases or recent travel or visits (e.g. to low-veld = malaria).
- Relevant negative data obtained by direct questioning (e.g. no visits to possible malaria areas).

What do the parents think about the present problem and what are their expectations?

If the symptoms occur in clusters or attacks – a typical attack should be described with regard to frequency, duration and degree of symptoms.
Further questioning depends on the age of the patient and the diagnostic possibilities as indicated by the history.

Previous history

The detail is problem and age dependant

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1. Antenatal	• Age of mother • Gravity, parity, abortions, perinatal deaths • Birth weight and health of previous infants • Planned or unplanned pregnancy • Gestational age of present pregnancy • Mother's medical health during pregnancy • Complications of pregnancy, e.g. eclampcia • Results of RPR. Treatment if syphilis was diagnosed. • HIV status and CD_4 count if HIV positive • Antiretroviral prophylaxis or treatment detail • Blood group of mother • Foetal growth and wellbeing • Exposure to medicines, smoking, alcohol
2. Labour and delivery	• Date • Place • Spontaneous or induction of labour. • Duration of labour • Method of delivery • Signs of foetal distress • Problems during labour and delivery • Medicine given to mother
3. Infant at delivery	• Apgar score • Detail if the infant needed resuscitation. • Birth weight, head circumference • Estimated gestational age • Vit K and medicine given to baby • Congenital abnormalities

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4. Neonatal period	• Diseases • Feeding problems • Breathing problems • Convulsions • Anaemia • Cyanosis • Haemorrhages • Skin rash • Jaundice
5. How long was the baby in hospital	• Why
6. Nutritional history	• The detail is problem and age dependant
7. Baby	• Breast feeding • Formula feed - volume, frequency, type, preparation, dilution, change of formula • Weaning age • Supplements, vitamins, iron, fluoride • Solid foods
8.Feeding problems	• A 24 hour dietary history is useful • When did the problem begin and how long did it last? • Type of feed • Allergy • Food intolerance • Change in mass • Appetite

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Growth and development

Document the mass, length and skull circumference. Use the "Road to Health Card" to judge physical growth. Questions about the developmental history must be adapted to the specific age group. Unless there is obvious developmental delay, rather question an 8 year old child about his/her school performance. The specific questions to determine milestone development are discussed in Chapter 5.

Immunization

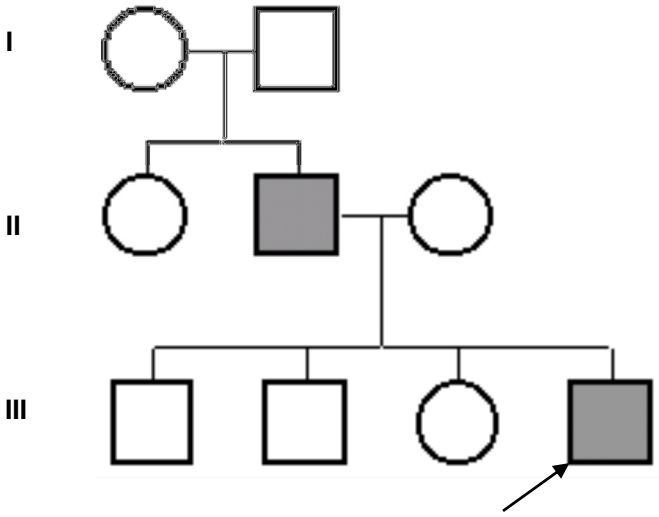
Documentation of immunization must be obtained from the "Road to Health Card". Also utilize the opportunity to give advice if immunization was incomplete. Note abnormal reactions after immunization.

Previous diseases

Information with regard to serious diseases, hospitalizations, injury, accidents or surgical procedures should be written down.

Family history

A pedigree is a diagram of family relationships that uses symbols to represent people and lines to represent genetic relationships. These diagrams make it easier to visualize relationships within families, particularly large extended families. Pedigrees are often used to determine the mode of inheritance (dominant, recessive, etc.) of genetic diseases. A sample pedigree is below.



Symbols

□	Healthy male	□–○	Married
○	Healthy female	□‖○	Divorced

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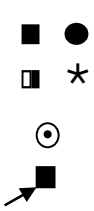
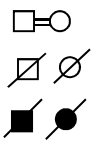


Affected male/female

Carrier male/female

Heterozygote (X-linked)

Index case



Consanguineous marriage

Deceased

Deceased (and affected)

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Social history

Every child functions in a specific social environment. The following questionnaire screens for psycho-social problems:

- Occupation of parents
- Employment history of parents
- Long parental absences from home?
- Housing and movement
- Financial problems
- Support systems; family, friends
- Psychiatric diseases
- Marital state and stability
- Substance abuse
- Family violence
- Recreation as a family
- Traumatic family episodes, deaths, divorce or accidents.

The aspects listed above are frequently sensitive, thus indirect questioning is used, observing family interaction and "body language". A question like, "what do you as a family do for recreation and leisure," can provide paramount information about interpersonal relationships within the family.

Systematic questioning

(Also see each specific system for detail).

1. General	• Increase or loss of mass. Tiredness, skin colour, skin temperature, mental state, hydration
2. Eyes	• Vision, glasses, infection, strabismus
3. Ears	• Hearing, pain, infections
4. Nose	• Obstruction, snoring, sinusitis, colds, runny nose, epistaxis, sneezing
5. Mouth	• Carious teeth, stomatitis
6. Throat	• Sore throat, tonsillitis, adenitis
7. Nervous system and muscles	• Headache, mental state, seizures, tremors, paralysis, ataxia, weakness, gait, co-ordination, dizziness, muscle and joint pains, postural deformity
8. Skeleton and joints	• Pain, swelling, fractures, gait, loss of function
9. Respiratory	• Coughing, shortness of breath, stridor, cyanosis, sputum, haemoptysis, asthma, bronchitis,

	pneumonia, foreign body, wheezing, clubbing, precipitating factors – e.g. exercise, dust, animals
10. Cardiovascular	• Shortness of breath, tires with feeds, excessive sweating (in infants=sign of CCF), limitation of exercise, oedema, cyanosis • chest pain, palpitations, fainting spells, clubbing
11. Haemopoietic	• Pallor, tiredness, shortness of breath, bleeding tendency, bruising, enlarged glands, spleen

System

1. Alimentary system	Appetite, loss of weight, vomiting (amount, character, projectile). Constipation, diarrhoea, stools (amount, frequency, odour, colour, consistency, mucus, blood), pain, thirst
2. Genito-urinary	Frequency, pain, character of stream, urine (colour, quantity, odour), enuresis, menstruation, vaginal discharge
3. Skin	Rash, pruritus, pigmentation, eczema
4. Endocrine	Growth, requirement for new shoes and clothing, headache, abnormal thirst, polyuria, apathy, vision, skin (temperature, dryness, yellow colour), hoarse voice
5. Genitalia/Puberty	Testes, muscularity, voice, breasts, menstruation, growth, pubic hair

Problem orientated recording and accounting

Much of the basic information needs to be documented once only. It should be complete, correct and legible. With readmissions, only updating should be necessary.

Problem–orientated strategies focus on the patient as a whole – the child as well as the family. Problems should be carefully identified and written down and the doctor must pay attention to all of them. Such information is extremely helpful and valuable to other doctors and will prevent repetition of expensive special investigations, as well as being of the utmost importance in medico-legal cases.

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The problem orientated recording system consists of:

1. Database
   - History
   - Clinical findings
2. Problem List
   - Record findings/facts
   - Active problems necessitating a plan of action
   - Non-active problems, forming part of the patient's history, which could influence treatment
3. Plan of action
   - **Evaluation**
   - Diagnosis or differential diagnosis
   - Level (degree) of seriousness
   - **Diagnostic information**
   - Special investigations
   - **Treatment plan**
   - Medical
   - Surgical
   - Paramedical
4. **Monitoring**
   - Disease course
   - Side effects (drugs, treatment)
   - Follow-up notes
5. **Communication**
   - Parents and/or patient

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Referral Letters and Summaries

Good communication is of prime importance for the sustained care of the child. It should contain all the essential information but must be concise and to the point.

The following sub-division is handy:

1. Child
   - Full name
   - Date of birth
   - Sex
2. Hospitalization
   - Admission date
   - Discharge date
   - Admission and discharge weight
   - Hospital number
3. Caretaker
   - Name
   - Address
   - Telephone numbers
   - Relation to patient
4. Problems
   - Chronological history
   - Physical examination
   - Diagnosis
   - Findings
5. Relevant additional information
   - Developmental level
   - Allergies
6. Management
   - Treatment
   - Present medication and dosages
7. Information
   - Information forwarded to parents
   - Follow-up instructions

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8.	Doctor	• Name • Address • Telephone number • Official capacity • Date

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