Paediatric History

OPENING THE CONSULTATION		
1	Introduces themselves	
2	Confirms patient's details	
3	Establishes presenting complaint using open questioning	
HISTORY OF PRESENTING COMPLAINT		
4	Onset / Duration	
5	Severity	
6	Intermittent / Continuous	
7	Exacerbating / Relieving factors	
8	Associated symptoms	
9	Ideas / Concerns / Expectations	
KEY SYMPTOMS		
10	Feeding / Oral intake - *food / fluids*	
11	Vomiting	
12	Fever	
13	Wet nappies / Urine output	
14	Stools - *consistency / frequency*	
15	Rash	
16	Cough	
17	Rhinorrhoea	
18	Behavioural changes	
19	Weight change - *loss vs gain*	
20	Sleeping pattern	
PAST MEDICAL HISTORY		
21	Diet	
22	Occupation	
23	Relationships	
24	Alcohol related crime	
DEVELOPMENTAL HISTORY		
36	Current height and weight	
26	Developmental milestones	

IMMUNISATION HISTORY		
27	Confirms child is up to date with their immunsations	
DRUG HISTORY		
28	Prescribed medication	
29	Over the counter medication	
30	ALLERGIES	
FAMILY HISTORY		
31	Diseases in first degree relatives	
SOCIAL HISTORY		
32	Home situation	
33	Parental details (*primary carer / occupation)*	p
34	Second hand smoke exposure	
35	Schooling	
SYSTEMIC ENQUIRY		
36	Screens for symptoms in other body systems	
CLOSING THE CONSULTATION		
37	Thanks patient	
38	Summarises salient points of the history	
KEY COMMUNICATION SKILLS		
39	Active listening	
40	Summarising	
41	Signposting	