

Writer: Nikolas Desilet

Editor: Dianna Louie, MD

Pediatric Gastrointestinal History Taking

Principles

- Use your judgement when asking questions. The child should feel involved, but the parents may have more objective or detailed observations.
- Ensure the environment is comfortable and allows the child to be occupied while you gather information.
- Determine the reliability of the child or parent. Would a different caregiver be more suitable for detailed day-to-day questions?
- Confidentiality is important in all patient interactions. In particular, older children and adolescents should have a good understanding of the confidentiality of their medical interview and examination.
- Document a complete growth record, dietary information, and patterns of feeding and bowel movements in addition to obtaining the presenting complaint and history of presenting illness. If appropriate, start with history from birth.
- Throughout the interview, ensure that information obtained is relevant to the presenting complaint and if the child's/parent's needs are being met. Is there another reason they are visiting the doctor today?

Biographical Information

- Name/preferred name, date of birth, sex, ethnicity, contact information for parent or guardian, living situation and home environment.

Presenting Complaint

- A brief description by the patient or parent of the complaint(s) bringing the child to see the doctor.
- Is it the child's complaint or is it the caregiver's or a teacher's?

History of Present Illness

- Timing of the problem: onset, frequency, time of day, and duration. Is it ongoing? Has it happened before? If so, characterize.
- Pinpoint location of the symptoms or pain as much as possible, and ask about position, quality, radiation, and severity.
- Aggravating and alleviating factors: “does anything seem to make it better or make it worse?” Is the pain better with food or worsened with consumption of food? Bowel movements? School avoidance?
- Associated symptoms: ask about vomiting, character of vomitus, colour of vomitus (bilious? bloody?), regurgitation, heartburn, abdominal pain or discomfort, abdominal distension, bowel movement patterns, stool character and colour (red, black, brown, steatorrhea/fatty), fever, systemic symptoms. Are any symptoms associated with eating or bowel movements?
- Use the FIFE acronym: ask about Feelings, Impressions, Function, and Expectations. How do the symptoms affect the child and the family? What does the child or parent think is causing the symptoms? How have the symptoms affected the child’s appetite, sleeping patterns, or ability to play? What would you like to get out of the visit today?

Past Medical History

- Antenatal History: health of mother during pregnancy (ask about medications, vitamins, diet, alcohol use, tobacco use, illnesses, stresses, vomiting, complications (for example, polyhydramnios, toxemia, gestational diabetes, hypertension, or eclampsia), Rh serology, radiation exposure, bleeding); mother’s previous pregnancy history.
- Prenatal History: timeline of prenatal care, onset of fetal movement
- Birth History: duration of pregnancy, location and time of delivery, type of delivery (breach, cesarean section, vaginal), length of labor, amount/type of anesthetics or analgesics used.
- Peri- and Postnatal History: APGAR score, onset of crying, first breath, breathing problems, birth weight, birth length, head circumference, presence of jaundice or cyanosis, presence of convulsions, fever, haemorrhage or birth injury, congenital

abnormalities, presence of meconium, feeding history, number of days in hospital, NICU admission, discharge weight, illness in first month of life.

- Screening procedures (types, such as sickle cell, G6PD, lead, HIV, genetic or metabolic screens, and results); immunizations (ages, types, presence of reactions, seasonal influenza).
- Infant nutrition: formula (type, concentration, amount with each feeding and within 24 hours, changes, duration, problems, burping, regurgitation); breast (frequency, length, problems, weaning – how were they weaned, and at what age), introduction to solid foods (when, how, what types, how were they taken, what was the reaction to the solid foods), following Canada Food Guide.
- Overfeeding can be a common problem for new breastfeeding mothers.
- Childhood nutrition: vitamin supplements (what types, when were they started, amount), appetite (likes and dislikes), eating habits, food variety, fruit and vegetable consumption, protein, “junk” food, food allergies (for example, cow milk protein).
- General childhood health
- Past illnesses: infections (type, quantity, severity, age), past hospitalizations (age, indication), past operations (age, indication), allergies (insulting agent; ask patient or parent to specify the reaction; if anaphylactic, ask if they carry an EpiPen).
- History of trauma. Is/was there any lasting sequelae?
- Developmental history: physical growth (height/weight growth charts – is or has the child been failing to thrive?), time of milestones (age when first held head up, rolled over, sat up alone, crawled, walked alone, said first word, toilet trained, dressed without help, tied shoes without help; compare milestones to siblings if applicable), dentition (age of first teeth, loss/eruption of teeth), development of secondary sexual characteristics (females – development of breasts, axillary hair, pubic hair, menarche; males – development of pubic hair, voice changes, emissions).
- Family history: age and health status of immediate family members, communicable disease history, genetic disease history, health status of living children.

Current Health Status

- Allergies (food, medications, environmental irritants, eczema, asthma, allergic rhinitis).
- Current medications: prescriptions (type, indication, dose, frequency), over-the-counter drugs (including antipyretics, cough and cold remedies, supplements), and alternative medications/herbal remedies.
- Environmental risks/exposures (for example, underprepared meals or contaminated drinking water).
- Safety measures (car seats, choking, falls, injury prevention, drowning, bicycle safety, seat belts, sexual practices, violence)
- Exercise (type, duration, frequency)
- Sleep: length of sleep at night, naps, and character of sleep. Does the child experience nightmares? Sleep-walk? Sleep-talk?
- Elimination: urination patterns (discomfort, blood, control).
- Personal habits: nail biting, thumbsucking, tobacco, alcohol, caffeine, drug use.
- Psychosocial history: infant/child-parental attachment, school (ability to function, strengths/weaknesses, special classes), home situation (marital status, type of home, parent occupations, principal caretaker), socioeconomic status of family, support systems, religious beliefs/preference, personality (anxiety, independence, relationship with peers and family, self-concept), stressors (parental, body image, substance use, work/school/home surroundings).

Review of Systems

- Serves to obtain additional symptoms or signs and to probe further systems related to the present illness.
- General/constitutional symptoms: unusual weight gain or loss, fatigue, temperature sensitivity, mentality, growth pattern (height/weight charts), timing of puberty.
- Skin: rashes (for example, eczema or diaper rashes), hair, skin texture, colour, hives.
- Eyes: vision, crossed eyes, foreign body, nystagmus, colour, glasses.
- Ears, nose, throat: sore throat, post-nasal drip, frequent infections, congestion,

ear infections, hearing, sneezing, snoring.

- Cardiorespiratory: chest pain, cyanosis, edema, syncope, tachycardia, dyspnea, coughing, wheezing, sputum, stridor, secretions, snoring, sleep apnea.
- Gastrointestinal: vomiting, abdominal pain, type of stool (diarrhea, constipation).
- Genitourinary: urinary patterns (dysuria, polyuria, enuresis, frequency), toilet training, urine character (hematuria, pyuria), discharge, menstrual history, abnormalities of genitalia, precocious puberty.
- Neuromuscular: headache, anxiety, dizziness, tingling, convulsions, seizures, problems with movement (eg. ataxia), muscle/joint pain, exercise tolerance, gait.
- Endocrine: liquid/solid food intake, growth disturbances.

References

Byrnes K. Conducting the pediatric health history: a guide. *Pediatric Nurs* 1996; 22(2):135-137.

Chen YA, Tran C. *The Toronto Notes*, 27th edition. 2011. Types & Graphics Inc, Toronto, ON.

Gallagher R. *Approach to the OSCE: The Edmonton Manual of Common Clinical Scenarios*, 2nd edition. 2011. University of Alberta Medical Student's Association, Edmonton, AB.