

PEDIATRIC HISTORY AND PHYSICAL EXAM TEMPLATE

Informant: Mother

Primary Care Physician: Dr. J. Alexander

Chief Complaint: 15 month Latino female presents for 15 month check-up.

History of Present Illness: Well-nourished, ambulatory child brought into clinic today for routine examination and scheduled immunizations. Child has had typical and expected age-appropriate findings to date: Well-Baby Visit (1 week)-dry, peeling skin; mother was instructed to keep moisturized; no other treatment needed. PKU repeated results negative. **Dx: Erythema toxicum neonatorium.** Child seen in office at 2 weeks for c/o constipation; treated with prune juice alternating with Karo Syrup; **Dx: Constipation.** Pt was seen for 2 month check-up in 08/ 2011; she was feeding well with all body systems wnl; 2 month immunizations received and tol well. Infant was seen in office at 2-1/2 months for c/o of vomiting and diarrhea x 6 days; she had good wt gain (12-7 oz) and tolerated feedings of Sim Advance 56ml q 2 hrs well. Pt was treated with Pedalyte and hydration; **Dx: 1. Vomiting, 2. Diarrhea, 3. Dehydration.** Infant was seen in office in October, 2011 for 4 month check-up; she continued to develop and feed well; 4 month immunizations received and tol well. Mother was taught how to introduce solid foods. Infant was seen in office in November (5-1/2 months) for c/o vomiting and loose sticky green stools. Mother had placed infant on Alimentum milk. Mother was educated to keep infant on Sim Advance and importance of checking with MD before changing formula. **Dx: 1. Formula Intolerance, 2. Vomiting.** Infant was seen in office 2 weeks later for c/o runny nose x 3 days, afebrile, alert and playful with good weight gain; treated with Bromfed-DM 1ml po bid, prn; home humidifier, Little Noses Saline Drops. Pt was seen in office 01/2012 for 6 month check-up; all body systems wnl, developmental milestones met; 6 month immunizations given and tol well. Pt received 1 year check-up in 07/2012. Mother states they had big birthday party with extended family present. Infant tries to walk and can speak and understand approx 8 words in English and Spanish. Formula changed to whole milk this visit; 1 year immunizations received and tol well. Pt returned to office on 09/10/12 with c/o runny nose with cough x 2 days; afebrile, lungs cta; treated with Zyrtec Children's-2ml po qd; Tylenol/Advil prn; family taught hand. **Dx: 1. Allergic Rhinitis, 2. Vomiting.** Patient presents to office today for 15 month check-up.

Past Medical History:

Prenatal/Perinatal: Prenatal care with local MD, 38 weeks gestation, 3 term pregnancies with 2 live births. No perinatal complications with pitocin-assisted delivery; epidural anesthesia. Full-term delivery (female), birth wt 8-11 oz, APGAR=10. NKDA.

Birth and Neonatal Period: Condition and vigor of infant at birth good. Good mother/infant bonding. Supportive spouse and large extended family support.

Feeding History: Initial feeding breast milk with Similac Advantage Supp. Good suck/latched well. Weaned at 1 month, continued Sim Advance feedings. Solid foods introduced at 4 months. Mother changed formula to Alimentum for a brief period at 5-1/2 months causing vomiting and dehydration; infant was placed back on Sim Adv and mother educated not to change formula without MD consent. Mother was educated on how to advance to solid foods:

- 1-2 teaspoon of rice cereal to soupy consistency thinned w/formula daily x 3 days.
- If tol well, may add applesauce to cereal, thicken as desired and increase to BID x 1 month.
- Increase feeds to 2-3 times per day the second month
- Increase feeds to 3 times per day the third month. After cereal /applesauce has been tol well, strained or pureed vegetables, fruits, and meats may be added. Start only one new food at a time, and give that food each day for three days in a row. If baby tolerates it without showing signs of an allergic reaction (hives, repeated vomiting, or wheezing and difficulty breathing), then add that food to baby's list of safe foods and move on to another one. The infant can have one of the safe foods at any time.

- An approximate serving size to work toward is one-half to one of the small baby food containers (2.5 oz.), plus an equal volume of cereal at a meal.

Infant was placed on whole milk at 1 year old.

Current Medications:

Bromfed-DM 1ml po bid, prn
 Zyrtec Children's-2ml po qd Tylenol/Advil prn
 Tylenol 2.5 ml po q 4 hrs, prn
 Little Noses Saline Drops – 3 to 4 drops each nostril, prn

Immunizations:

Birth: Hep B #1
 1 month: Hep B #2
 2 months: Pentacel, Prevnar13, Rotavirus
 4 months: Pentacel, Prevnar, Rotavirus
 6 months: Pentacel, Prevnar, Rotavirus
 12months: Prevnar, MMR

Allergies: NKDA (Hx of allergic rhinitis at 1 year.

Growth and Development: (Weight, length, head circumference, history of dentition).

	WEIGHT	LENGTH	HEAD CIRC	DENTITION	FONTANELLES
BIRTH	8-11 oz	20 in	14 in`		Ant/Post-Open
1 months	10-4	21	15		Ant/Post-Open
2 months	11-13	22	15-1/2		Ant/Post-Open
4 months	14-12	24	(unavailable)		Post -closed
6 months	16-7	26	(unavailable)	2 lower	Ant-Open
12 months	21-8	30	19	5 lower/5upper	Ant-Open

**Developmental landmarks: first smile, sat alone, stood with support, crawled, walked, and used words appropriate for age.

**Walked alone 13 months.

Family History: Mother Latino, 27 years old, father Latino, 32 years old, construction worker, 1 sibling-sister, 4 years old. Lives in family home with maternal grandmother and aunt. Mother/father/sibling speaks English fairly well.

Funding: Medicaid

Review of Systems:

Infectious diseases: none

HEENT: Mother denies scalp irritations, eye discharge, pulling at ear, mouth sores.

Respiratory system: Mother denies fever, cough, croup. Sleeps well at night.

Gastrointestinal: Mother denies feeding problems, vomiting, diarrhea, constipation. Soft brown stools daily; currently not potty trained.

Cardiovascular: Mother denies fatigue, dyspnea, syncope, epistaxis.

Genitourinary: Mother denies s/s of uti; 7-8 wet diapers/ daily; diapers at night.

Musculoskeletal: Mother denies s/s of painful ambulation, accidents, weakness, poor coordination; child active, runs and plays at will.

Integument: Mother denies rash, dry skin, excessive bruising, bleeding.

Psychological: Mother states usual tantrums, fussiness to have her way and when sleepy. Interacts well with sibling; sibling very loving towards pt. Mother does not work outside of home. Father lives in home, works day shift, home with family at night. Rear facing car seat in back seat for safety.

Neurological: Mother denies convulsions, tics, tremors and uncoordination.

OBJECTIVE

General information: Appears healthy and happy with spontaneous movement; neat, clean, infant in no acute distress.

Vital signs: HT 32 in, WT 22-13oz, HC 19-1/2 in, T97.0, P96, R24

Percentiles: HT 50%, WT 40%, HC 40%,

Head: Anterior fontanel open, flat and soft, normal cephalic atraumatic. or closed, no scalp lesions.

Eyes: PERRL, follows past midline, sclera white.

Ears: Normal tympanic membranes bilat, external canals free of lesions and s/s of infection.

Nose: Inferior turbinates slightly pale, no drainage or nasal flaring.

Neck: Supple, no lymphadenopathy; trachea midline, no masses or swelling; head tilt normal ranges.

Mouth: MM/lip/gums/buccals moist, pink; tonsils wnl; 12 teeth: 4 lower/4 upper incisors, 2 lower/2 upper molars.

CV: RRR, no murmurs, femoral pulses positive/equal bilat. Exts warm and well perfused.

Chest/Lungs: Symmetrical movement with respirations, effort unlabored, no retractions, CTA, no wheezing, rhonci, or rales.

Abdomen: Soft, BS+, NTND, no masses, no umbilical protrusion/hernia.

Genitalia: Normal female external genitalia, no vaginal discharge, anus wnl, no diaper rash.

Extremities: Pink color, bilat symmetrical movements, normal ROM, capillary refill brisk.

Skin: Turgor good, no rashes/edema/erythema.

Neurological: Alert/playful, responds appropriately to parents/sibling. Motor, sensory, reflexes intact. Coordination and gait wnl, neg. babinski.

Assessment:

15 month old toddler with normal growth and development.

Diagnosis:

1. V20.2 Well-Child Check
2. 477.9 History of allergic rhinitis cause unknown.
3. 787.91 History of diarrhea
4. 276.51 History of dehydration

Plan

Well-Child Check

1. 15 month immunizations: Dtap, Hib this visit.
2. Health Maintenance: Continue scheduled immunizations, smoke-free environment.
3. Safety: Teach family to childproof home (hot liquids, sharp objects, outlets, cords, etc). Cont carseat in backseat
4. Diet: Regular food as tol. No peanuts, popcorn, wieners that may cause choking hazard.

Allergic Rhinitis

1. Zyrtec Children's 2 ml daily, prn. Teach family hand hygiene.
2. Little Noses Saline Drops 3-4 drops each nostril, prn. Humidifier prn
3. Refer to allergist if symptoms continue.
4. Teach family hand hygiene.

Diarrhea

1. Educate caregiver in treatment/home care: Spontaneous recovery usually in 24-48 hrs.
Diet: Clear liquids frequently (popsicles, broth, gelatin, gatorade, 7-up) until s/s disappear. Avoid fruit including fruit juices.
Pedialyte to restore essential electrolytes.
Teach hand hygiene
Notify MD if s/s persists greater than 2 days.

Dehydration

1. Pedialyte X 1-2 days. Hold fruit, juices, milk. Diet same as for diarrhea

Return to clinic in 3 months for 18 months immunizations

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Subjective: Very comprehensive.

Objective: Shouldn't fontanels be closed by 15 months? Good assessment.

Assessment/Analysis: Good

Plan/Intervention : Well done!

Grade = 100