Complete Pediatric History and Physical

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SUBJECTIVE

Patient: A.L. is a 16yo Caucasian male.
Informant Reliability: The patient and his mother provided all information. Both appear to be reliable sources.

Chief Complaint: Recurrent nosebleeds. "I'm getting a lot of nosebleeds again and had to get my nose cauterized last week".

HPI: A.L. presents 21 APR 2014 with his mother for intermittent nosebleeds, which have occurred on more than 10 occasions since December 2013. He complains of sometimes waking up in the morning with blood on his pillow and occasionally passing dime-sized clots when blowing his nose. No aggravating or relieving factors have been determined. He also complains of nasal congestion, the need to "pop" his ears numerous times per day, and had to visit an off-post ENT the prior week for nasal cauterization of a persistent nosebleed. Patient does not complain of any pain at this time and presents today seeking a referral to ENT for further evaluation and care.

Medications: Allegra 180mg, PO daily; Singulair 10mg, PO daily; Concerta 36mg, PO twice per day; Advair 250/50mcg, 1 puff twice per day; Albuterol inhaler, 2 puffs as needed. **OTC:** Immune Health Basics 75mg, PO daily; Vitamin D 500mg, PO daily. **Allergies:** NKDA and denies latex, food, or environmental allergies.

PMH:

General Health: Describes health as "excellent".
Past Illnesses: Multiple nosebleeds and sinus infections, seasonal allergies, asthma, ADHD, hypoparathyroidism, bicuspid aortic valve disease, and neurocardiogenic syncope / orthostatic hypotension. Is currently being evaluated at Vanderbilt University for possible DiGeorge / 22q11.2 deletion syndrome and is enrolled in the EFMP program. No accidents, major injuries, or hospitalizations reported.
Birth Hx: Full-term, vaginal delivery, no issues.
Developmental Hx: Met all milestones on time but did not walk until age 2 due to "short / tight tendons in his lower legs".
Nutrition: Eats two meals per day (skips breakfast) and supplements with three protein shakes per day.

PSH*:* Circumcision at birth, umbilical hernia repair at 8 months (1998), PE tubes at 10 months (1999), tonsillectomy (2006), bilateral lower leg tendon release (2008).

FH*:* *Paternal grandfather*, 78, Alzheimer's; *paternal grandmother*, 75, MI/CAD; *father*, 33, DM type 2, obesity; *maternal grandfather*, 60, ETOH; *maternal grandmother*, 58, HLD, HTN; *mother*, 38, HLD, asthma, stage 2 cervical cancer; *sister*, 18, DM type 1.

Social Hx / Habits / Patient Profile / Environmental Hx: No exposure to environmental hazards. ***Home:*** Lives at home with his mother, father, and sister. ***Education:*** Currently in the

10th grade. ***Employment:*** None. ***Activities:*** Lifts weight 45-60 minutes, 5 days/week. ***Drugs:*** Denies tobacco, ETOH, or illicit drug use. ***Depression:*** Denies. ***Sex:*** Denies any sexual contact. ***Suicide:*** Denies suicidal ideation or past attempts. ***Sleep:*** Reports 8-10hrs of restful sleep/night.

Preventive Health Practices / Immunizations: Received flu shot in the fall. All other immunizations are UTD. Does not see an optometrist on a regular basis and has not been to a dentist since 2012.

ROS:

General/Constitutional: No fevers, chills, general body aches, night sweats or recent weight loss/gain. Denies feeling unusually tired or sleepy.
Skin: No rashes, hives, problems with hair or nails, and no moles that are changing in color, size or shape.
HEENT: **Head:** No hx of headaches or trauma. **Eyes:** No hx of eye pain, tearing, blurriness, or discharge. **Ears:** No hx of pain, discharge, dizziness and no difficulty hearing **Nose:** Hx of recent recurrent nosebleeds, congestion, and nasal discharge. **Mouth and throat:** No difficulty with chewing or eating. No pain with throat, gums, teeth, face, or sinuses.
C-V: No chest pain, edema, syncope, tachycardia, or claudication
Chest/Respiratory/Breast: No dyspnea, cough, sputum, wheezing, cyanosis, or nipple discharge.
GI: No vomiting, diarrhea, constipation, change in stools, abdominal pain or discomfort.
GU: No enuresis, dysuria, hematuria, pyuria, or polyuria. Reports frequency due to high fluid intake.
MSK: No change in gait, joint pain or stiffness, bone pain or spasms. Reports muscle pain and cramps in bilateral lower extremities.
Neuro: No headaches, nervousness, tingling, convulsions, or problems with balance /coordination. Reports occasional dizziness when rising from a reclined or sitting position.
Mental health: No anxiety, depression, hallucinations, suicidal/homicidal ideations, obsessions/compulsions, or violent/defiant behavior.
Allergy/Immune/Lymph/Endocrine: No polyphagia, goiter, swollen glands, bruising, masses, or disturbances of growth. Reports seasonal allergies and decreased calcium d/t hypoparathyroidism.

OBJECTIVE

VS: BP: 129/79, HR: 78, RR: 18, T: 98.9F, Pain: 0/10, Ht: 186cm, Wt: 82.4kg, BMI: 23.8

PE:

General Appearance: Well developed, well nourished, and in no acute distress. Well-groomed, cooperative, and alert.
Skin: Pink, no cyanosis present, good turgor, warm, moist, and free of rashes. No lesions or jaundice noted.
HEENT: **Head:** normocephalic without signs of trauma. **Eyes:** bilateral red reflex, PERRLA without discharge, sclera clear and no conjunctiva injection noted. Visual acuity without glasses using Snellen chart: (OD) 20/20, (OS) 20/20; visual fields full bilaterally, all EOMs intact. **Ears:** normal position, no tenderness; Rinne test, air

conduction>bone conduction bilaterally; Weber test, no lateralization; both tympanic membranes appear normal with no bulging, perforation, or fluid noted behind either and landmarks are clearly seen, normal light reflex. **Nose:** straight without masses, patent bilaterally, mucosa red without discharge, inferior turbinates enlarged. **Sinuses:** no tenderness present over frontal or maxillary sinuses. **Mouth and throat:** lips and buccal mucosa pink, all teeth present and in good condition, tongue midline, uvula elevates midline, gag reflect intact, no tonsillar enlargement, posterior pharynx normal with no discharge noted.

Neck/Lymphatic: Supple without adenopathy or masses. No enlargement, pain or tenderness of lymph nodes in neck, axillae, or groin.

CV: S1S2 present. No murmurs, rubs, or gallops. RRR. PMI at 5th ICS-MCL.

Chest/Respiratory/Breast: All lung fields CTA. No labored breathing, accessory muscle use, wheezing or rhonchi. No gynecomastia.

GI: Abdomen is flat, soft, and non-tender. Bowel sounds normal in all quadrants. Percussion normal. No organomegaly.

GU: Circumcised with two testicles present and descended. Tanner stage V. No varicocele or hypospadias.

MSK: Normal range of motion in neck, spine, and major joints of the upper and lower extremities. Weight-bearing with good muscle development and no popping, grinding, or effusions noted in major joints. Spine is straight and no cervical step-offs noted.

Neuro: Alert and oriented to person, place, and time. Cranial nerves II to XII intact. DTR's 2+ for biceps, triceps, knees, and Achilles.

Mental Health: Mood is euthymic and affect is normal. Patient is calm, articulate, and relaxed. Speech pattern and cadence is at a normal pace and volume.

ASSESSMENT/PLAN:

Differential Diagnoses: Infection (can be ruled out with a CBC); trauma (pt denies recent facial or digital trauma); HTN (R/O due to normal BP and hx of normal BP's); inherited bleeding disorders (no hx of familial bleeding D/O; can be ruled out with PT, PTT, and INR); ETOH abuse (denies hx); tumor (can R/O with CT/MRI if no other cause can be located).

Diagnoses:

1. **Epistaxis:** Discussed with patient and mother causes of nosebleeds, to include cold dry air in the winter months and inflammation of nasal mucosa with seasonal allergies.
   Diagnostics: None. Most likely due to allergic and/or idiopathic rhinitis.
   Therapeutics: Continue with Allegra and Singulair for allergies. Recommend gentle nose blowing. Chronic cases not manageable with traditional methods can be treated with surgical ligation or transarterial embolization (Willems, Farb, & Agid, 2009).
   Referrals: ENT
   Disposition & F/U: D/Cd home with mother. Return to clinic or ED for any further persistent episodes of nosebleeds.
2. **Bicuspid aortic valve disease**
   Diagnostics: None
   Therapeutics: Not to engage in sports involving running or other strenuous cardiovascular activity.

Referrals: Currently being followed by Vanderbilt University with plans for surgery at age 18.
F/U: Will continue to follow-up with Vanderbilt on a yearly basis and as needed with PCM.

3. **Orthostatic hypotension**
   Diagnostics: None
   Therapeutics: Instructed to rise out of bed slowly in the AM and sit on edge of bed for 2-3 minutes before standing. Advised to refrain from any sudden movement from supine/seated position to standing and take care when bathing with hot showers.
   Referrals: This condition is related to patient's diagnosis of bicuspid aortic valve disease and is being followed by Vanderbilt University.
   F/U: Return to clinic or ED for any acute episodes.
4. **Asthma:** Discussed importance of careful monitoring of symptoms as this is the height of spring allergy season. Stressed the need for strict medication adherence.
   Diagnostics: None
   Therapeutics: Continue with current dosages of Allegra, Singulair, Advair, and Albuterol inhaler. Follow Action Plan for acute exacerbations.
   Referrals: None
   F/U: Return to clinic or ED for any acute episodes.
5. **ADHD:** Noted stability of ADHD symptoms on present dosage of Concerta. No reports of difficulties at home or school by mother or patient.
   Diagnostics: None
   Therapeutics: Continue with current dosage of Concerta.
   Referrals: None
   F/U: With PCM as needed.

Anticipatory Guidance: (all from Blaz, 2014)

Physical & Development: Nutrition: 3 meals a day and snacks (fruits/vegetables/whole grains and low-fat dairy). Dental visit 2x/year and brush teeth/floss 2x/day.
Social and Academic: Peer Relations/Self-image/self-esteem/dating**.** Future plans (work/education). Stay connected with family and friends (friendships change)**.** Responsibility of school and work.
Emotional: Ways to deal with stress and emotional health**.** Disappointments and setbacks occur (temporary)**.** Sexual activity/identity concerns.
Activity/Safety/Risk taking: Helmets, seatbelts, weapons in the home, protective gear during sports**.** Physical activity (60 minutes per day). Sexual activity, STI's, decisions about sex**.** Tobacco, ETOH, drugs/Rx meds, steroids, diet pills**.**

Screening Tool: The Patient Health Questionnaire (PHQ-9) is used to screen, diagnose, monitor, and measure the severity of depression. It incorporates DSM-IV depression diagnostic criteria and rates the frequency of the depressive symptoms. Additionally, Simon et al. (2013) found that the response to item 9 of the PHQ-9 had a strong correlation identifying outpatients at increased risk of suicide attempt or death. The patient completes the form within a few minutes, it is graded by the provider, and can be administered repeatedly to monitor the improvement or worsening of depression. Richardson et al. (2010) found the PHQ-9 to be an excellent tool to implement for depression screening among adolescents, with a sensitivity and specificity similar

to the adult population. However, because it is self-reported information, the provider may misdiagnose a patient if he or she were to not answer truthfully.

References

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