**Pediatric H&P #1**

**Date:** 9/1/20

**Patient Name**: Y.S.

**DOB:** 6/13/2015

**CC:** “Cough that’s keeping me up at night” x 4 days

**HPI:** Y.S. is a 5 year old male with no significant PMH who presents to the office today with his mother complaining of cough and rhinorrhea x 4 days. The mother explains that she first noticed her son’s cough on Saturday night and described it as “sounding pretty bark-like.” The cough is worse at night resulting in the patient being unable to sleep well. The mother denies taking his temperature or giving any medication for relief. She does not believe that the patient is eating any less than normal. He is playing with his younger sister at home but seems to be more irritable. Patient’s mother denies any current fever, SOB, abdominal pain, nausea, vomiting, rash, diarrhea, dizziness, recent travel, or any sick contacts at home.

**PMH:** No significant past medical history. All immunizations are up to date

**PSH:** No significant surgical history

**Medications**: The patient is not currently on any medications

**Allergies**: The patient does not have any known drug, environmental, or food allergies

**Family History**:

Mother-35, alive and well

Father- 38, alive and well

Sister-2, alive and well

**Social History**: Y.S. has been home for the past few months due to the COVID-19 pandemic. He did not attend camp this summer or social gatherings with other children (besides sister), but will be starting school in the next few weeks.

**Review of Systems:**

General: Admits to fatigue. Denies recent weight loss, fever, chills, generalized weakness, night sweats.

Skin/Hair/Nails: Denies changes in texture, excessive dryness or sweating, discoloration, pigmentation, moles, rashes, pruritus, change in hair distribution

Head: Denies headache, trauma, unconsciousness, coma, fracture, vertigo

Eyes : Denies corrective lenses, visual disturbances, fatigue, photophobia, pruritus, lacrimation

Ears : Denies deafness, pain, discharge, tinnitus, hearing aids

Nose/Sinuses : Admits to copious clear nasal discharge x 4 days. Denies obstruction or epistaxis

Mouth/Throat : Admits to slight hoarseness. Denies bleeding gums, sore tongue, sore throat, mouth ulcers

Respiratory : Admits to barking non-productive cough x 4 days. Denies wheezing, hemoptysis, cyanosis, dyspnea, paroxysmal nocturnal dyspnea

Cardiovascular : Denies palpitations, chest pain, irregular heartbeat, edema, syncope, known heart murmur

Gastrointestinal : Denies change in appetite, abdominal pain, diarrhea, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructations, constipation, hemorrhoids, blood in stool

Genitourinary : Denies change in frequency, urgency, hesitancy, dribbling, nocturia, polyuria, oliguria, dysuria, change in urine color, incontinence, flank pain

Musculoskeletal : Denies muscle/joint pain, leg weakness, deformity, swelling, redness

Peripheral Vascular : Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, color change

Hematologic : Denies anemia, lymph node enlargement, history of DVT/PE, easy bruising/bleeding

Endocrine : Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, goiter, hirsutism Neurologic : Denies loss of strength, ataxia, seizures, loss of consciousness, sensory disturbances, paresthesia, dysesthesia, hyperesthesia, memory loss, asymmetric weakness

**Physical Exam:**

Vital Signs : T 98.6 degrees F (forehead), P 95 regular, RR 28, unlabored

Height: 40 inches Weight: 38 lbs

General Survey : 5 year old male in mild distress, well nourished and well developed

Skin : Warm and moist, non-icteric

Head : Normocephalic, atraumatic, non-tender to palpation throughout

Eyes : No conjunctival injection, pallor, or scleral icterus. PERRLA

Nose: Moist nasal mucosa with clear mucoid discharge bilaterally. No obvious masses, lesions or deformities noted. No evidence of foreign bodies

Mouth/Pharynx : Pharynx and uvula are pink and moist without evidence of erythema or lesions. Tonsils present 2+

Neck : Trachea midline. No masses, lesions, scars. Supple, nontender to palpation. Full range of motion. No palpable lymphadenopathy.

Chest : Normal expiration and no accessory muscle use. Respirations unlabored. Nontender to palpation.

Lungs : Lung fields are clear to auscultation bilaterally. No audible wheezing, rhonchi, or other adventitious sounds noted

Cardiovascular : S1 and S2 normal. Regular rate and rhythm. No S3, S4, splitting of heart sounds, murmurs, rubs.

Abdomen : Soft and non-distended abdomen. Non-tender to palpation throughout. BS present in all four quadrants.

Extremities/Peripheral Vascular : Extremities are normal in size and temperature. No clubbing/cyanosis/edema noted. Full ROM.

**Differential Diagnosis:**

1. Laryngotracheobronchitis (croup)
	1. Most likely diagnosis based on patient’s presentation and age
2. Viral “common cold” (i.e. adenovirus, rhinovirus)
	1. Also a possible diagnosis due to the presence of nasal discharge, however the “barking” cough is quintessential of croup
3. Bacterial pharyngitis
	1. Not as likely of a diagnosis since patient’s pharynx was not erythematous and there is no fever present
4. COVID-19
	1. Unlikely diagnosis due to patient’s age, lack of fever, no known exposure to sick contacts
5. Influenza
	1. Unlikely diagnosis due to time of year and patient is up to date on immunization

**Assessment:**

Y.S. is a 5 year old male with no significant PMH who presented to the office today with his mother complaining of cough and rhinorrhea x 4 days. Findings are most consistent with laryngotracheobronchitis (aka croup)

**Plan**:

* Dexamethasone (0.15mg/kg) oral, single dose
* Cool humified air mist as needed for supportive treatment
* Encourage continued hydration (i.e. soup, water, Pedialyte)
* Educate mother that this is a viral illness that requires hydration and supportive care to alleviate the child’s symptoms
* Instruct mother to return if symptoms worsen over the next couple of days