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| --- | --- | --- | --- | --- | --- | --- |
| **IDENTIFICACION** |  |  |  |  |  |  |
| Nombre: | | | Fecha de nacimiento: | |  |  |
| Identificación: | | | Domicilio: | | Teléfono: | |
| Nombre del padre: | | | Nombre de la madre: | |  |  |

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| **ANAMNESIS** |  |  |  |  |  |  |  |
|  | Normal | Anormal |  |  | Si | No |  |
| Vía oral seno |  |  |  | Vomito |  |  |  |
| Hábitos de micción |  |  |  | Fiebre |  |  |  |
| Deposición |  |  |  | Dificultad respiratoria |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  | Resultado TSH: | | Hemoclasificación: | | |
| Observaciones: | | | | | | | |

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| **EVALUACIÓN DE CONDUCTAS** | |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  | Normal | Anormal |  |  | Normal | Anormal |  |
| Tipo de alimentación |  |  |  | Cuidado muñón umbilical |  |  |  |
| Frecuencia de alimentación |  |  |  | Vestido |  |  |  |
| Condiciones del baño |  |  |  | Afecto |  |  |  |
| Frecuencia del baño |  |  |  | Vacunación (BCG-HB) |  |  |  |
|  |  |  |  | |  | | |
| Observaciones: | | | | | | | |

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| **DIAGNÓSTICOS:** | | |
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|
| **CONDUCTAS** | Diagnósticas |  |
| Remisorias |  |
| Terapéuticas/ Preventivas |  |
| Preventivas |  |
| Educativas |  |
| Otras |  |

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| **EXAMEN FISICO** | | | |  |  |  |
| **Peso \_\_\_\_\_\_\_ gr. Talla \_\_\_\_\_\_ cm. PC \_\_\_\_\_\_ cm. PT \_\_\_\_\_\_ cm. FC \_\_\_\_\_ x min. FR \_\_\_\_\_ x min. T \_\_\_\_\_\_ °C** | | | | | | |
|  | Normal | Anormal | Observaciones | | | |
| Cabeza |  |  |  | | | |
| Ojos |  |  |  | | | |
| Oídos |  |  |  | | | |
| Nariz |  |  |  | | | |
| Boca |  |  |  | | | |
| Cuello |  |  |  | | | |
| Tórax |  |  |  | | | |
| Cardiopulmonar |  |  |  | | | |
| Mamas |  |  |  | | | |
| Abdomen |  |  |  | | | |
| Muñón umbilical |  |  |  | | | |
| Genitales |  |  |  | | | |
| Espalda |  |  |  | | | |
| Extremidades |  |  |  | | | |
| Signos de luxación de cadera |  |  |  | | | |
| Piel y anexos |  |  |  | | | |
| SNC |  |  |  | | | |

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| **PROGRAMACIÓN DE CITAS** | | |  |  |  |  |
| \* Cita para consulta de primera vez en C y D: (dd/mm/aaaa) | | | | |  |  |
| \* Cita para continuación de Esquema de vacunación: (dd/mm/aaaa) | | | | | |  |
| \* Cita para consulta de primera vez en PF a la madre: (dd/mm/aaaa) | | | | | |  |
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| Firma del médico: | | | | Reg. | | |
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