## ANEXO No. 1: HISTORIA CLÍNICA DE INGRESO CRN

**HISTORIA MÉDICA**

FECHA DE INGRESO DÍA \_\_\_\_\_\_\_\_\_MES \_\_\_\_\_\_\_\_\_\_\_\_AÑO\_\_\_\_\_\_\_\_

CENTRO DE RECUPERACIÓN NUTRICIONAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DEPARTAMENTO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MUNICIPIO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **DATOS DE IDENTIFICACIÓN DEL PACIENTE:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Apellidos y Nombres | | | | | | Cama | | Historia Clínica | |
| Sexo M F | | Fecha de Nacimiento  Día Mes Año | | | | | Edad Completa  A M D | | |
| Lugar de Nacimiento | Procedencia ( Barrio, Vereda, comunidad indígena) | | | | | | | | Informante |
| Nombre del Padre | | | | Nombre de la Madre | | | | | |
| Dirección de la residencia | | | | | Teléfono de la residencia y/o Contacto | | | | |
| Afiliación al SGSSS. Marque con una (X)  Contributivo Subsidiado Régimen Especial Vinculado  EPS : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  IPS Primaria o de Remisión: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Tipo de Identificacion del paciente:  Sin identificacion  ( en este caso coloque el número de identificacion de la madre o acudiente seguido de 0 y el numero de hijo que corresponde el paciente)  Registro Civil | | | Numero de identificacion del paciente: | | | | | | |

1. **MOTIVO DE CONSULTA Y ENFERMEDAD ACTUAL:**

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1. **ANTECEDENTES FAMILIARES** (Marque con una (X) e indique el parentesco)

|  |  |
| --- | --- |
| Diabetes | Congénitas |
| Cáncer | Epilepsia |
| Hipertensión Arterial | Tuberculosis |
| Otras alteraciones Cardiovasculares ( ECV, infarto al miocardio, entre otras) | Tabaquismo |
| Asma | Alcoholismo |
| Alergias | VIH/ Sida |
| Desnutrición | Otras: |

1. **ANTECEDENTES PERINATALES**

|  |  |
| --- | --- |
| Asistió a controles prenatales ( CPN)  Si No No sabe Cuántos? | Embarazo Normal  Si No No sabe |
| Complicaciones durante el embarazo  No Si No sabe  Si, cuál?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Complicaciones durante el parto  No Si No sabe  Si, cuál? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| Peso al nacer \_\_\_\_\_\_\_\_\_\_\_\_ gramos | Talla al nacer \_\_\_\_\_\_\_\_\_\_\_\_\_cm. |
| Complicaciones neonatales ( primeros 30 días de vida)  No Si No sabe  Si, cual?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Hospitalizaciones neonatales  No Si No sabe  Si, por qué? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Observaciones ( indicar diagnósticos y tratamientos en el periodo neonatal ) | |
|  | |
|  | |
|  | |

1. **DESARROLLO**

|  |  |  |  |
| --- | --- | --- | --- |
| Control o sostén cefálico  \_\_\_\_\_\_\_\_\_\_\_\_\_meses | Sonrisa social  \_\_\_\_\_\_\_\_\_\_\_\_\_meses | | Giros ( supino-prono)  \_\_\_\_\_\_\_\_\_\_\_\_\_meses |
| Sedestación sin apoyo  \_\_\_\_\_\_\_\_\_\_\_\_\_meses | Gateo  \_\_\_\_\_\_\_\_\_\_\_\_\_meses | | Marcha sin apoyo  \_\_\_\_\_\_\_\_\_\_\_\_\_meses |
| Primeros dientes  \_\_\_\_\_\_\_\_\_\_\_\_\_meses | Control de esfínteres  \_\_\_\_\_\_\_\_\_\_\_\_\_meses | | Sonidos guturales  \_\_\_\_\_\_\_\_\_\_\_\_\_meses |
| Disilabos  \_\_\_\_\_\_\_\_\_\_\_\_\_meses | Palabras completas  \_\_\_\_\_\_\_\_\_\_\_\_\_meses | | Frases completas  \_\_\_\_\_\_\_\_\_\_\_\_\_meses |
| Adecuada relación con los demás  Si No  No, porque? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Adecuada Escolaridad/Rendimiento  Si No  No, porque? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

1. **VACUNACIÓN (Marque con una (X). Utilice esta misma grafica para actualizar información en nuevas consultas, verificando con el carnet de vacunación)**

| **EDAD** | **VACUNAS** | **VERIFICACION** |
| --- | --- | --- |
| Nacimiento | BCG Hepatitis B(HB) -0 | Si No |
| 2 meses | Polio-1 DPT-1 HB-1  Rotavirus-1 Neumococo-1  Haemophilus influenzae tipo b (Hib)-1 | Si No |
| 4 meses | Polio-2 DPT-2 HB-2 (Hib)-2  Rotavirus-2 Neumococo-2 | Si No |
| 6 meses | Polio-3 DPT-3 HB-3 (Hib)-3 | Si No |
| 1 año | Sarampión-Rubeola-Paperas(SRP)-1 Fiebre Amarilla (única dosis)  Refuerzo Fiebre Amarilla cada 20años | Si No |
| 18 meses | Polio-R1 DPT-R1 | Si No |
| 5 años | (SRP)-R1 DPT-R2 Polio-R2 | Si No |
| Otras | Vacuna: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Vacuna: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Vacuna: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

1. **ANTECEDENTES PERSONALES** (En caso positivo escriba el numero a la derecha y describa)

|  |  |  |
| --- | --- | --- |
| 1.Patológicos | Si No |  |
| 2.Hospitalarios | Si No |  |
| 3.Farmacológicos | Si No |  |
| 4.Quirúrgicos | Si No |  |
| 5.Alérgicos | Si No |  |
| 6.Traumáticos | Si No |  |
| 7.Tóxicos | Si No |  |
| 8.Transfusionales | Si No |  |

1. **REVISIÓN POR SISTEMAS ( si es positivo marque con (X) y describa a la derecha)**

|  |
| --- |
| Piel y Faneras |
| Ojos |
| Otorrinolaringológico (ORL) |
| Cardiovascular |
| Respiratorio |
| Digestivo |
| Genito/Urinario |
| Endocrino |
| Hematológico/Inmunológico |
| Neurológico |
| Mental |

1. **EXAMEN FÍSICO**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Peso \_\_\_\_\_\_\_\_ kg | | | Talla \_\_\_\_\_\_\_ cm | | | | Perímetro Cefálico  \_\_\_\_\_\_\_\_\_\_\_cm | | Perímetro Abdominal  \_\_\_\_\_\_\_\_\_\_\_ cm |
| FC \_\_\_\_\_\_\_ / min. | | FR \_\_\_\_\_\_\_/ min. | | | | Tensión Arterial  \_\_\_\_\_\_/\_\_\_\_\_ mmHg | | Temperatura \_\_\_\_\_\*C  Axilar Rectal Oral | |
| Aspecto General (hidratación, orientación, estado de conciencia, etc.) | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | | | | | | |
|  | | | | | | | | | |
| Sistema | Positivo | | | Negativo | Descripción (si es positivo escriba el numero del sistema y describa los hallazgos, importante enfatizar en signos clínicos de desnutrición) | | | | |
| 1.Cabeza |  | | |  |  | | | | |
| 2.Cara |  | | |  |  | | | | |
| 3.Ojos |  | | |  |  | | | | |
| 4.Oidos |  | | |  |  | | | | |
| 5.Nariz |  | | |  |  | | | | |
| 6.Orofaringe |  | | |  |  | | | | |
| 7.Boca |  | | |  |  | | | | |
| 8.Cuello |  | | |  |  | | | | |
| 9.Torax |  | | |  |  | | | | |
| 10.Corazón |  | | |  |  | | | | |
| 11.Pulmones |  | | |  |  | | | | |
| 12.Abdomen |  | | |  |  | | | | |
| 13.Genitourinario |  | | |  |  | | | | |
| 14.Periné/Ano |  | | |  |  | | | | |
| 15.Osteoarticular |  | | |  |  | | | | |
| 16.Caderas |  | | |  |  | | | | |
| 17.Neurologico |  | | |  |  | | | | |
| 18.Piel y Faneras |  | | |  |  | | | | |
| 19.Otros |  | | |  |  | | | | |

1. **AMPLIACIÓN DEL EXAMEN FÍSICO PARA VERIFICACIÓN DE PATOLOGÍAS PREVALENTES EN LA INFANCIA**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SIGNOS** | | | **PRESENTA** | | **DESCRIPCIÓN** | |
| **VERIFICACIÓN SIGNOS GENERALES DE PELIGRO** | | | | | | |
| No puede beber o tomar del pecho | | | Si  No | |  | |
| Vomita todo | | | Si  No | |  | |
| Letárgico o Inconsciente | | | Si  No | |  | |
| Convulsiones | | |  | |  | |
| **VERIFICACIÓN DE SIGNOS DE TOS Y DIFICULTAD PARA RESPIRAR** | | | | | | |
| Presenta Tos | | | Si  No | Días de evolución: \_\_\_\_\_\_\_\_\_ | | |
| Dificultad Respiratoria | | | Si  No | Días de evolución: \_\_\_\_\_\_\_\_\_\_ FR \_\_\_\_\_\_/ min. | | |
| Presenta Sibilancias Actualmente | | | Si  No |  | | |
| Ha presentado sibilancias anteriormente | | | Si  No |  | | |
| Presenta tiraje subcostal | | | Si  No |  | | |
| Presenta Estridor en Reposo | | | Si  No |  | | |
| **VERIFICACIÓN DE SIGNOS DE DIARREA** | | | | | | |
| Presenta Diarrea | | | Si  No | Días de evolución: \_\_\_\_\_\_\_\_\_\_ | | |
| Presenta Sangre en las Heces | | | Si  No |  | | |
| Letárgico o no puede beber | | | Si  No |  | | |
| Ojos hundidos | | | Si  No |  | | |
| Bebe ávidamente con sed | | | Si  No |  | | |
| Intranquilo o irritable | | | Si  No |  | | |
| Pliegue cutáneo | | | Si  No | Muy lento ( > 2 seg.): \_\_\_\_\_\_\_ lento : \_\_\_\_\_\_\_ | | |
| **FIEBRE** | | | | | | |
| Presenta Fiebre | | Si  No | | | | Número de días de evolución: \_\_\_\_\_\_\_\_\_\_    Temperatura promedio \_\_\_\_\_\_\_\_\_\_\*C |
| Vive o visito zona de riesgo de dengue | | Si  No | | | |  |
| Rigidez de Nuca | | Si  No | | | |  |
| Aspecto Tóxico | | Si  No | | | |  |
| Manifestación de hemorragia | | Si  No | | | |  |
| Dolor abdominal intenso | | Si  No | | | |  |
| Piel diaforética y fría | | Si  No | | | |  |
| Pulso rápido y débil | | Si  No | | | |  |
| Inquieto o irritable | | Si  No | | | |  |
| Erupción cutánea generalizada | | Si  No | | | |  |
| **VALORACIÓN DE SÍNTOMAS DEL OÍDO** | | | | | | |
| Tiene dolor de oído | Si  No | | | |  | |
| Tiene supuración | Si  No | | | | Días de evolución: \_\_\_\_\_\_\_\_\_\_  Ha presentado episodios previos?: \_\_\_\_\_\_\_\_\_\_ | |
| Tímpano rojo y abombado | Si  No | | | |  | |
| Tumefacción dolorosa al tacto detrás de la oreja | Si  No | | | |  | |
| **VALORACIÓN DE SÍNTOMAS DE GARGANTA** | | | | | | |
| Tiene dolor de garganta | Si  No | | | |  | |
| Adenopatías cervicales | Si  No | | | |  | |
| Exudados blanquecinos | Si  No | | | |  | |
| Eritema | Si  No | | | |  | |

1. **MALTRATO INFANTIL – VIOLENCIA INTRAFAMILIAR** (Marque con una (X) y explique en la descripción en caso afirmativo)

|  |  |  |
| --- | --- | --- |
| **Signo** | **Presencia** | **Descripción** |
| Negligencia | Si  No |  |
| Maltrato Físico | Si  No |  |
| Maltrato Emocional | Si  No |  |
| Maltrato o violencia sexual | Si  No |  |
| Otros | Si  No |  |

1. **PARA CLÍNICOS** ( Transcribir a continuación resultados de hemograma, uroanálisis, radiografías y otros)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **IMPRESIONES DIAGNÓSTICAS**

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| 1. |
| 2. |
| 3. |
| 4. |
| 5. |

1. **ANÁLISIS Y PLAN DE MANEJO**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| Nombre del Médico | Firma , Sello y Registro Médico |

##### HISTORIA CLÍNICA NUTRICIONAL Y ALIMENTARIA VALORACIÓN POR PRIMERA VEZ

Fecha de Ingreso

Día       Mes       Año

Centro de de Recuperación Nutricional:

Departamento: Municipio:

Operador:

## I DATOS GENERALES

Nombres y Apellidos: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teléfono Contacto: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fecha Nacimiento: D \_\_\_ M \_\_\_ A \_\_\_ Edad: \_\_\_\_ (m) (a) Sexo (F) (M)

Nombre Acudiente: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parentesco: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnostico Médico: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tratamiento Médico: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**II ANTECEDENTES**

NEONATALES:

Edad Estacional: \_\_\_\_\_\_\_\_\_\_\_\_ Peso al Nacer: \_\_\_\_\_\_\_\_\_\_\_\_ (g) Talla al Nacer: \_\_\_\_\_\_\_\_\_\_ (cm)

Observaciones: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATOLÓGICOS (Marcar con una X):

Respiratorias: \_\_\_\_\_ Diarreicas: \_\_\_\_ Eruptivas: \_\_\_ Alergias: \_\_\_ Qx: \_\_\_\_\_\_

Cual (es) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vacunación: Esquema completo para la edad: \_\_\_\_\_\_\_\_ Esquema incompleto para la edad: \_\_\_\_\_\_\_\_\_

Otras: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILIARES:

Obesidad ( ) Alergias ( ) HTA ( ) Diabetes ( ) Enf Cardio Vascular ( ) Cancer ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Otras: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**III EXAMEN FÍSICO** (Observación de Signos de Malnutrición)

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| **ÁREA A EVALUAR** | **OBSERVACIÓN** | **INTERPRETACIÓN** |
| Cabello |  |  |
| Cara |  |  |
| Cavidad Oral y Estructuras |  |  |
| Tronco (Estomago) |  |  |
| Miembros Inferiores Superiores |  |  |
| Manos - Uñas |  |  |
| Piel |  |  |

Interpretación General: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**IV DATOS ANTROPOMÉTRICOS**

Peso Actual: \_\_\_\_\_\_\_\_Kg. Peso Anterior (Ultima Vez) \_\_\_\_\_\_\_\_Kg Talla Actual: \_\_\_\_\_\_\_\_cm

Perímetro Cefálico: \_\_\_\_\_\_\_\_\_\_cm Perímetro Braquial: \_\_\_\_\_\_\_\_\_\_ cm Perímetro Torácico: \_\_\_\_\_\_\_\_\_\_cm

|  |  |  |
| --- | --- | --- |
| **INDICADOR** | **D ESTÁNDAR (Z SCORE)** | **INTERPRETACIÓN** |
| Peso/ Talla |  |  |
| Talla/ Edad |  |  |
| Peso/ Edad |  |  |

% Déficit de Peso/ Talla: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clasificación Nutricional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**V EXÁMENES DE LABORATORIO**

**EXAMEN VALOR ACTUAL REFERENCIA NORMAL**

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Interpretación: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VI ANTECEDENTES ALIMENTARIOS**

*LACTANCIA MATERNA: LM*

Recibió LM Exclusiva: Si ( ) Duración: \_\_\_\_\_\_\_\_\_\_ Frecuencia: \_\_\_\_\_\_\_\_\_\_

No ( ) Causa: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recibió Formulas Infantiles: Si ( ) No ( )

Tipo de Formula: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No Tomas/ día: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preparación: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*ALIMENTACIÓN COMPLEMENTARIA:*

A qué edad inicio la alimentación Complementaria: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **EDAD** | **TIPO ALIMENTO** | **PREPARACIÓN** |
| 0-2 Meses |  |  |
| 2- 4 Meses |  |  |
| 4- 6 Meses |  |  |
| 6- 8 Meses |  |  |
| 8- 12 Meses |  |  |

A qué edad inicio la dieta familiar? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Persona encargada de la alimentación del menor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

En qué lugar recibe alimentos el menor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### HÁBITOS ALIMENTARIOS

**Apetito:** Bueno ( ) Regular ( ) Malo ( ) Aumentado ( ) Disminuido ( )

**Ingesta:** Rápida ( ) Despacio ( ) Normal ( ) DEGLUCIÓN: Normal ( ) Deficiente ( )

**Mastica:** Si ( ) No ( ) Explicar: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hábito intestinal**: Normal ( ) Estreñimiento ( ) Diarrea ( )

Alimentos Preferidos: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alimentos Rechazados: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alimentos no tolerados: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VII ANAMNESIS ALIMENTARIA**

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| **HORA** | **ALIMENTO Y PREPARACIÓN** | **CANTIDAD** |
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## VIII FRECUENCIA DE CONSUMO

| **ALIMENTO** | **DIARIO** | **SEMANAL** | **QUINCENAL** | **MENSUAL** | **NUNCA** |
| --- | --- | --- | --- | --- | --- |
| Leche Sola |  |  |  |  |  |
| Yogurt, Kumis |  |  |  |  |  |
| Queso |  |  |  |  |  |
| Verduras |  |  |  |  |  |
| Frutas  Enteras  Jugo |  |  |  |  |  |
| Cereales Tubérculos Plátanos |  |  |  |  |  |
| Leguminosas |  |  |  |  |  |
| Carnes |  |  |  |  |  |
| Huevo |  |  |  |  |  |
| Embutidos |  |  |  |  |  |
| Aceites, Mantequilla y Grasas |  |  |  |  |  |
| Azúcar Dulces |  |  |  |  |  |
| Paquetes, Comidas Rápidas |  |  |  |  |  |
| Gaseosas |  |  |  |  |  |

**IX % ADECUACIÓN**

|  |  |  |  |
| --- | --- | --- | --- |
| **NUTRIENTES** | **CONSUMO** | **RECOMENDADO** | **% ADECUACIÓN** |
| Líquidos |  |  |  |
| Calorías |  |  |  |
| Proteínas |  |  |  |
| Grasas |  |  |  |
| Carbohidratos |  |  |  |
| Calcio |  |  |  |
| Hierro |  |  |  |
| Vitamina A |  |  |  |

**X INTERPRETACIÓN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**XI DIAGNOSTICO NUTRICIONAL**

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**XII PRESCRIPCIÓN DIETARIA**

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XIII FORMULA DIETARIA

|  |  |  |  |
| --- | --- | --- | --- |
| **NUTRIENTES** | **Por /Kg peso actual** | **Aporte Total** | **Observaciones** |
| Líquidos (cc) |  |  |  |
| Calorías (Kcal) |  |  |  |
| Proteínas (g) |  |  |  |
| Grasas (g) |  |  |  |
| Carbohidratos (g) |  |  |  |
| Calcio (mg) |  |  |  |
| Hierro (mg) |  |  |  |
| Zinc (mg) |  |  |  |
| Vitamina A (UI) |  |  |  |

XIV MENÚ (descripción general del menú indicado)

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XV RECOMENDACIONES

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| Nombre del Nutricionista Dietista | Firma , Sello y tarjeta profesional |

**FORMATO DE EVOLUCIÓN DIARIA DE LA HISTORIA CLÍNICA**

| FECHA:  DIA \_\_\_\_MES \_\_\_\_AÑO \_\_\_ | Nombre del CRN: | Municipio/Departamento: | | Historia Clínica #: |
| --- | --- | --- | --- | --- |
| **NOMBRE Y APELLIDOS DEL NIÑO/NIÑA:** | | | Sexo:  F M | Edad: |
| **NOTAS DE EVOLUCIÓN (MÉDICO, NUTRICIONAL, SOCIAL)** | | | | |
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