**FORMATO HISTORIA MÉDICA Y NUTRICIONAL DE INGRESO**

**PARTE A. HISTORIA MÉDICA AL INGRESO**

FECHA DE INGRESO: DÍA \_\_\_\_\_\_ MES \_\_\_\_\_\_ AÑO \_\_\_\_\_\_

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

DEPARTAMENTO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MUNICIPIO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

|  |  |  |
| --- | --- | --- |
| Apellidos y Nombres: | Cama: | Historia de Atención: |
| 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 residencia: | Teléfono de 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 [ ]  | Número de identificación del paciente: |

1. **MOTIVO DE CONSULTA:**

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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 embarazoSi [ ]  No [ ]  No sabe [ ] Si, ¿cuál? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Complicaciones durante el partoSi [ ]  No [ ]  No sabe [ ] Si, ¿cuál? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| Peso al nacer: \_\_\_\_\_\_\_\_\_\_\_\_ gramos | Talla al nacer: \_\_\_\_\_\_\_\_\_\_\_\_\_cm. |
| Complicaciones neonatales (primeros 30 días de vida)Si [ ]  No [ ]  No sabe [ ] Si, ¿cuál? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Hospitalizaciones neonatalesSi [ ]  No [ ]  No sabe [ ] Si, ¿por qué? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Observaciones (indicar diagnósticos y tratamientos en el periodo neonatal) |
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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 demásSi [ ]  No [ ]  No, ¿por qué? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Adecuada Escolaridad/RendimientoSi [ ]  No [ ]  No, ¿por qué? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ¿Asiste a programa de Crecimiento y Desarrollo del sector Salud?Si [ ]  No [ ]  No, ¿por qué? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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-1Haemophilus 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)-3Influenza-1 | Si [ ]  No [ ]  |
| 7 meses  | Influenza-2 | Si [ ]  No [ ]  |
| 1 año | Sarampión-Rubeola-Paperas(SRP)-1 Fiebre Amarilla-1, Neumococo-refuerzoInfluenza-anual, Hepatitis A-únicaRefuerzo Fiebre Amarilla cada 20años | Si [ ]  No [ ]  |
| 18 meses | Polio-R1 DPT-R1 | Si [ ]  No [ ]  |
| 5 años | (SRP)-R1 DPT-R2 Polio-R2 | Si [ ]  No [ ]  |
| Niñas 9 años o más | VPH: 1ª. dosis; 2ª.dosis a 6 meses, 3ª.dosis a 60 meses (5 años) | Si [ ]  No [ ]  |
| Otras | Vacuna: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Vacuna: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Vacuna: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fecha: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

1. **ANTECEDENTES PERSONALES (en caso positivo escriba el número 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 |
| Peso con edema **Si:** ( ) **No:** ( )Si presenta edema, indique el grado del mismo: Leve ( ) Moderado ( ) Severo ( )  |
| FC \_\_\_\_\_\_\_ / min. | FR \_\_\_\_\_\_\_/ min. | Tensión Arterial\_\_\_\_\_\_/\_\_\_\_\_ mmHg | Temperatura \_\_\_\_\_\*CAxilar [ ]  Rectal [ ]  Oral [ ]  |
| Aspecto General (hidratación, orientación, estado de conciencia, etc.) |
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| Sistema | Positivo | Negativo | Descripción (si es positivo escriba el número 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 | Si [ ]  No [ ]  |  |
| **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, uro análisis, radiografías y otros):**

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1. **IMPRESIONES DIAGNÓSTICAS:**

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1. **ANALISIS Y PLAN DE MANEJO**

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| **Nombre del Médico:**  | **Firma, Sello y Registro Médico:**  |

**FORMATO HISTORIA MÉDICA Y NUTRICIONAL DE INGRESO**

**PARTE B. HISTORIA NUTRICIONAL**

Fecha de Ingreso: Día \_\_\_\_\_\_ Mes \_\_\_\_\_\_ Año \_\_\_\_\_\_

Centro de Recuperación Nutricional: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Departamento: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Municipio: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## I. DATOS GENERALES

Nombres y Apellidos: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teléfono o contacto: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fecha Nacimiento: D \_\_\_\_\_ M \_\_\_\_\_ A \_\_\_\_\_ Edad: \_\_\_\_ Meses [ ]  Años [ ]  Sexo: F [ ]  M [ ]

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

Diagnóstico 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 [ ]

¿Cuál (es)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vacunación: Esquema completo para la edad: \_\_\_\_\_\_\_\_ Esquema incompleto para la edad: \_\_\_\_\_\_\_\_\_

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

FAMILIARES:

Obesidad [ ]  Alergias [ ]  HTA [ ]  Diabetes [ ]  Enf. Cardio Vascular [ ]  Cáncer [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

|  |  |  |
| --- | --- | --- |
| **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. Presenta edema: Si [ ]  No [ ]  Grado: \_\_\_\_\_\_\_\_\_\_\_

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 Fórmulas Infantiles: Si [ ]  No [ ]

Tipo de Fórmula: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No. Tomas/día: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Si el niño o niña aún lacta, solicite a la madre que amamante en un espacio tranquilo. Observe durante 15 minutos y describa:

Condición de los pechos: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Posición del bebe durante la lactancia: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Agarre del pecho: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Succión – Deglución: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

La niña o niño mamó durante \_\_\_\_\_\_\_ minutos durante la entrevista para el diligenciamiento del formato.

Plan para programar acciones con el fin de iniciar lactancia o relactancia materna: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*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 [ ]

**Ingesta:** Rápida [ ]  Despacio [ ]  Normal [ ]

**Deglución:** Normal [ ]  Deficiente [ ]

**Mastica:** Si [ ]  No [ ]  Explicar: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hábito intestinal:** Normal [ ]  Estreñimiento [ ]  Diarrea [ ]

**Síntomas gastrointestinales:** Vómito [ ]  Reflujo [ ]  Otro [ ]  ¿Cuál? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

**VII. ANAMNESIS ALIMENTARIA:**

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

## Indique ¿cuál es la frecuencia de consumo de alimentos de cada uno de los siguientes grupos?

##

| **ALIMENTO** | **DIARIO / No. VECES** | **SEMANAL / No. VECES** | **QUINCENAL** | **NUNCA** |
| --- | --- | --- | --- | --- |
| **1** | **2-3** | **4-6** | **1** | **2-3** | **4-6** |
| Arroz, pasta |  |  |  |  |  |  |  |  |
| Papa, plátano, arracacha, ñame |  |  |  |  |  |  |  |  |
| Pan, Arepa |  |  |  |  |  |  |  |  |
| Tomate, zanahoria, ahuyama |  |  |  |  |  |  |  |  |
| Habichuela, alverja verde, acelga, espinaca, brócoli, cebolla,  |  |  |  |  |  |  |  |  |
| Mango, maracuyá, Papaya, Guayaba |  |  |  |  |  |  |  |  |
| Banano, lulo, piña, naranja, |  |  |  |  |  |  |  |  |
| Leche entera |  |  |  |  |  |  |  |  |
| Fórmula láctea |  |  |  |  |  |  |  |  |
| Yogurt, Kumis |  |  |  |  |  |  |  |  |
| Queso |  |  |  |  |  |  |  |  |
| Preparaciones con leche |  |  |  |  |  |  |  |  |
| Carne, Pollo, pescado |  |  |  |  |  |  |  |  |
| Huevo |  |  |  |  |  |  |  |  |
| Leguminosa |  |  |  |  |  |  |  |  |
| Bienestarina |  |  |  |  |  |  |  |  |
| Embutidos |  |  |  |  |  |  |  |  |
| Aceites, Mantequilla y Grasas |  |  |  |  |  |  |  |  |
| Aguacate, coco |  |  |  |  |  |  |  |  |
| Azúcar, panela  |  |  |  |  |  |  |  |  |
| Dulces |  |  |  |  |  |  |  |  |
| Paquetes, Comidas Rápidas |  |  |  |  |  |  |  |  |
| Gaseosas |  |  |  |  |  |  |  |  |
| Otros |  |  |  |  |  |  |  |  |
| **FUENTE:** Construcción propia con aportes del Instrumento para evaluar los hábitos de consumo de alimentos en mujeres gestantes y lactantes, y niños menores de 5 años participantes del proyecto de complementación alimentaria del municipio de Itagüí.**IX.** **CÁLCULO DE CONSUMO APROXIMADO CALORÍAS Y NUTRIENTES DEL NIÑO O NIÑA AL INGRESO DEL PROGRAMA Y RECOMENDADO**De acuerdo con la anamnesis alimentaria, estime el consumo de calorías y nutrientes y el porcentaje de adecuación.

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

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

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**XI. DIAGNOSTICO NUTRICIONAL:**

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**XII. PRESCRIPCIÓN DIETARIA:**

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XIII. INTERVENCIÓN NUTRICIONAL:

A continuación, debe realizar el cálculo de calorías y nutrientes que se deben suministrar al inicio de la atención en el CRN, teniendo en cuenta las necesidades de acuerdo al peso actual y el vehículo de aporte (Fórmula terapéutica lista para el consumo – FTLC, alimentación regular y suplementación con micronutrientes).

Tenga en cuenta que, si el niño o niña tiene lactancia materna, deberá promoverla y esta debe realizarse antes del suministro de la FTLC.

| **Alimento terapéutico listo para el consumo a suministrar** |
| --- |
| **Gramos / día** | **Presentación comercial** | **Observaciones** |
|  |  |  |

| **NUTRIENTES** | **dato/Kg peso actual** | **Aporte Total** | **Aporte total por FTLC** | **Aporte total por alimentación** | **Aporte total suplementación[[1]](#footnote-1) micronutrientes** | **Observaciones** |
| --- | --- | --- | --- | --- | --- | --- |
| Calorías (Kcal) |  |  |  |  |  |  |
| Proteínas (g) |  |  |  |  |  |  |
| Grasas (g) |  |  |  |  |  |  |
| Carbohidratos (g) |  |  |  |  |  |  |
| Calcio (mg) |  |  |  |  |  |  |
| Hierro (mg) |  |  |  |  |  |  |
| Zinc (mg) |  |  |  |  |  |  |
| Vitamina A (UI) |  |  |  |  |  |  |
| Ácido fólico  |  |  |  |  |  |  |

XIV. MENÚ (descripción general del menú indicado, mínimo debe contener: No. De tiempos de comida, alimentos a suministrar en cada tiempo de comida, lactancia materna, tipo de formula con la que se inicia la atención, frecuencia, volumen por toma de formula):

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XV. RECOMENDACIONES:

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| **Nombre del Nutricionista Dietista:**  | **Firma, sello y tarjeta profesional:**  |

1. Para ello debe tener en cuenta la prescripción médica. [↑](#footnote-ref-1)