**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:**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 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, ¿cuál? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Hospitalizaciones neonatales  No Si No sabe  Si, ¿por qué? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Observaciones (indicar diagnósticos y tratamientos en el periodo neonatal) | |
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1. **DESARROLLO:**

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| --- | --- | --- | --- |
| 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, ¿por qué? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Adecuada Escolaridad/Rendimiento  Si 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-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  Influenza-1 | Si No |
| 7 meses | Influenza-2 |  |
| 1 año | Sarampión-Rubeola-Paperas(SRP)-1 Fiebre Amarilla-1, Neumococo-refuerzo  Influenza-anual, Hepatitis A-única  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 |
| 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 \_\_\_\_\_\*C  Axilar 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 | | |  | |  | |
| **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):**

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

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 |

**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: \_\_\_\_ (m) (a) 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 a 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 |  |  |  | | | | | | | | | |

**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)