|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **IDENTIFICACION** |  |  |  |  |  |  |  |  |
| Nombre: | | | | | Fecha del parto: | | | |
| Identificación: | | | Domicilio: | | | Teléfono: | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **ANAMNESIS** |  |  |  |  |  |  |  |
|  | Si | No |  |  | Adecuado | Inadecuado |  |
| Fiebre/escalofríos |  |  |  | Cuidado de heridas |  |  |  |
| Dolor |  |  |  | Lactancia materna |  |  |  |
| Depresión |  |  |  | Alimentación |  |  |  |
|  | normal | Anormal |  | Deambulación |  |  |  |
| Características loquios |  |  |  | Sueño y descanso |  |  |  |
| Eliminación urinaria |  |  |  | Anticoncepción y sexualidad |  |  |  |
| Deposición |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Observaciones: | | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **EXAMEN FISICO** |  | | |  | |  |
|  |  | | |  | |  |
| PESO       kg. T/A        mm Hg. FC        x min. FR        x min. T        °C | | | | | | |
|  | |  |  | |  | |
|  | | Normal | Anormal | | Observaciones | |
| Cavidad oral y mucosas | |  |  | |  | |
| Cardiorrespiratorio | |  |  | |  | |
| Mamas | |  |  | |  | |
| Secreción láctea | |  |  | |  | |
| Abdomen | |  |  | |  | |
| Involución uterina | |  |  | |  | |
| Genitales | |  |  | |  | |
| Características loquios | |  |  | |  | |
| Herida quirúrgica y/o episiorrafia | |  |  | |  | |
| Recto | |  |  | |  | |
| Extremidades inferiores | |  |  | |  | |
| Adaptación sicológica | |  |  | |  | |

|  |  |  |
| --- | --- | --- |
| **DIAGNÓSTICOS:** | | |
| **Conductas** | Diagnósticas |  |
| Remisorias |  |
| Terapéuticas/  Preventivas |  |
| Educativas |  |
| Otras |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
|  | **PROGRAMACIÓN DE CITAS** | |  |  |  |
|  |  |  |  |  |  |
|  | \* Cita para consulta de primera vez en PF: **(dd/mm/aaaa)** | | | | |
|  |  |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
|  | Firma del médico: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reg. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
|  |  |  |  |  |  |  |