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

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| **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:       |

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| **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 |  [ ]  | [ ]   |        |

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

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

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