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| **INSTITUCIÓN** | **ÁREA** | **CARRERA** | **LOCALIZACIÓN** | | | **N° HISTORIA CLÍNICA** |
| PARROQUIA | CANTÓN | PROVINCIA |
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| **FACULTAD** |  |

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| **1 REGISTRO DE ADMISION** | | | | | | | | | | | | | | | | | | | | | | | | | |
| APELLIDO PATERNO APELLIDO MATERNO | | | | | | | | | | | NOMBRES NACIONALIDAD | | | | | | | | | Nº CÉDULA DE CIUDADANIA | | | | | |
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| DIRECCIÓN DE RESIDENCIA HABITUAL | | | | | | | | | | | CANTÓN PROVINCIA | | | | | | | | | Nº TELÉFONO | | | | | |
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| FECHA DE ATENCION | HORA | EDAD | SEXO | | | | ESTADO CIVIL | | | | | INSTRUCCIÓN | | | | | OCUPACIÓN | | | TIPO SEGURO DE SALUD | | | | | |
| MAS | FEM | | | SOL | CAS | DIV | VIU | UL | S/INST | BÁS | BACH | SUP | POST | IESS |  | OTRO |  | N/A |  |
|  |  |  |  |  | | |  |  |  |  |  |  |  |  |  |  |  | | |  | | | | | |
| NOMBRE DE LA PERSONA PARA NOTIFICACION | | | | | PARENTESCO O AFINIDAD | | | | | | DIRECCION | | | | | | | | | Nº TELEFONO | | | | | |
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MAS: MASCULINO - FEM: FEMENINO / SOL: SOLTERO – CAS: CASADO - DIV: DIVORCIADO - VIU: VIUDO - UL: UNÓN LIBRE // S/INST: SIN INSTRUCCIÓN - BÁS: BÁSICA - BACH: BACHILLERATO - SUP: SUPERIOR - POST: POSTGRADO

| **2 INSPECCIÓN SOMÁTICA GENERAL** | |
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| **Cabeza** |  |
| **Tórax** |  |
| **Abdomen** |  |
| **Extremidades** |  |
| **Exámenes complementarios** |  |

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| **3 IMPRESIÓN DIAGNÓSTICA** | NO APLICA |  |
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| **4. ANTECEDENTES PERSONALES Y FAMILIARES RELEVANTES** | | | | | | | PARA DESCRIBIR SEÑALE EL NUMERO Y LA LETRA CORRESPONDIENTE  P= PERSONAL F= FAMILIAR | | | | | | | | | NO APLICA |  |
| 1. ALÉRGICOS |  | 2. CLÍNICOS |  | 3.GINECOLÓGICOS |  | 4.TRAUMATOLÓGICOS | |  | 5. PEDIATRICOS |  | 6. QUIRÚRGICOS |  | 7.FARMACOLOGICOS |  | 8. OTROS | |  |
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| **5 ENFERMEDAD ACTUAL Y REVISIÓN DE SISTEMAS** | CRONOLOGÍA - LOCALIZACIÓN - CARACTERÍSTICAS - INTENSIDAD - FRECUENCIA - FACTORES AGRAVANTES | NO APLICA |  |
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| **6 CARACTERÍSTICAS DEL DOLOR** | | **EVOLUCIÓN** | | | **TIPO** | | | **MODIFICACIONES** | | | | | **ALIVIA CON** | | | | NO APLICA |  |
| REGIÓN ANATÓMICA | PUNTO DOLOROSO | AGUDO | SUB AGUDO | CRÓNICO | EPISODICO | CONTINUO | CÓLICO | POSICIÓN | INGESTA | ESFUERZO | DIGITO PRESIÓN | SE IRRADIA | ANTIES PASMÓDICO | OPIACEO | A I N E | NO ALIVIA | INTENSIDAD  (LEVE / MODERADO / GRAVE) | |
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| **7 SIGNOS VITALES, MEDICIONES Y VALORES** | | | | | | | | | | | | | | | |
| PRESIÓN ARTERIAL |  | FRECUENCIA CARDIACA min |  | FRECUENCIA RESPIRATORIA min |  | TEMPERATURA  BUCAL  °C |  | TEMPERATURA  AXILAR  °C |  | PESO  Kg |  | TALLA  cm |  | | |
| GLASGOW INICIAL |  | OCULAR |  | VERBAL |  | MOTORA |  | TOTAL |  | REACCIÓN PUPILAR DER |  | REACCIÓN PUPILAR IZQ |  | T. LLENADO CAPILAR |  |

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| **8 EXAMEN FISICO** | | | R= REGIONAL S= SISTÉMICO | | | CP = CON EVIDENCIA DE PATOLOGÍA: MARCAR "X" Y DESCRIBIR ABAJO ANOTANDO EL NÚMERO Y LETRA CORRESPONDIENTES | | | | | | SP =SIN EVIDENCIA DE PATOLOGIA: MARCAR "X" Y NO DESCRIBIR | | |
|  | C P S P | |  | C P S P | |  | C P S P | |  | C P S P | |  | CP SP | |
| 1*R* PIEL Y FANERAS  2*R* CABEZA |  |  | 6*R* BOCA  7*R* ORO FARINGE |  |  | 11*R* ABDOMEN  12*R* COLUMNA  VERTEBRAL |  |  | 1*S* ORGANOS DE LOS SENTIDOS  2*S* RESPIRATORIO |  |  | 6*S* URINARIO  7*S* MUSCULO ESQUÉLETICO |  |  |
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| 3*R* OJOS | 8*R* CUELLO | 13*R* INGLE-PERINE | 3*S* CARDIO VASCULAR | 8*S* ENDOCRINO |
| 4*R* OIDOS |  |  | 9*R* AXILAS - MAMAS |  |  | 14*R* MIEMBROS SUPERIORES |  |  | 4*S* DIGESTIVO |  |  | 9*S* HEMO LINFÁTICO |  |  |
| 5*R* NARIZ |  |  | 10*R* TORAX |  |  | 15*R* MIEMBROS INFERIORES |  |  | 5*S* GENITAL |  |  | 10*S* NEUROLÓGICO |  |  |
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| **10 EMBARAZO - PARTO** | | | | | | | | | | | | | NO APLICA |  |
| GESTAS |  | PARTOS |  | | ABORTOS |  | CESAREAS |  | FECHA ULTIMA MENSTRUACION |  | SEMANAS GESTACION |  | MOVIMIENTO FETAL |  |
| FRECUENCIA  C. FETAL |  | MEMBRANAS ROTAS |  | | TIEMPO |  | ALTURA UTERINA |  | PRESEN-  TACION |  | DILATACION |  | BORRA-MIENTO |  |
| PLANO |  | PELVIS UTIL |  | SANGRADO VAGINAL | |  | CONTRACCIONES |  |
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| **11 ANALISIS DE PROBLEMAS** | NO APLICA |  |
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| **12 PLAN DIAGNOSTICO** | | |  | |  | |  | REGISTRAR ABAJO COMENTARIOS Y RESULTADOS, ANOTANDO EL NUMERO | | | | | | | | | | NO APLICA |  | |
| 1. BIOMETRIA |  | 3. QUIMICA SANGUINEA | |  | | 5. GASOMETRIA | | |  | 7. ENDOSCOPIA |  | 9. R-X ABDOMEN |  | 11. TOMOGRAFIA |  | 13. ECOGRAFIA PELVICA |  | 15. INTERCONSULTA | |  |
| 2. UROANALISIS |  | 4. ELECTROLITOS | |  | | 6. ELECTRO CARDIOGRAMA | | |  | 8. R-X TORAX |  | 10. R-X OSEA |  | 12. RESONANCIA |  | 14. ECOGRAFIA ABDOMEN |  | 16. OTROS | |  |
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| **13 DIAGNÓSTICOS PRESUNTIVOS CIE** | | | **14 DIAGNÓSTICOS DEFINITIVOS CIE** | | |
| 1  2  3 |  |  | 1  2  3 |  |  |
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| **15 PLAN DE TRATAMIENTO** | | | |  | |  | | |  | |  | DESCRIBIR ABAJO, ANOTANDO EL NUMERO | | | | | | | |
|  | MEDICAMENTO GENÉRICO | | VIA | | | | DOSIS | | POSO LOGIA | | DIAS | **1**.INDICACIONES GENERALES |  | **2**.PROCEDI-MIENTOS |  | **3**.CONSENTIMIENTO INFORMADO |  | **4**. OTROS |  |
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**Elaborado y aprobado por: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Dr. xxxxxxxxxxxxxxx)**

**Médico Departamento Bienestar Universitario**