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| **DATOS BASICOS** |

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| **FECHA DE CONSULTA** |  |
| **HORA DE CONSULTA** |  |

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| **NOMBRE COMPLETO** |  | | | |
| **TIPO DE DOCUMENTO** |  | | **NUMERO** |  |
| **CÓDIGO** |  | | **EDAD** |  |
| **FECHA DE NACIEMIENTO** |  | | **ESTADO CIVIL** |  |
| **SEXO** | M | F | **TELEFONO** |  |
| **DIRECCIÓN** |  | | | |

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| **ANAMNESIS** |

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| **MOTIVO DE CONSULTA:**    **ENFERMEDAD GENERAL:**  **REVISIÓN POR SISTEMAS:** |

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| **ANTECEDENTES** |

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| **PATOLOGICOS** |  |
| **QUIRURGICOS** |  |
| **TRAUMATICOS** |  |
| **TOXICO ALERGICO** |  |
| **FARMACOLÓGICOS** |  |
| **VENÉREOS** |  |
| **FAMILIARES** |  |
| **GINECOLOGICOS** |  |
| **FAMILIARES** |  |
| **OTROS** |  |

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| **EXAMEN FISICO** |

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| **F. CARDIACA** | **F.RESPIRATORIA** | **TENSIÓN ARTERIAL** | **TEMPRATURA** | **PESO** | **TALLA** |
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| **ESTADO GENERAL** |  |
| **CABEZA / CUELLO** |  |
| **CARDIO / PULMONAR** |  |
| **ABDOMEN** |  |
| **GENITOURINARIO** |  |
| **EXTREMIDADES** |  |
| **PIEL / FUNERAS** |  |
| **SISTEMA NERVIOSO** |  |

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| **DIAGNOSTICO** |  |
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| **TIPO DE DIAGNOSTICO** |  |
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| **PLAN DE TRATAMIENTO** |
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| **RECOMENDACIONES** |
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**FIRMA DEL MEDICO Y REGISTRO**