**PRONTUÁRIO MÉDICO ANEXO**

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| **Dados do Servidor** | |
| Nome:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Matricula:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Data de Nasc:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_RG:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CPF:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Função:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Admissão:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Antecedentes** | |
| Patologias:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Tabagismo: ( ) Sim ( ) Não ( ) Ex Fumante Cigarros por Dia:\_\_\_\_\_\_Ha Quantos Anos:\_\_\_\_\_\_\_\_\_\_\_\_\_  Etilismo ( )Não ( ) Eventual ( ) Diário ( ) Fim de Semana  Atividade Física ( ) Sedentário ( ) \_\_\_\_\_\_X/Semana  Alergias:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cirurgias:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Histórico Familiar:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Histórico Laboral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Situação vacinal** | |
| ( ) Febre Amarela ( ) Hepatite B ( ) Dupla Adulto  ( ) Tríplice Viral ( ) Dupla Viral ( ) Influenza | |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_** | **Médico Examinador**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Assinatura /Carimbo** |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Assinatura Servidor** | |

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| **PRONTUÁRIO MÉDICO ANEXO** |
| **Tipo de Exame Médico** |
| ( )Admissional ( )Periódico ( ) Demissional ( )Mudança de Função ( )Retorno ao Trabalho  ( )Acidente de Trabalho ( )Doença Ocupacional ( )Acidente / Doença Não Ocupacional  ( )período de afastamento: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ à \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ |
| **Exame Físico** |
| PA:\_\_\_\_\_\_\_X\_\_\_\_\_\_\_mmhg Peso:\_\_\_\_\_\_\_\_\_Kg Estatura:\_\_\_\_\_\_\_\_\_cm |
| **Exame Médico:**   |  | | --- | |  | |  | |  | |  | |  | |  | |  | |  | |  | | Medicamentos em Uso: | |
| **Exames Complementares:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Data | Exame | Resultado | Observação | | |  |  |  | |  | |  |  |  | |  | |  |  |  | |  | |  |  |  | |  | |
| Conduta:   |  | | --- | |  | |  | |  | |  | |  | |

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| Anexar cópia (s) de Notificações / CAT, CAS /Atestados Médicos e resultado dos exames solicitados a este prontuário. |
| **Local/Data:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Carimbo e Assinatura – Médico Responsável** |

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