|  |  |  |
| --- | --- | --- |
| MODULO 2 | VALUTAZIONE MEDICA (a cura del MMG dell’utente) | Cod. ROG26/1.2  Rev.02 del 30.06.2025 |

**La compilazione del presente modulo può essere sostituita dalla stampa della scheda medica dal sistema informatizzato del medico di famiglia dell’utente (fascicolo sanitario elettronico).**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| PAZIENTE: |  |  | ANNO |  |  | N°prog. |  |

|  |  |
| --- | --- |
| **Codice Tessera Sanitaria** |  |

## **ANAMNESI**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| |  | | --- | |  |  |  | | --- | |  |  |  | | --- | |  |  |  | | --- | |  | |  | |

**DIAGNOSI ATTUALE**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  |  | | --- | --- | | Patologia prevalente: |  |  |  |  | | --- | --- | | Patologia secondaria 1: |  |  |  |  | | --- | --- | | Patologia secondaria 2: |  |  |  |  | | --- | --- | | Patologia secondaria 3: |  | |  | | |

|  |  |
| --- | --- |
| ❒ EON (Esame Obiettivo Neurologico) |  |

|  |
| --- |
|  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| TAO: | ❒ SI ❒ NO | Ossigenoterapia: | ❒ SI ❒ NO | ❒**altro:** |  | ❒ altro: |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| POSITIVITA’ SIEROLOGICA: | Epatite | ❒ | A | ❒ | B | ❒ | C | ❒ | D | ❒ | E | ❒ | HIV | ❒ | Altro: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| ALLERGIA FARMACI: | ❒ SI ❒ NO | se SI quali: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| INTOLLERANZE ALIMENTARI: |  | DIETE SPECIALI: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| ALLERGIE: |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Piano Riabilitativo: | ❒ SI ❒ NO | Piano Terapeutico: | ❒ SI ❒ NO |

**TERAPIA FARMACOLOGICA IN ATTO**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| FARMACO (principio attivo) | DOSAGGIO | ORARI somministrazione |  | FARMACO (principio attivo) | DOSAGGIO | ORARI somministrazione |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

OPPURE ❏**allegata prescrizione terapia farmacologica del M.M.G.**

|  |  |
| --- | --- |
| Indagini/consulenze effettuate: |  |

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Indagini/consulenze da effettuare: |  |

|  |
| --- |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ❏**Cadenza Monitoraggio clinico parametri vitali**: | | |  | |
|  |  | |  |
| ❏**Patologie da monitorare:** | |  | | |

|  |  |  |
| --- | --- | --- |
| **DATA** |  | **Timbro e Firma del M.M.G.** |

NOTA: numerare progressivamente ogni modulo e archiviare i moduli cronologicamente in un unico plico per ogni singolo anno.