Patients name Chart number MA

Est or New Patient Vitals: BP____/_____ P______ Ht____'/____" Wt______ T_______ SS___________

Medical Allergies:____Pharm_________________________________

Chief Complaint:____

N: Nature of the problem____

____

L: Location of the pain or problem____

____

D: Duration of the pain or problem____

____

O: Onset of the pain or problem____

____

C: Characteristic of the pain or problem pain 1out of 10____

____

A: Things that Aggravate the pain or problem____

____

T: Treatments the patient has tried at home or with another provider*: Have you taken any Nsaids/ Antibiotic/pain meds*____

____

X-rays: R L B/L Views: 2 or 3 of Foot Ankle Toes Scanned for Orthos:____________

Ultrasound: R L B/L VPT:_______ ABI/PVR:________ CVI:_________

Tentative Diagnosis: ____

____

____

CV: DP 0 1 2 3 4 L DP 0 1 2 3 4 R PT 0 1 2 3 4 L PT 0 1 2 3 4 R
CFT ____ sec immediate
EDEMA: Foot R L Bil Ankle R L Bil Leg R L Bil
VARICOSITIES: Blue Enlarged Tortuous Foot R L Bil Ankle R L Bil Leg R L Bil
FEET: Cool Warm Blue Pink
DERM: Nails 1 2 3 4 5 L 1 2 3 4 5 R __Crumbly __ Yellow __ Incurvated __ Thickened

Patients name Chart number MA

Subungal Debris All ____
Shoewear:________________________________ **Compression Hose** yes no
NEURO: Sensations Intact Decreased **GAIT:** Walker W/C Shuffle Scooter Cane Amb
M/S: Bunions Mild L R Bil Hammertoes 1 2 3 4 5 L 1 2 3 4 5 R

Wound Measurements: L______W______D_______CM or MM Odor___Drainage_______Redness_______

Qualifiers: *Class A (1); Class B (2) Class C (1B&2C)*	
***Class A*:** non-traumatic amputation	
Class B: absent pulse: PT R L Bil DP R L Bil	
<u>Three</u> of the following advanced trophic changes**:**	
1. decreased/absent hair growth	2. nail changes
3. pigment changes	4. skin: thin and/or shiny
5. skin: reddened	
Class C:	
1. claudication	2. temperature change
3. edema	4. paresthesias
5. burning	

Plan:____

Results given: Skin/Bio Nail/Bio MRI ABI/PVR/CVI C&S

DME Items Dispensed:____

Rx:____

OTC items dispensed:____

Other Specialist consults:_______________________________________

Reason for return visit: ____

Patient is to be scheduled with which doctor and why:________________

Diabetic shoes ordered: Y or N Code#__________Size________Width______ Biofoam or Prefab

Orthotics Ordered Y or N and type to be ordered________________________