Center for
Clinical Research Inc

Patient Initial____________

PHYSICIAN CONSULTATION

Prior Medical/Medication HX	YES	NO	Date of Onset/ Comments
Diabetes Type I/II			
ESRD/ Dialysis			
Hx of Cancer within 5 years			
Chemotherapy			
Hepatitis			
Immunosuppressive Therapy			
Corticosteroids			
Prednisone			
Antibiotics? Oral/topical			

GENERAL PHYSICAL EXAMINATION

	Normal	Abnormal	Brief Description of Abnormality
General Appearance			
HEENT			
Musculoskeletal/ Extremities			
Cardiovascular			
Lungs			
Chest			
Abdomen			
Back and Spine			
Neurological			

ULCER HISTORY
Ulcer Present? Yes / No
Location of Ulcer? Foot / Ankle / Leg If Foot, plantar or not
Size of Ulcer? __________

I have received permission from the above patient to have a coordinator from Center For Clinical Research obtain contact information to discuss potential study participation.

Physician Signature: ______________________________ Date: ______________________

Printed Name of Physician: ____

Office Phone Number: ____