TABLE 1

What to ask (1 minute)

Does the patient have a history of:

- previous leg/foot ulcer or lower limb amputation/surgery?
- prior angioplasty, stent, or leg bypass surgery?
- foot wound requiring more than 3 weeks to heal?
- smoking or nicotine use?
- diabetes? (If yes, what are the patient's current control measures?)

Does the patient have:

- burning or tingling in legs or feet?
- leg or foot pain with activity or at rest?
- changes in skin color, or skin lesions?
- loss of lower extremity sensation?

Has the patient established regular podiatric care?

TABLE 2

What to look for (1 minute)

Dermatologic exam:

- Does the patient have discolored, ingrown, or elongated nails?
- Are there signs of fungal infection?
- Does the patient have discolored and/or hypertrophic skin lesions, calluses, or corns?
- Does the patient have open wounds or fissures?
- Does the patient have interdigital maceration?

Neurologic exam:

- Is the patient responsive to the Ipswich Touch Test?

Musculoskeletal exam:

- Does the patient have full range of motion of the joints?
- Does the patient have obvious deformities? If yes, for how long?
- Is the midfoot hot, red, or inflamed?

Vascular exam:

- Is the hair growth on the foot dorsum or lower limb decreased?
- Are the dorsalis pedis and posterior tibial pulses palpable?
- Is there a temperature difference between the calves and feet, or between the left and right foot?

TABLE 3

What to teach (1 minute)

Recommendations for daily foot care:

- Visually examine both feet, including soles and between toes. If the patient can't do this, have a family member do it.
- Keep feet dry by regularly changing shoes and socks; dry feet after baths or exercise.
- Report any new lesions, discolorations, or swelling to a health care professional.

Education regarding shoes:

- Educate the patient on the risks of walking barefoot, even when indoors.
- Recommend appropriate footwear and advise against shoes that are too small, tight, or rub against a particular area of the foot.
- Suggest yearly replacement of shoes—more frequently if they exhibit high wear.

Overall health risk management:

- Recommend smoking cessation (if applicable).
- Recommend appropriate glycemic control.

Table 4

Time for a specialist? Mapping out a treatment and follow-up plan*

Priority	Indications	Timeline	Suggested follow-up by specialist
Urgent (active pathology)	Open wound or ulcerative area, with or without signs of infection New neuropathic pain or pain at rest Signs of active Charcot neuroarthropathy (red, hot, swollen midfoot or ankle) Vascular compromise (sudden absence of DP/PT pulses or gangrene)	Immediate referral/consult	As determined by specialist
High (ADA risk category 3)	Presence of diabetes with a previous history of ulcer, Charcot neuroarthropathy, or lower extremity amputation	Immediate or "next available" outpatient referral	Every 1-2 months
Moderate (ADA risk category 2)	Peripheral artery disease +/- LOPS DP/PT pulses diminished or absent Presence of swelling or edema	Referral within 1-3 weeks (if not already receiving regular care)	Every 2-3 months
Low (ADA risk category 1)	LOPS +/- longstanding, nonchanging deformity Patient requires prescriptive or accommodative footwear	Referral within 1 month	Every 4-6 months
Very low (ADA risk category 0)	No LOPS or peripheral artery disease Patient seeks education regarding: foot care, athletic training, appropriate footwear, preventing injury, etc.	Referral within 1-3 months	Annually at minimum

ADA, American Diabetes Association; DP, dorsalis pedis; LOPS, loss of protective sensation; PT, posterior tibial.

*All patients with diabetes should be seen at least once a year by a foot specialist.