WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

Medical Records - CONFIDENTIAL

FROM: TN - Faculty Physicians

Tina W
1415 OLD WEISGARBER RD SUITE 350, KNOXVILLE, TN 37909-1381
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TO:

Name: WILLIAMS, RALPH G

DOB: 05/05/1948

Date Range: 01/01/2025 to 09/17/2025

This document contains the following records of the patient:
- **Encounters and Procedures**

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

Encounters and Procedures

Clinical Encounter Summaries

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

Encounter Date: 04/22/2025

Patient

Name	WILLIAMS, RALPH (76yo, M) ID# 28189	**Appt. Date/Time**	04/22/2025 03:30PM
DOB	05/05/1948	**Service Dept.**	TAZEWELL
Provider	KYLER DALTON VOGEL, PA-C		
Insurance	Med Contracts: OPTUM - VA COMMUNITY CARE NETWORK (VA CCN) Insurance # : 408862654 Prescription: SURESCRIPTS LLC - This member could not be found in the payer's files. Please verify coverage and all member demographic information. details		

Chief Complaint

Bilateral Wound Care

Patient's Care Team

Primary Care Provider: MOUNTAIN HOME VA CLINIC: 705 E CENTRAL AVE, LAFOLLETTE, TN 37766, Ph (423) 562-3531, Fax (423) 566-9993

Patient's Pharmacies

WALGREENS DRUG STORE #11435 (ERX): 915 N BROAD ST, NEW TAZEWELL, TN 37825, Ph (423) 626-5511, Fax (423) 626-5544

Vitals

2025-04-22 15:16

Ht: 6 ft 1 in **Wt:** 222 lbs **BMI:** 29.3

Allergies

Reviewed Allergies

CODEINE, high criticality: Rash

MORPHINE, high criticality: Rash

Medications

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

Reviewed Medications

amiodarone 200 mg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
apixaban 5 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
carbidopa ER 50 mg-levodopa 200 mg tablet,extended release Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
carvediloL 3.125 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
cephALEXin 500 mg capsule TAKE 1 CAPSULE BY MOUTH TWICE DAILY FOR 7 DAYS	02/13/25	filled
citalopram 20 mg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
cyanocobalamin (vit B-12) 1,000 mcg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
doxycycline hyclate 100 mg capsule Take 1 capsule(s) every day by oral route for 30 days.	04/22/25	prescribed
levoFLOXacin 750 mg tablet TAKE ONE TABLET TWICE A DAY	12/17/24	filled
mirtazapine 15 mg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
mupirocin 2 % topical ointment APPLY TO THE AFFECTED AREA(S) EVERY DAY AS DIRECTED	02/13/25	filled
rifAXIMin 550 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
sacubitriL 24 mg-valsartan 26 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
spironolactone 100 mg tablet Take 0.5 tablet(s) every day by oral route.	02/21/25	entered
sucralfate 1 gram tablet TAKE ONE TABLET TWICE A DAY	05/13/24	filled
Synthroid 125 mcg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered

Vaccines

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

None recorded.

Problems

Reviewed Problems
- Type 2 diabetes mellitus - Onset: 02/21/2025
- Neuropathy - Onset: 02/21/2025
- Heart disease - Onset: 02/21/2025
- Kidney disease - Onset: 02/21/2025
- History of hypertension - Onset: 02/21/2025

Family History

Reviewed Family History

Unspecified Relation	- Hypertensive disorder
	- Heart disease

Social History

Reviewed Social History
Advance Directive
Do you have an advance directive?: Yes
Do you have a medical power of attorney?: No
Substance Use
Do you or have you ever smoked tobacco?: Never smoker
Do you or have you ever used any other forms of tobacco or nicotine?: No
What was the date of your most recent tobacco screening?: 02/21/2025
Has tobacco cessation counseling been provided?: Yes
On what date was tobacco cessation counseling provided?: 02/21/2025
What is your level of alcohol consumption?: None
Activities of Daily Living
Are you able to care for yourself?: Yes
Are you able to walk?: Yes: walks with assistive device(s)

Surgical & Procedure History

Surgical & Procedure History not reviewed (last reviewed 04/14/2025)
- Open heart surgery
- Prosthetic arthroplasty of shoulder

Past Medical History

Past Medical History not reviewed (last reviewed 04/07/2025)
Artificial Joints: **Y**
Diabetes: **Y**
Heart Disease: **Y**
Hypertension: **Y**
Kidney Disease: **Y**
Liver Disease: **Y**
Neuropathy: **Y**
Thyroid Problems: **Y**

HPI

Pleasant 76-year-old diabetic male presents today for 1 week follow-up on wound to his right foot. Patient reports his wife has changed the dressing twice since last visit but did not disrupt the skin graft. He reports no problems to the area. Patient also reports he has been in both postop shoes daily since last visit. They believe his daily blood sugars have been normal. Patient reports he did do a lot of walking this past weekend. No other complaints at this time.

ROS

Patient reports **weight gain (___lbs)** but reports no fever, no night sweats, no significant weight loss, no exercise intolerance, no chills, and no malaise. He reports **arm pain on exertion** but reports no chest pain, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, no known heart murmur, and no ankle swelling. He reports **urinary loss of control** but reports no difficulty urinating, no hematuria, and no increased frequency. He reports **muscle weakness and arthralgias/joint pain** but reports no muscle aches, no back pain, no swelling in the extremities, no neck pain, no difficulty walking, no cramps, no osteoporosis, and no fractures. He reports no dry eyes, no vision change, no irritation, and no eye disease/injury. He reports no difficulty hearing and no ear pain. He reports no frequent nosebleeds, no nose problems, and no sinus problems. He reports no sore throat, no bleeding gums, no snoring, no dry mouth, no mouth ulcers, no oral abnormalities, no teeth problems, no ringing in the ears, and no sinusitis. He reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. He reports no abdominal pain, no nausea, no vomiting, no constipation, normal appetite, no diarrhea, not vomiting blood, no dyspepsia, and no GERD. He reports no abnormal mole, no jaundice, no rashes, no laceration, no non-healing areas, no changes in hair/nails, no psoriasis, no change in skin color, and no breast lump. He reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no migraines, no headaches, no tremor, no gait dysfunction, and no paralysis. He reports no depression, no sleep disturbances, feeling safe in a relationship, no alcohol abuse, no anxiety, no hallucinations, no suicidal thoughts, no mood swings, no memory loss, no agitation, no dementia, and no delirium. He reports no fatigue. He reports no swollen glands, no bruising, no excessive bleeding, no anemia, and no phlebitis. He reports no runny nose, no sinus pressure, no itching, no

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

hives, and no frequent sneezing.

Physical Exam

Constitutional: General Appearance: well-developed. Level of Distress: NAD.

Cardiovascular: Arterial Pulses Right: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Arterial Pulses Left: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Edema Right: **edema**. Edema Left: **edema**. Varicosities Right: **varicosities**. Varicosities Left: **varicosities**.

Integumentary: Foot Right: no lesions, ulcers, skin rash, or subcutaneous nodules;**dry**, **atrophic**, and **hair absent**; and skin temperature normal. Foot Left: no lesions, ulcers, skin rash, or subcutaneous nodules; **dry**, **atrophic**, and **hair absent**; and skin temperature normal.

Neurological: Neurological Right: **paresthesias**, **gross sensation diminished**, and **pin prick sensation decreased**. Neurological Left: **paresthesias**, **gross sensation diminished**, and **pin prick sensation decreased**. Manual Muscle Test Right: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5 (movement against resistance). Manual Muscle Test Left: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5 (movement against resistance).

Musculoskeletal: Muscle Strength and Tone Right: normal and normal tone. Muscle Strength and Tone Left: normal and normal tone. Joints, Bones, and Muscles Right: **contractures**, **limited ROM**, **bony abnormalities**, and **pain to palpation**. Joints, Bones, and Muscles Left: **contractures**, **limited ROM**, **bony abnormalities**, and **pain to palpation**.

Class: Class B Right: **skin texture shiny** and **thin**; **dorsalis pedis pulse diminished**, **posterior tibial pulse diminished**, **advanced trophic changes**, **hair growth decrease**, **nail changes**, and **pigmentary changes**; and skin color normal and no redness. Class B Left: **skin texture shiny** and **thin**; **dorsalis pedis pulse diminished**, **posterior tibial pulse diminished**, **advanced trophic changes**, **hair growth decrease**, **nail changes**, and **pigmentary changes**; and skin color normal and no redness. Class C Right: **burning**, **paresthesias**, **edema**, **cold foot**, and **temperature changes** and no claudication. Class C Left: **burning**, **paresthesias**, **edema**, **cold foot**, and **temperature changes** and no claudication.

Toenails 1 through 5 are thickened, discolored, dystrophic, clinically mycotic, and not elongated bilaterally.
Full-thickness ulceration noted right foot medial first MTPJ measuring approximately 2.5 cm x 2.5 cm with 0 depth. Some surrounding erythema noted but improved
Dry eschar noted distal tip left hallux with no surrounding drainage, approximately 1 cm x 1 cm.
DP, PT palpable bilaterally.

Procedure Documentation

DR 11042 - Debridment of Open Wound, Subcutaneous:

After obtaining informed consent, all wounds and wound edges were sharply debrided to level of subcutaneous tissue using a 15 blade scalpel and curette, removing all nonviable/necrotic tissue. Following debridement, punctate bleeding was noted with healthy granular margins. Hemostasis was maintained utilizing manual compression and silver nitrate as necessary. A dry sterile compressive dressing was applied.

Skin Graft-Innovamatrix:

Skin Graft To advance wound healing, an appropriate skin substitute was selected and applied to wound after debridement.
Skin Substitute: Innovamatrix AC
Size-- 2 cm x 2 cm
Product ID--IMX-0202-01
Lot Number-- 072623-1
Expiration Date-- 07/26/2025
Application number-- 3
Zero graft wastage.

Assessment / Plan

1. **Diabetic ulcer of right midfoot associated with type 2 diabetes mellitus, limited to breakdown of skin**

   E11.621: Type 2 diabetes mellitus with foot ulcer
   L97.411: Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin
   - doxycycline hyclate 100 mg capsule - Take 1 capsule(s) every day by oral route for 30 days. Qty: (30) capsule Refills: 0

   Pharmacy: WALGREENS DRUG STORE #11435

2. **Disorder of nervous system due to type 2 diabetes mellitus**

   E11.69: Type 2 diabetes mellitus with other specified complication
   G98.8: Other disorders of nervous system

3. **Onychomycosis**

   B35.1: Tinea unguium

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

4. **Atherosclerosis of arteries of extremities**
   I70.209: Unspecified atherosclerosis of native arteries of extremities, unspecified extremity

5. **Disability of walking**
   R26.2: Difficulty in walking, not elsewhere classified

6. **Antalgic gait**
   R26.89: Other abnormalities of gait and mobility

Discussion Notes

Patient evaluated today and a physical examination was performed.
Discussed diagnosis, etiology, and treatment options with patient.
Sharp debridement of full thickness ulceration to level of subcutaneous tissue was performed today without incident. Patient's wound was innovamatrix skin graft, adaptic gauze, steri strips, dry gauze dressing. Reviewed wound care instructions with patient. Patient's wife to change dressing without disturbing Adaptic gauze in 3 days and then do not change until we see him in a week.Patient to continue dry, sterile dressing daily. Patient to keep dressing clean, dry, and intact. Patient's wife is to help with wound care.
Begin taking doxycycline daily as directed.
Arterial ultrasounds normal.
Discussed need to keep heavy blankets off the tip of his toe.
Discussed importance of glycemic index and tight blood sugar control.
Patient is to avoid barefoot walking.
Continue daily foot inspections.
Continue post-op shoes to wear at all times. Post-op shoe modified further today to prevent pressure.
Patient instructed to keep all pressure off of the wound, especially when sleeping.
If patient develops any concerning pedal changes or possible signs of infection, patient instructed to contact office immediately for urgent evaluation.
Patient to follow-up in 1 weeks for wound care.

Return to Office

- Kyler Dalton Vogel, PA-C for ESTABLISHED PATIENT 15 at HARROGATE on 04/28/2025 at 03:30 PM
- Kyler Dalton Vogel, PA-C for ESTABLISHED PATIENT 15 at HARROGATE on 05/05/2025 at 03:30 PM
- Kyler Dalton Vogel, PA-C for ESTABLISHED PATIENT 15 at HARROGATE on 05/12/2025 at 03:15 PM
- Kyler Dalton Vogel, PA-C for ESTABLISHED PATIENT 15 at TAZEWELL on 05/21/2025 at 03:45 PM

Encounter Sign-Off

Encounter signed-off by Kyler Dalton Vogel, PA-C, 04/23/2025.

Encounter performed and documented by Kyler Dalton Vogel, PA-C
Encounter reviewed & signed by Kyler Dalton Vogel, PA-C on 04/23/2025 at 09:28 AM

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

Encounter Date: 04/14/2025

Patient

Name	WILLIAMS, RALPH (76yo, M) ID# 28189	**Appt. Date/Time**	04/14/2025 03:30PM
DOB	05/05/1948	**Service Dept.**	HARROGATE
Provider	KYLER DALTON VOGEL, PA-C		
Insurance	Med Contracts: OPTUM - VA COMMUNITY CARE NETWORK (VA CCN) Insurance # : 408862654 Prescription: SURESCRIPTS LLC - This member could not be found in the payer's files. Please verify coverage and all member demographic information. details		

Chief Complaint

Bilateral Wound Care

Patient's Care Team

Primary Care Provider: MOUNTAIN HOME VA CLINIC: 705 E CENTRAL AVE, LAFOLLETTE, TN 37766, Ph (423) 562-3531, Fax (423) 566-9993

Patient's Pharmacies

WALGREENS DRUG STORE #11435 (ERX): 915 N BROAD ST, NEW TAZEWELL, TN 37825, Ph (423) 626-5511, Fax (423) 626-5544

Vitals

2025-04-14 15:24

Ht: 6 ft 1 in **Wt:** 222 lbs **BMI:** 29.3

Allergies

Reviewed Allergies

CODEINE, high criticality: Rash

MORPHINE, high criticality: Rash

Medications

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

Reviewed Medications

amiodarone 200 mg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
apixaban 5 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
carbidopa ER 50 mg-levodopa 200 mg tablet,extended release Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
carvediloL 3.125 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
cephALEXin 500 mg capsule TAKE 1 CAPSULE BY MOUTH TWICE DAILY FOR 7 DAYS	02/13/25	filled
citalopram 20 mg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
cyanocobalamin (vit B-12) 1,000 mcg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
doxycycline hyclate 100 mg capsule TAKE 1 CAPSULE BY MOUTH TWICE DAILY FOR 10 DAYS	02/21/25	filled
levoFLOXacin 750 mg tablet TAKE ONE TABLET TWICE A DAY	12/17/24	filled
mirtazapine 15 mg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
mupirocin 2 % topical ointment APPLY TO THE AFFECTED AREA(S) EVERY DAY AS DIRECTED	02/13/25	filled
rifAXIMin 550 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
sacubitriL 24 mg-valsartan 26 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
spironolactone 100 mg tablet Take 0.5 tablet(s) every day by oral route.	02/21/25	entered
sucralfate 1 gram tablet TAKE ONE TABLET TWICE A DAY	05/13/24	filled
Synthroid 125 mcg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered

Vaccines

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

None recorded.

Problems

Reviewed Problems
- Type 2 diabetes mellitus - Onset: 02/21/2025
- Neuropathy - Onset: 02/21/2025
- Heart disease - Onset: 02/21/2025
- Kidney disease - Onset: 02/21/2025
- History of hypertension - Onset: 02/21/2025

Family History

Reviewed Family History

Unspecified Relation	- Hypertensive disorder
	- Heart disease

Social History

Reviewed Social History
Advance Directive
Do you have an advance directive?: Yes
Do you have a medical power of attorney?: No
Substance Use
Do you or have you ever smoked tobacco?: Never smoker
Do you or have you ever used any other forms of tobacco or nicotine?: No
What was the date of your most recent tobacco screening?: 02/21/2025
Has tobacco cessation counseling been provided?: Yes
On what date was tobacco cessation counseling provided?: 02/21/2025
What is your level of alcohol consumption?: None
Activities of Daily Living
Are you able to care for yourself?: Yes
Are you able to walk?: Yes: walks with assistive device(s)

Surgical & Procedure History

Reviewed Surgical & Procedure History
- Open heart surgery
- Prosthetic arthroplasty of shoulder

Past Medical History

Past Medical History not reviewed (last reviewed 04/07/2025)
Artificial Joints: **Y**
Diabetes: **Y**
Heart Disease: **Y**
Hypertension: **Y**
Kidney Disease: **Y**
Liver Disease: **Y**
Neuropathy: **Y**
Thyroid Problems: **Y**

HPI

Pleasant 76-year-old diabetic male presents today for 2-week follow-up on wound to his right foot. Patient reports his wife has been dressing the area every day with Adaptic gauze, dry gauze dressing. She believes that the redness has improved since last visit. He has been trying to keep the pressure of shoes off of the area when he is not walking. He is unsure of his blood sugars over the last 2 weeks.He reports that the tip of the left great toe has turned more black recently. No other complaints at this time.

Pleasant 76-year-old diabetic male presents today for 1 week follow-up on wound to his right foot. Patient reports his wife has changed the dressing twice since last visit but did not disrupt the skin graft. He reports no problems to the area. Patient also reports he has been in both postop shoes daily since last visit. He did have his arterial ultrasound performed which was normal. No other complaints at this time.

ROS

Patient reports **weight gain (___lbs)** but reports no fever, no night sweats, no significant weight loss, no exercise intolerance, no chills, and no malaise. He reports **arm pain on exertion** but reports no chest pain, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, no known heart murmur, and no ankle swelling. He reports **urinary loss of control** but reports no difficulty urinating, no hematuria, and no increased frequency. He reports **muscle weakness and arthralgias/joint pain** but reports no muscle aches, no back pain, no swelling in the extremities, no neck pain, no difficulty walking, no cramps, no osteoporosis, and no fractures. He reports no dry eyes, no vision change, no irritation, and no eye disease/injury. He reports no difficulty hearing and no ear pain. He reports no frequent nosebleeds, no nose problems, and no sinus problems. He reports no sore throat, no bleeding gums, no snoring, no dry mouth, no mouth ulcers, no oral abnormalities, no teeth problems, no ringing in the ears, and no sinusitis. He reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. He reports no abdominal pain, no nausea, no vomiting, no constipation, normal appetite, no diarrhea, not vomiting blood, no dyspepsia, and no GERD. He reports no abnormal mole, no jaundice, no rashes, no laceration, no non-healing areas, no changes in

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

hair/nails, no psoriasis, no change in skin color, and no breast lump. He reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no migraines, no headaches, no tremor, no gait dysfunction, and no paralysis. He reports no depression, no sleep disturbances, feeling safe in a relationship, no alcohol abuse, no anxiety, no hallucinations, no suicidal thoughts, no mood swings, no memory loss, no agitation, no dementia, and no delirium. He reports no fatigue. He reports no swollen glands, no bruising, no excessive bleeding, no anemia, and no phlebitis. He reports no runny nose, no sinus pressure, no itching, no hives, and no frequent sneezing.

Physical Exam

Constitutional: General Appearance: well-developed. Level of Distress: NAD.

Cardiovascular: Arterial Pulses Right: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Arterial Pulses Left: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Edema Right: **edema**. Edema Left: **edema**. Varicosities Right: **varicosities**. Varicosities Left: **varicosities**.

Integumentary: Foot Right: no lesions, ulcers, skin rash, or subcutaneous nodules;**dry**, **atrophic**, and **hair absent**; and skin temperature normal. Foot Left: no lesions, ulcers, skin rash, or subcutaneous nodules; **dry**, **atrophic**, and **hair absent**; and skin temperature normal.

Neurological: Neurological Right: **paresthesias**, **gross sensation diminished**, and **pin prick sensation decreased**. Neurological Left: **paresthesias**, **gross sensation diminished**, and **pin prick sensation decreased**. Manual Muscle Test Right: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5 (movement against resistance). Manual Muscle Test Left: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5 (movement against resistance).

Musculoskeletal: Muscle Strength and Tone Right: normal and normal tone. Muscle Strength and Tone Left: normal and normal tone. Joints, Bones, and Muscles Right: **contractures**, **limited ROM**, **bony abnormalities**, and **pain to palpation**. Joints, Bones, and Muscles Left: **contractures**, **limited ROM**, **bony abnormalities**, and **pain to palpation**.

Class: Class B Right: **skin texture shiny** and **thin**; **dorsalis pedis pulse diminished**, **posterior tibial pulse diminished**, **advanced trophic changes**, **hair growth decrease**, **nail changes**, and **pigmentary changes**; and skin color normal and no redness. Class B Left: **skin texture shiny** and **thin**; **dorsalis pedis pulse diminished**, **posterior tibial pulse diminished**, **advanced trophic changes**, **hair growth decrease**, **nail changes**, and **pigmentary changes**; and skin color normal and no redness. Class C Right: **burning**, **paresthesias**, **edema**, **cold foot**, and **temperature changes** and no claudication. Class C Left: **burning**, **paresthesias**, **edema**, **cold foot**, and **temperature changes** and no claudication.

Toenails 1 through 5 are thickened, discolored, dystrophic, clinically mycotic, and not elongated bilaterally.
Full-thickness ulceration noted right foot medial first MTPJ measuring approximately 2.0 cm x 1.5 cm with 0 depth. Some surrounding erythema noted but improved
Dry eschar noted distal tip left hallux with no surrounding drainage, approximately 1 cm x 1 cm.
DP, PT palpable bilaterally.

Procedure Documentation

DR 11042 - Debridment of Open Wound, Subcutaneous:

After obtaining informed consent, all wounds and wound edges were sharply debrided to level of subcutaneous tissue using a 15 blade scalpel and curette, removing all nonviable/necrotic tissue. Following debridement, punctate bleeding was noted with healthy granular margins. Hemostasis was maintained utilizing manual compression and silver nitrate as necessary. A dry sterile compressive dressing was applied.

Skin Graft-Innovamatrix:

Skin Graft To advance wound healing, an appropriate skin substitute was selected and applied to wound after debridement.
Skin Substitute: Innovamatrix AC
Size-- 2 cm x 2 cm
Product ID--IMX-0202-01
Lot Number-- 052924-1
Expiration Date-- 05/29/2026
Application number-- 2
Zero graft wastage.

Assessment / Plan

1. **Diabetic ulcer of right midfoot associated with type 2 diabetes mellitus, limited to breakdown of skin**
   E11.621: Type 2 diabetes mellitus with foot ulcer
   L97.411: Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin

2. **Disorder of nervous system due to type 2 diabetes mellitus**
   E11.69: Type 2 diabetes mellitus with other specified complication
   G98.8: Other disorders of nervous system

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

3. **Onychomycosis**
   B35.1: Tinea unguium

4. **Atherosclerosis of arteries of extremities**
   I70.209: Unspecified atherosclerosis of native arteries of extremities, unspecified extremity

5. **Disability of walking**
   R26.2: Difficulty in walking, not elsewhere classified

6. **Antalgic gait**
   R26.89: Other abnormalities of gait and mobility

Discussion Notes

Patient evaluated today and a physical examination was performed.
Discussed diagnosis, etiology, and treatment options with patient.
Sharp debridement of full thickness ulceration to level of subcutaneous tissue was performed today without incident. Patient's wound was innovamatrix skin graft, adaptic gauze, steri strips, dry gauze dressing. Reviewed wound care instructions with patient. Patient's wife to change dressing without disturbing Adaptic gauze in 3 days and then do not change until we see him in a week.Patient to continue dry, sterile dressing daily. Patient to keep dressing clean, dry, and intact. Patient's wife is to help with wound care.
Arterial ultrasounds normal.
Discussed need to keep heavy blankets off the tip of his toe.
Discussed importance of glycemic index and tight blood sugar control.
Patient is to avoid barefoot walking.
Continue daily foot inspections.
Continue post-op shoes to wear at all times.
Patient instructed to keep all pressure off of the wound, especially when sleeping.
If patient develops any concerning pedal changes or possible signs of infection, patient instructed to contact office immediately for urgent evaluation.
Patient to follow-up in 1 weeks for wound care.

Return to Office

- Kyler Dalton Vogel, PA-C for ESTABLISHED PATIENT 15 at TAZEWELL on 04/22/2025 at 03:30 PM
- Kyler Dalton Vogel, PA-C for ESTABLISHED PATIENT 15 at HARROGATE on 04/28/2025 at 03:30 PM

Encounter Sign-Off

Encounter signed-off by Kyler Dalton Vogel, PA-C, 04/14/2025.

Encounter performed and documented by Kyler Dalton Vogel, PA-C
Encounter reviewed & signed by Kyler Dalton Vogel, PA-C on 04/14/2025 at 04:31 PM

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

Encounter Date: 04/07/2025

Patient

Name	WILLIAMS, RALPH (76yo, M) ID# 28189	**Appt. Date/Time**	04/07/2025 03:45PM
DOB	05/05/1948	**Service Dept.**	HARROGATE
Provider	KYLER DALTON VOGEL, PA-C		
Insurance	Med Contracts: OPTUM - VA COMMUNITY CARE NETWORK (VA CCN) Insurance # : 408862654 Prescription: SURESCRIPTS LLC - This member could not be found in the payer's files. Please verify coverage and all member demographic information. details		

Chief Complaint

Bilateral Wound Care

Patient's Care Team

Primary Care Provider: MOUNTAIN HOME VA CLINIC: 705 E CENTRAL AVE, LAFOLLETTE, TN 37766, Ph (423) 562-3531, Fax (423) 566-9993

Patient's Pharmacies

WALGREENS DRUG STORE #11435 (ERX): 915 N BROAD ST, NEW TAZEWELL, TN 37825, Ph (423) 626-5511, Fax (423) 626-5544

Vitals

2025-04-07 15:34

Ht: 6 ft 1 in **Wt:** 222 lbs **BMI:** 29.3

Allergies

Reviewed Allergies

CODEINE, high criticality: Rash

MORPHINE, high criticality: Rash

Medications

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

Reviewed Medications

amiodarone 200 mg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
apixaban 5 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
carbidopa ER 50 mg-levodopa 200 mg tablet,extended release Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
carvediloL 3.125 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
cephALEXin 500 mg capsule TAKE 1 CAPSULE BY MOUTH TWICE DAILY FOR 7 DAYS	02/13/25	filled
citalopram 20 mg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
cyanocobalamin (vit B-12) 1,000 mcg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
doxycycline hyclate 100 mg capsule TAKE 1 CAPSULE BY MOUTH TWICE DAILY FOR 10 DAYS	02/21/25	filled
levoFLOXacin 750 mg tablet TAKE ONE TABLET TWICE A DAY	12/17/24	filled
mirtazapine 15 mg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
mupirocin 2 % topical ointment APPLY TO THE AFFECTED AREA(S) EVERY DAY AS DIRECTED	02/13/25	filled
rifAXIMin 550 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
sacubitriL 24 mg-valsartan 26 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
spironolactone 100 mg tablet Take 0.5 tablet(s) every day by oral route.	02/21/25	entered
sucralfate 1 gram tablet TAKE ONE TABLET TWICE A DAY	05/13/24	filled
Synthroid 125 mcg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered

Vaccines

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

None recorded.

Problems

Reviewed Problems
- Type 2 diabetes mellitus - Onset: 02/21/2025
- Neuropathy - Onset: 02/21/2025
- Heart disease - Onset: 02/21/2025
- Kidney disease - Onset: 02/21/2025
- History of hypertension - Onset: 02/21/2025

Family History

Reviewed Family History

Unspecified Relation	- Hypertensive disorder
	- Heart disease

Social History

Reviewed Social History
Advance Directive
Do you have an advance directive?: Yes
Do you have a medical power of attorney?: No
Substance Use
Do you or have you ever smoked tobacco?: Never smoker
Do you or have you ever used any other forms of tobacco or nicotine?: No
What was the date of your most recent tobacco screening?: 02/21/2025
Has tobacco cessation counseling been provided?: Yes
On what date was tobacco cessation counseling provided?: 02/21/2025
What is your level of alcohol consumption?: None
Activities of Daily Living
Are you able to care for yourself?: Yes
Are you able to walk?: Yes: walks with assistive device(s)

Surgical & Procedure History

Reviewed Surgical & Procedure History
- Open heart surgery
- Prosthetic arthroplasty of shoulder

Past Medical History

Reviewed Past Medical History
Artificial Joints: **Y**
Diabetes: **Y**
Heart Disease: **Y**
Hypertension: **Y**
Kidney Disease: **Y**
Liver Disease: **Y**
Neuropathy: **Y**
Thyroid Problems: **Y**

HPI

Pleasant 76-year-old diabetic male presents today for 2-week follow-up on wound to his right foot. Patient reports his wife has been dressing the area every day with Adaptic gauze, dry gauze dressing. She believes that the redness has improved since last visit. He has been trying to keep the pressure of shoes off of the area when he is not walking. He is unsure of his blood sugars over the last 2 weeks.He reports that the tip of the left great toe has turned more black recently. No other complaints at this time.

ROS

Patient reports **weight gain (___lbs)** but reports no fever, no night sweats, no significant weight loss, no exercise intolerance, no chills, and no malaise. He reports **arm pain on exertion** but reports no chest pain, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, no known heart murmur, and no ankle swelling. He reports **urinary loss of control** but reports no difficulty urinating, no hematuria, and no increased frequency. He reports **muscle weakness and arthralgias/joint pain** but reports no muscle aches, no back pain, no swelling in the extremities, no neck pain, no difficulty walking, no cramps, no osteoporosis, and no fractures. He reports no dry eyes, no vision change, no irritation, and no eye disease/injury. He reports no difficulty hearing and no ear pain. He reports no frequent nosebleeds, no nose problems, and no sinus problems. He reports no sore throat, no bleeding gums, no snoring, no dry mouth, no mouth ulcers, no oral abnormalities, no teeth problems, no ringing in the ears, and no sinusitis. He reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. He reports no abdominal pain, no nausea, no vomiting, no constipation, normal appetite, no diarrhea, not vomiting blood, no dyspepsia, and no GERD. He reports no abnormal mole, no jaundice, no rashes, no laceration, no non-healing areas, no changes in hair/nails, no psoriasis, no change in skin color, and no breast lump. He reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no migraines, no headaches, no tremor, no gait dysfunction, and no paralysis. He reports no depression, no sleep disturbances, feeling safe in a relationship, no alcohol abuse, no anxiety, no hallucinations, no suicidal thoughts, no mood swings, no memory loss, no agitation, no dementia, and no delirium. He reports no fatigue. He reports no swollen glands, no bruising, no excessive bleeding, no anemia, and no phlebitis. He reports no runny nose, no sinus pressure, no itching, no

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

hives, and no frequent sneezing.

Physical Exam

Constitutional: General Appearance: well-developed. Level of Distress: NAD.

Cardiovascular: Arterial Pulses Right: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Arterial Pulses Left: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Edema Right: **edema**. Edema Left: **edema**. Varicosities Right: **varicosities**. Varicosities Left: **varicosities**.

Integumentary: Foot Right: no lesions, ulcers, skin rash, or subcutaneous nodules;**dry**, **atrophic**, and **hair absent**; and skin temperature normal. Foot Left: no lesions, ulcers, skin rash, or subcutaneous nodules; **dry**, **atrophic**, and **hair absent**; and skin temperature normal.

Neurological: Neurological Right: **paresthesias**, **gross sensation diminished**, and **pin prick sensation decreased**. Neurological Left: **paresthesias**, **gross sensation diminished**, and **pin prick sensation decreased**. Manual Muscle Test Right: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5 (movement against resistance). Manual Muscle Test Left: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5 (movement against resistance).

Musculoskeletal: Muscle Strength and Tone Right: normal and normal tone. Muscle Strength and Tone Left: normal and normal tone. Joints, Bones, and Muscles Right: **contractures**, **limited ROM**, **bony abnormalities**, and **pain to palpation**. Joints, Bones, and Muscles Left: **contractures**, **limited ROM**, **bony abnormalities**, and **pain to palpation**.

Class: Class B Right: **skin texture shiny** and **thin**; **dorsalis pedis pulse diminished**, **posterior tibial pulse diminished**, **advanced trophic changes**, **hair growth decrease**, **nail changes**, and **pigmentary changes**; and skin color normal and no redness. Class B Left: **skin texture shiny** and **thin**; **dorsalis pedis pulse diminished**, **posterior tibial pulse diminished**, **advanced trophic changes**, **hair growth decrease**, **nail changes**, and **pigmentary changes**; and skin color normal and no redness. Class C Right: **burning**, **paresthesias**, **edema**, **cold foot**, and **temperature changes** and no claudication. Class C Left: **burning**, **paresthesias**, **edema**, **cold foot**, and **temperature changes** and no claudication.

Toenails 1 through 5 are thickened, discolored, dystrophic, clinically mycotic, and not elongated bilaterally.
Full-thickness ulceration noted right foot medial first MTPJ measuring approximately 2.0 cm x 1.5 cm with 0 depth. Some surrounding erythema noted but improved
Dry ecchymosis/gangrene noted distal tip left hallux with no surrounding drainage, approximately 1 cm x 1 cm. Area is cold to the touch.
DP, PT palpable bilaterally.

Procedure Documentation

DR 11042 - Debridment of Open Wound, Subcutaneous:

After obtaining informed consent, all wounds and wound edges were sharply debrided to level of subcutaneous tissue using a 15 blade scalpel and curette, removing all nonviable/necrotic tissue. Following debridement, punctate bleeding was noted with healthy granular margins. Hemostasis was maintained utilizing manual compression and silver nitrate as necessary. A dry sterile compressive dressing was applied.

Skin Graft-Innovamatrix:

Skin Graft To advance wound healing, an appropriate skin substitute was selected and applied to wound after debridement.
Skin Substitute: Innovamatrix AC
Size-- 2 cm x 2 cm
Product ID--IMX-0202-01
Lot Number-- 052924-1
Expiration Date-- 05/29/2026
Application number-- 1
Zero graft wastage.

Assessment / Plan

1. **Diabetic ulcer of right midfoot associated with type 2 diabetes mellitus, limited to breakdown of skin**
   E11.621: Type 2 diabetes mellitus with foot ulcer
   L97.411: Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin

2. **Disorder of nervous system due to type 2 diabetes mellitus**
   E11.69: Type 2 diabetes mellitus with other specified complication
   G98.8: Other disorders of nervous system

3. **Onychomycosis**
   B35.1: Tinea unguium

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

4. **Atherosclerosis of arteries of extremities**
   I70.209: Unspecified atherosclerosis of native arteries of extremities, unspecified extremity

5. **Disability of walking**
   R26.2: Difficulty in walking, not elsewhere classified

6. **Antalgic gait**
   R26.89: Other abnormalities of gait and mobility

Discussion Notes

Patient evaluated today and a physical examination was performed.
Discussed diagnosis, etiology, and treatment options with patient.
Sharp debridement of full thickness ulceration to level of subcutaneous tissue was performed today without incident. Patient's wound was innovamatrix skin graft, adaptic gauze, steri strips, dry gauze dressing. Reviewed wound care instructions with patient. Patient's wife to change dressing without disturbing Adaptic gauze in 3 days and then do not change until we see him in a week.Patient to continue dry, sterile dressing daily. Patient to keep dressing clean, dry, and intact. Patient's wife is to help with wound care.
Due to worsening dry ecchymosis to distal tip left hallux, will send patient for stat ABIs and arterial ultrasounds.
Discussed need to keep heavy blankets off the tip of his toe.
Discussed importance of glycemic index and tight blood sugar control.
Patient is to avoid barefoot walking.
Continue daily foot inspections.
Dispensed 2 postop shoes today, 1 for each foot for each wound. Patient to wear at all times.
Patient instructed to keep all pressure off of the wound, especially when sleeping.
If patient develops any concerning pedal changes or possible signs of infection, patient instructed to contact office immediately for urgent evaluation.
Patient to follow-up in 1 weeks for wound care.

Return to Office

- Kyler Dalton Vogel, PA-C for ESTABLISHED PATIENT 15 at HARROGATE on 04/14/2025 at 03:30 PM
- Kyler Dalton Vogel, PA-C for ESTABLISHED PATIENT 15 at HARROGATE on 04/21/2025 at 03:30 PM
- Kyler Dalton Vogel, PA-C for ESTABLISHED PATIENT 15 at HARROGATE on 04/28/2025 at 03:30 PM

Encounter Sign-Off

Encounter signed-off by Kyler Dalton Vogel, PA-C, 04/07/2025.

Encounter performed and documented by Kyler Dalton Vogel, PA-C
Encounter reviewed & signed by Kyler Dalton Vogel, PA-C on 04/07/2025 at 04:31 PM

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

Encounter Date: 03/24/2025

Patient

Name	WILLIAMS, RALPH (76yo, M) ID# 28189	**Appt. Date/Time**	03/24/2025 02:15PM
DOB	05/05/1948	**Service Dept.**	HARROGATE
Provider	KYLER DALTON VOGEL, PA-C		
Insurance	Med Contracts: OPTUM - VA COMMUNITY CARE NETWORK (VA CCN) Insurance # : 408862654 Prescription: SURESCRIPTS LLC - This member could not be found in the payer's files. Please verify coverage and all member demographic information. details		

Chief Complaint

Bilateral Wound Care

Patient's Care Team

Primary Care Provider: MOUNTAIN HOME VA CLINIC: 705 E CENTRAL AVE, LAFOLLETTE, TN 37766, Ph (423) 562-3531, Fax (423) 566-9993

Patient's Pharmacies

WALGREENS DRUG STORE #11435 (ERX): 915 N BROAD ST, NEW TAZEWELL, TN 37825, Ph (423) 626-5511, Fax (423) 626-5544

Vitals

2025-03-24 15:39

Ht: 6 ft 1 in **Wt:** 222 lbs **BMI:** 29.3

Allergies

Reviewed Allergies

CODEINE, high criticality: Rash

MORPHINE, high criticality: Rash

Medications

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

Reviewed Medications

amiodarone 200 mg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
apixaban 5 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
carbidopa ER 50 mg-levodopa 200 mg tablet,extended release Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
carvediloL 3.125 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
cephALEXin 500 mg capsule TAKE 1 CAPSULE BY MOUTH TWICE DAILY FOR 7 DAYS	02/13/25	filled
citalopram 20 mg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
cyanocobalamin (vit B-12) 1,000 mcg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
doxycycline hyclate 100 mg capsule TAKE 1 CAPSULE BY MOUTH TWICE DAILY FOR 10 DAYS	02/21/25	filled
levoFLOXacin 750 mg tablet TAKE ONE TABLET TWICE A DAY	12/17/24	filled
mirtazapine 15 mg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
mupirocin 2 % topical ointment APPLY TO THE AFFECTED AREA(S) EVERY DAY AS DIRECTED	02/13/25	filled
rifAXIMin 550 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
sacubitriL 24 mg-valsartan 26 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
spironolactone 100 mg tablet Take 0.5 tablet(s) every day by oral route.	02/21/25	entered
sucralfate 1 gram tablet TAKE ONE TABLET TWICE A DAY	05/13/24	filled
Synthroid 125 mcg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered

Vaccines

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

None recorded.

Problems

Reviewed Problems
- Type 2 diabetes mellitus - Onset: 02/21/2025
- Neuropathy - Onset: 02/21/2025
- Heart disease - Onset: 02/21/2025
- Kidney disease - Onset: 02/21/2025
- History of hypertension - Onset: 02/21/2025

Family History

Reviewed Family History

Unspecified Relation	- Hypertensive disorder
	- Heart disease

Social History

Reviewed Social History
Advance Directive
Do you have an advance directive?: Yes
Do you have a medical power of attorney?: No
Substance Use
Do you or have you ever smoked tobacco?: Never smoker
Do you or have you ever used any other forms of tobacco or nicotine?: No
What was the date of your most recent tobacco screening?: 02/21/2025
Has tobacco cessation counseling been provided?: Yes
On what date was tobacco cessation counseling provided?: 02/21/2025
What is your level of alcohol consumption?: None
Activities of Daily Living
Are you able to care for yourself?: Yes
Are you able to walk?: Yes: walks with assistive device(s)

Surgical & Procedure History

Reviewed Surgical & Procedure History
- Open heart surgery
- Prosthetic arthroplasty of shoulder

Past Medical History

Reviewed Past Medical History
Artificial Joints: **Y**
Diabetes: **Y**
Heart Disease: **Y**
Hypertension: **Y**
Kidney Disease: **Y**
Liver Disease: **Y**
Neuropathy: **Y**
Thyroid Problems: **Y**

HPI

Pleasant 76-year-old diabetic male presents today for 2-week follow-up on wound to his right foot. Patient reports his wife has been dressing the area every day with Adaptic gauze, dry gauze dressing. She believes that the redness has improved since last visit. He has been trying to keep the pressure of shoes off of the area when he is not walking. He is unsure of his blood sugars over the last 2 weeks. He did notice a new blood blister to the tip of his left big toe. He does report he walks a lot on inclines and declines. No other complaints at this time.

ROS

Patient reports **weight gain (___lbs)** but reports no fever, no night sweats, no significant weight loss, no exercise intolerance, no chills, and no malaise. He reports **arm pain on exertion** but reports no chest pain, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, no known heart murmur, and no ankle swelling. He reports **urinary loss of control** but reports no difficulty urinating, no hematuria, and no increased frequency. He reports **muscle weakness and arthralgias/joint pain** but reports no muscle aches, no back pain, no swelling in the extremities, no neck pain, no difficulty walking, no cramps, no osteoporosis, and no fractures. He reports no dry eyes, no vision change, no irritation, and no eye disease/injury. He reports no difficulty hearing and no ear pain. He reports no frequent nosebleeds, no nose problems, and no sinus problems. He reports no sore throat, no bleeding gums, no snoring, no dry mouth, no mouth ulcers, no oral abnormalities, no teeth problems, no ringing in the ears, and no sinusitis. He reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. He reports no abdominal pain, no nausea, no vomiting, no constipation, normal appetite, no diarrhea, not vomiting blood, no dyspepsia, and no GERD. He reports no abnormal mole, no jaundice, no rashes, no laceration, no non-healing areas, no changes in hair/nails, no psoriasis, no change in skin color, and no breast lump. He reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no migraines, no headaches, no tremor, no gait dysfunction, and no paralysis. He reports no depression, no sleep disturbances, feeling safe in a relationship, no alcohol abuse, no anxiety, no hallucinations, no suicidal thoughts, no mood swings, no memory loss, no agitation, no dementia, and no delirium. He reports no fatigue. He reports no swollen

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

glands, no bruising, no excessive bleeding, no anemia, and no phlebitis. He reports no runny nose, no sinus pressure, no itching, no hives, and no frequent sneezing.

Physical Exam

Constitutional: General Appearance: well-developed. Level of Distress: NAD.

Cardiovascular: Arterial Pulses Right: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Arterial Pulses Left: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Edema Right: **edema**. Edema Left: **edema**. Varicosities Right: **varicosities**. Varicosities Left: **varicosities**.

Integumentary: Foot Right: no lesions, ulcers, skin rash, or subcutaneous nodules;**dry**, **atrophic**, and **hair absent**; and skin temperature normal. Foot Left: no lesions, ulcers, skin rash, or subcutaneous nodules; **dry**, **atrophic**, and **hair absent**; and skin temperature normal.

Neurological: Neurological Right: **paresthesias**, **gross sensation diminished**, and **pin prick sensation decreased**. Neurological Left: **paresthesias**, **gross sensation diminished**, and **pin prick sensation decreased**. Manual Muscle Test Right: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5 (movement against resistance). Manual Muscle Test Left: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5 (movement against resistance).

Musculoskeletal: Muscle Strength and Tone Right: normal and normal tone. Muscle Strength and Tone Left: normal and normal tone. Joints, Bones, and Muscles Right: **contractures**, **limited ROM**, **bony abnormalities**, and **pain to palpation**. Joints, Bones, and Muscles Left: **contractures**, **limited ROM**, **bony abnormalities**, and **pain to palpation**.

Class: Class B Right: **skin texture shiny** and **thin**; **dorsalis pedis pulse diminished**, **posterior tibial pulse diminished**, **advanced trophic changes**, **hair growth decrease**, **nail changes**, and **pigmentary changes**; and skin color normal and no redness. Class B Left: **skin texture shiny** and **thin**; **dorsalis pedis pulse diminished**, **posterior tibial pulse diminished**, **advanced trophic changes**, **hair growth decrease**, **nail changes**, and **pigmentary changes**; and skin color normal and no redness. Class C Right: **burning**, **paresthesias**, **edema**, **cold foot**, and **temperature changes** and no claudication. Class C Left: **burning**, **paresthesias**, **edema**, **cold foot**, and **temperature changes** and no claudication.

Toenails 1 through 5 are thickened, discolored, dystrophic, clinically mycotic, and not elongated bilaterally.
Full-thickness ulceration noted right foot medial first MTPJ measuring approximately 2.0 cm x 1.5 cm with 0 depth. Some surrounding erythema noted but improved
Blood blister noted distal tip right hallux.
DP, PT palpable bilaterally.

Procedure Documentation

DR 11042 - Debridment of Open Wound, Subcutaneous:

After obtaining informed consent, all wounds and wound edges were sharply debrided to level of subcutaneous tissue using a 15 blade scalpel and curette, removing all nonviable/necrotic tissue. Following debridement, punctate bleeding was noted with healthy granular margins. Hemostasis was maintained utilizing manual compression and silver nitrate as necessary. A dry sterile compressive dressing was applied.

Assessment / Plan

1. **Diabetic ulcer of right midfoot associated with type 2 diabetes mellitus, limited to breakdown of skin**
   E11.621: Type 2 diabetes mellitus with foot ulcer
   L97.411: Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin

2. **Disorder of nervous system due to type 2 diabetes mellitus**
   E11.69: Type 2 diabetes mellitus with other specified complication
   G98.8: Other disorders of nervous system

3. **Onychomycosis**
   B35.1: Tinea unguium

4. **Atherosclerosis of arteries of extremities**
   I70.209: Unspecified atherosclerosis of native arteries of extremities, unspecified extremity

5. **Disability of walking**
   R26.2: Difficulty in walking, not elsewhere classified

6. **Antalgic gait**

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

R26.89: Other abnormalities of gait and mobility

Discussion Notes

Patient evaluated today and a physical examination was performed.
Discussed diagnosis, etiology, and treatment options with patient.
Sharp debridement of full thickness ulceration to level of subcutaneous tissue was performed today without incident. Patient's wound was dressed with betadine, adaptic gauze, dry gauze, and bandaid. Reviewed wound care instructions with patient.
Patient to continue dry, sterile dressing daily. Patient to keep dressing clean, dry, and intact. Patient's wife is to help with wound care.
*Recommend skin grafting due to slow healing of wound.
Discussed need to keep heavy blankets off the tip of his toe.
Discussed importance of glycemic index and tight blood sugar control.
Patient is to avoid barefoot walking.
Continue daily foot inspections.
Patient instructed to keep all pressure off of the wound, especially when sleeping.
If patient develops any concerning pedal changes or possible signs of infection, patient instructed to contact office immediately for urgent evaluation.
Patient to follow-up in 2 weeks for wound care.

Return to Office

- Kyler Dalton Vogel, PA-C for ESTABLISHED PATIENT 15 at HARROGATE on 04/07/2025 at 03:45 PM

Encounter Sign-Off

Encounter signed-off by Kyler Dalton Vogel, PA-C, 03/25/2025.

Encounter performed and documented by Kyler Dalton Vogel, PA-C
Encounter reviewed & signed by Kyler Dalton Vogel, PA-C on 03/25/2025 at 09:50 AM

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

Encounter Date: 03/10/2025

Patient

Name	WILLIAMS, RALPH (76yo, M) ID# 28189	**Appt. Date/Time**	03/10/2025 03:00PM
DOB	05/05/1948	**Service Dept.**	HARROGATE
Provider	KYLER DALTON VOGEL, PA-C		
Insurance	Med Contracts: OPTUM - VA COMMUNITY CARE NETWORK (VA CCN) Insurance # : 408862654 Prescription: SURESCRIPTS LLC - This member could not be found in the payer's files. Please verify coverage and all member demographic information. details		

Chief Complaint

Wound Care

Patient's Care Team

Primary Care Provider: MOUNTAIN HOME VA CLINIC: 705 E CENTRAL AVE, LAFOLLETTE, TN 37766, Ph (423) 562-3531, Fax (423) 566-9993

Patient's Pharmacies

WALGREENS DRUG STORE #11435 (ERX): 915 N BROAD ST, NEW TAZEWELL, TN 37825, Ph (423) 626-5511, Fax (423) 626-5544

Vitals

2025-03-10 14:06

Ht: 6 ft 1 in **Wt:** 222 lbs **BMI:** 29.3

Allergies

Reviewed Allergies

CODEINE, high criticality: Rash

MORPHINE, high criticality: Rash

Medications

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

Reviewed Medications

amiodarone 200 mg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
apixaban 5 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
carbidopa ER 50 mg-levodopa 200 mg tablet,extended release Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
carvediloL 3.125 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
cephALEXin 500 mg capsule TAKE 1 CAPSULE BY MOUTH TWICE DAILY FOR 7 DAYS	02/13/25	filled
citalopram 20 mg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
cyanocobalamin (vit B-12) 1,000 mcg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
doxycycline hyclate 100 mg capsule TAKE 1 CAPSULE BY MOUTH TWICE DAILY FOR 10 DAYS	02/21/25	filled
levoFLOXacin 750 mg tablet TAKE ONE TABLET TWICE A DAY	12/17/24	filled
mirtazapine 15 mg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered
mupirocin 2 % topical ointment APPLY TO THE AFFECTED AREA(S) EVERY DAY AS DIRECTED	02/13/25	filled
rifAXIMin 550 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
sacubitriL 24 mg-valsartan 26 mg tablet Take 1 tablet(s) twice a day by oral route.	02/21/25	entered
spironolactone 100 mg tablet Take 0.5 tablet(s) every day by oral route.	02/21/25	entered
sucralfate 1 gram tablet TAKE ONE TABLET TWICE A DAY	05/13/24	filled
Synthroid 125 mcg tablet Take 1 tablet(s) every day by oral route.	02/21/25	entered

Vaccines

WILLIAMS, Ralph G (id #28189, dob: 05/05/1948)

None recorded.

Problems

Reviewed Problems
- Type 2 diabetes mellitus - Onset: 02/21/2025
- Neuropathy - Onset: 02/21/2025
- Heart disease - Onset: 02/21/2025
- Kidney disease - Onset: 02/21/2025
- History of hypertension - Onset: 02/21/2025

Family History

Reviewed Family History

Unspecified Relation	- Hypertensive disorder
	- Heart disease

Social History

Reviewed Social History
Advance Directive
Do you have an advance directive?: Yes
Do you have a medical power of attorney?: No
Substance Use
Do you or have you ever smoked tobacco?: Never smoker
Do you or have you ever used any other forms of tobacco or nicotine?: No
What was the date of your most recent tobacco screening?: 02/21/2025
Has tobacco cessation counseling been provided?: Yes
On what date was tobacco cessation counseling provided?: 02/21/2025
What is your level of alcohol consumption?: None
Activities of Daily Living
Are you able to care for yourself?: Yes
Are you able to walk?: Yes: walks with assistive device(s)

Surgical & Procedure History

Reviewed Surgical & Procedure History
- Open heart surgery
- Prosthetic arthroplasty of shoulder

Past Medical History

Reviewed Past Medical History
Artificial Joints: **Y**
Diabetes: **Y**
Heart Disease: **Y**
Hypertension: **Y**
Kidney Disease: **Y**
Liver Disease: **Y**
Neuropathy: **Y**
Thyroid Problems: **Y**

HPI

Pleasant 76-year-old diabetic male new patient presents today for evaluation of a wound to his right foot. Patient and his wife reports that the wound has been present for approximately 1 week. They report he went to the urgent care last Thursday who prescribed an antibiotic as well as a cream to place on the wound. His wife believes that the wound looks less deep but is more red than it was previously. She has been covering it with the antibiotic ointment as well as a few different types of dressing. He wear shoes when out of the house but likes to walk barefoot at home. He reports his last A1c was 6.7% but he has been removed from all of his diabetic medication due to newly diagnosed cirrhosis. He has not had any vascular studies performed on his legs in the past. He reports that the VA normally trims his toenails form and keeps him up-to-date on diabetic his inserts. Patient reports he has been hospitalized for diabetic ulcer before and developed C. difficile from usage of clindamycin. No other complaints at this time.

Pleasant 76-year-old diabetic male presents today for 2-week follow-up on wound to his right foot. Patient reports his wife has been dressing the area every day with Adaptic gauze, dry gauze dressing. She believes that the redness has improved since last visit. He did complete his antibiotic as directed. He has been trying to keep the pressure of shoes off of the area when he is not walking. He is unsure of his blood sugars over the last 2 weeks. No other complaints at this time.

ROS

Patient reports **weight gain (___lbs)** but reports no fever, no night sweats, no significant weight loss, no exercise intolerance, no chills, and no malaise. He reports **arm pain on exertion** but reports no chest pain, no shortness of breath when walking, no shortness of breath when lying down, no palpitations, no known heart murmur, and no ankle swelling. He reports **urinary loss of control** but reports no difficulty urinating, no hematuria, and no increased frequency. He reports**muscle weakness and arthralgias/joint pain** but reports no muscle aches, no back pain, no swelling in the extremities, no neck pain, no difficulty walking, no cramps, no osteoporosis, and no fractures. He reports no dry eyes, no vision change, no irritation, and no eye disease/injury. He reports no difficulty hearing and no ear pain. He reports no frequent nosebleeds, no nose problems, and no sinus problems. He

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reports no sore throat, no bleeding gums, no snoring, no dry mouth, no mouth ulcers, no oral abnormalities, no teeth problems, no ringing in the ears, and no sinusitis. He reports no cough, no wheezing, no shortness of breath, no coughing up blood, and no sleep apnea. He reports no abdominal pain, no nausea, no vomiting, no constipation, normal appetite, no diarrhea, not vomiting blood, no dyspepsia, and no GERD. He reports no abnormal mole, no jaundice, no rashes, no laceration, no non-healing areas, no changes in hair/nails, no psoriasis, no change in skin color, and no breast lump. He reports no loss of consciousness, no weakness, no numbness, no seizures, no dizziness, no migraines, no headaches, no tremor, no gait dysfunction, and no paralysis. He reports no depression, no sleep disturbances, feeling safe in a relationship, no alcohol abuse, no anxiety, no hallucinations, no suicidal thoughts, no mood swings, no memory loss, no agitation, no dementia, and no delirium. He reports no fatigue. He reports no swollen glands, no bruising, no excessive bleeding, no anemia, and no phlebitis. He reports no runny nose, no sinus pressure, no itching, no hives, and no frequent sneezing.

Physical Exam

Constitutional: General Appearance: well-developed. Level of Distress: NAD.

Cardiovascular: Arterial Pulses Right: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Arterial Pulses Left: **dorsalis pedis diminished** and **posterior tibialis diminished** and capillary refill test immediate. Edema Right: **edema**. Edema Left: **edema**. Varicosities Right: **varicosities**. Varicosities Left: **varicosities**.

Integumentary: Foot Right: no lesions, ulcers, skin rash, or subcutaneous nodules;**dry**, **atrophic**, and **hair absent**; and skin temperature normal. Foot Left: no lesions, ulcers, skin rash, or subcutaneous nodules; **dry**, **atrophic**, and **hair absent**; and skin temperature normal.

Neurological: Neurological Right: **paresthesias**, **gross sensation diminished**, and **pin prick sensation decreased**. Neurological Left: **paresthesias**, **gross sensation diminished**, and **pin prick sensation decreased**. Manual Muscle Test Right: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5 (movement against resistance). Manual Muscle Test Left: plantarflexors 5/5 (movement against resistance), dorsiflexors 5/5 (movement against resistance), invertors 5/5 (movement against resistance), and evertors 5/5 (movement against resistance).

Musculoskeletal: Muscle Strength and Tone Right: normal and normal tone. Muscle Strength and Tone Left: normal and normal tone. Joints, Bones, and Muscles Right: **contractures**, **limited ROM**, **bony abnormalities**, and **pain to palpation**. Joints, Bones, and Muscles Left: **contractures**, **limited ROM**, **bony abnormalities**, and **pain to palpation**.

Class: Class B Right: **skin texture shiny** and **thin**; **dorsalis pedis pulse diminished**, **posterior tibial pulse diminished**, **advanced trophic changes**, **hair growth decrease**, **nail changes**, and **pigmentary changes**; and skin color normal and no redness. Class B Left: **skin texture shiny** and **thin**; **dorsalis pedis pulse diminished**, **posterior tibial pulse diminished**, **advanced trophic changes**, **hair growth decrease**, **nail changes**, and **pigmentary changes**; and skin color normal and no redness. Class C Right: **burning**, **paresthesias**, **edema**, **cold foot**, and **temperature changes** and no claudication. Class C Left: **burning**, **paresthesias**, **edema**, **cold foot**, and **temperature changes** and no claudication.

Toenails 1 through 5 are thickened, discolored, dystrophic, clinically mycotic, and not elongated bilaterally.
Full-thickness ulceration noted right foot medial first MTPJ measuring approximately 2.0 cm x 1.5 cm with 0 depth. Some surrounding erythema noted but improved
Dry stable eschar noted distal tip bilateral hallux.
DP, PT palpable bilaterally.

Procedure Documentation

DR 11042 - Debridment of Open Wound, Subcutaneous:

After obtaining informed consent, all wounds and wound edges were sharply debrided to level of subcutaneous tissue using a 15 blade scalpel and curette, removing all nonviable/necrotic tissue. Following debridement, punctate bleeding was noted with healthy granular margins. Hemostasis was maintained utilizing manual compression and silver nitrate as necessary. A dry sterile compressive dressing was applied.

Assessment / Plan

1. **Diabetic ulcer of right midfoot associated with type 2 diabetes mellitus, limited to breakdown of skin**
   E11.621: Type 2 diabetes mellitus with foot ulcer
   L97.411: Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin

2. **Disorder of nervous system due to type 2 diabetes mellitus**
   E11.69: Type 2 diabetes mellitus with other specified complication
   G98.8: Other disorders of nervous system

3. **Onychomycosis**
   B35.1: Tinea unguium

4. **Atherosclerosis of arteries of extremities**

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I70.209: Unspecified atherosclerosis of native arteries of extremities, unspecified extremity

5. **Disability of walking**

R26.2: Difficulty in walking, not elsewhere classified

6. **Antalgic gait**

R26.89: Other abnormalities of gait and mobility

Discussion Notes

Patient evaluated today and a physical examination was performed.
Discussed diagnosis, etiology, and treatment options with patient.
Sharp debridement of full thickness ulceration to level of subcutaneous tissue was performed today without incident. Patient's wound was dressed with betadine, adaptic gauze, dry gauze, and bandaid. Reviewed wound care instructions with patient.
Patient to continue dry, sterile dressing daily. Patient to keep dressing clean, dry, and intact. Patient's wife is to help with wound care.
Discussed importance of glycemic index and tight blood sugar control.
Patient is to avoid barefoot walking.
Continue daily foot inspections.
Patient instructed to keep all pressure off of the wound, especially when sleeping.
If patient develops any concerning pedal changes or possible signs of infection, patient instructed to contact office immediately for urgent evaluation.
Patient to follow-up in 2 weeks for wound care.

Return to Office

- Kyler Dalton Vogel, PA-C for ESTABLISHED PATIENT 15 at HARROGATE on 03/24/2025 at 02:15 PM

Encounter Sign-Off

Encounter signed-off by Kyler Dalton Vogel, PA-C, 03/10/2025.

Encounter performed and documented by Kyler Dalton Vogel, PA-C
Encounter reviewed & signed by Kyler Dalton Vogel, PA-C on 03/10/2025 at 02:37 PM