Comprehensive Diabetes Foot Examination Form

Name: ___________________________ Date: ___________________ Age: ________________

Age at Onset: _____ Diabetes Type □ 1 □ 2

I. Medical History
(Check all that apply.)
□ Peripheral Neuropathy □ Retinopathy
□ Cardiovascular Disease □ Peripheral Vascular Disease
□ Nephropathy □ __________

II. Current History
1. Any change in the foot or feet since the last evaluation?
□ Yes □ No
2. Current ulcer or history of a foot ulcer?
□ Yes □ No
3. Is there pain in the calf muscles when walking that is relieved by rest?
□ Yes □ No

III. Foot Exam
1. Are the nails thick, too long, ingrown or infected with fungal disease?
□ Yes □ No

2. Note foot deformities.
□ Toe deformities □ Bunions □ Charcot foot □ Foot drop
□ Prominent metatarsal heads
□ Amputation (Specify date, side and level.)

3. Pedal Pulses
(Fill in the blanks with a “P” or an “A” to indicate present or absent.)
Posterior tibial: □ Dorsalis pedis:
Left □ Left □
Right □ Right □

4. Is the skin thin, fragile, shiny and hairless?
□ Yes □ No

5. Is there evidence of callus formation?
□ Yes □ No

6. Are there signs of pre-ulceration?
□ Yes □ No

7. Any blood or discharge on the socks or hose?
□ Yes □ No

IV. Sensory Foot Exam
Label sensory level with a “+” in the five circled areas of the foot if the patient can feel the 5.07 Semmes-Weinstein (10-gram) nylon monofilament and “−” if the patient cannot feel the filament.

(Measure, draw in and label the patient’s skin condition)
(C) = Callus (R) = Redness (W) = Warmth
(F) = Fissure (S) = Swelling (U) = Ulcer
(M = Maceration (PU) = Pre-ulcerative lesion
(D) = Dryness

V. Risk Categorization (Check appropriate item.)
Low-Risk Patient
All of the following:
□ Intact protective sensation □ Pedal pulses present
□ No prior foot ulcer □ No amputation
□ No foot deformity

High-Risk Patient One or more of the following:
□ Loss of protective sensation
□ Absent pedal pulses
□ Foot deformity
□ History of foot ulcer
□ Previous Amputation

VI. Footwear Assessment
1. Does the patient wear appropriate shoes?
□ Yes □ No

2. Does the patient need diabetic shoes/inserts?
□ Yes □ No

VII. Education
1. Has the patient had prior foot care education?
□ Yes □ No

2. Can the patient demonstrate appropriate foot-care?
□ Yes □ No

VIII. Management Plan (Check all that apply)
□ Provide patient education for preventative foot care. Date: ________________
□ Provide patient education about HbA1c or other aspect of self-care.
□ Vascular Laboratory
□ Hemoglobin A1c
□ Other ________________

Date: ________________ Provider Signature: __________________________