



DIABETIC FOOT EXAM

TODAYS DATE: _____ PATIENT NAME: _____ DOB _____

Has patient received Diabetic Shoes and Inserts before? YES NO

History:

History of Diabetes? YES NO History of Foot Deformity? YES NO

History of Amputation? YES NO History of Foot Ulcer/Wounds? YES NO

History of Callus? YES NO History of Vascular Disease? YES NO

ASSESSMENT: Patient received a dermatologic, neurologic, musculoskeletal and vascular foot exam today including IpTT.

Is patient a partial toe/foot amputee, a below knee amputee or an above knee amputee? YES NO

If so, which side and what level? right left bilateral _____ Level _____

DERMATOLOGIC: Foot Discoloration Callus evidence Ulcer Fungal infections

Bluish skin Loss of hair Nail deformity Fissure

NEUROLOGICAL: Right Foot checked Left foot Checked

IS THERE A LOSS OF PROTECTIVE SENSATION? YES NO

VASCULAR: Normal Pulses Diminished Pulses Absent Pulses Edema Hair loss

MUSCULAR: Normal Range of Motion Abnormal Range of Motion

NOTED DEFORMITIES: Bunions Hammer toes Clawing Diminished Arch Charcot

Calcaneal Spur Prominent Met Heads Pronation Pes Planus

Other Deformity: _____

FUNCTIONAL GOALS FOR PATIENT: (check all that apply) Provision of therapeutic footwear/inserts for protection Protection of sensation-compromised foot through daily inspections, cleanliness and care of feet Refer to a Specialist Other _____

PATIENT QUALIFIES FOR DIABETIC SHOES AND INSERTS YES NO

Provider Name: _____

Provider Signature _____ Date _____