

ANNUAL COMPREHENSIVE DIABETES FOOT EXAM FORM

Name: _____ Date: _____ ID#: _____

I. Presence of Diabetes Complications

1. Check all that apply.

- ☐ Peripheral Neuropathy
- ☐ Nephropathy
- ☐ Retinopathy
- ☐ Peripheral Vascular Disease
- ☐ Cardiovascular Disease
- ☐ Amputation (Specify date, side, and level)

Current ulcer or history of a foot ulcer?
Y ___ N ___

For Sections II & III, fill in the blanks with "Y" or "N" or with an "R," "L," or "B" for positive findings on the right, left, or both feet.

II. Current History

1. Is there pain in the calf muscles when walking that is relieved by rest?
Y ___ N ___

2. Any change in the foot since the last evaluation? Y ___ N ___
3. Any shoe problems? Y ___ N ___
4. Any blood or discharge on socks or hose? Y ___ N ___
5. Smoking history? Y ___ N ___
6. Most recent hemoglobin A1c result
_____% ____ date

III. Foot Exam

1. Skin, Hair, and Nail Condition

Is the skin thin, fragile, shiny and hairless? Y ___ N ___

Are the nails thick, too long, ingrown, or infected with fungal disease? Y ___ N ___

Measure, draw in, and label the patient's skin condition, using the key and the foot diagram below.

C=Callus U=Ulcer PU=Pre-Ulcer
F=Fissure M=Maceration R=Redness
S=Swelling W=Warmth D=Dryness

2. Note Musculoskeletal Deformities

- ☐ Toe deformities
- ☐ Bunions (Hallus Valgus)
- ☐ Charcot foot
- ☐ Foot drop
- ☐ Prominent Metatarsal Heads

3. Pedal Pulses

Fill in the blanks with a "P" or an "A" to indicate present or absent.

Posterior tibial Left ___ Right ___
Dorsalis pedis Left ___ Right ___

4. Sensory Foot Exam

Label sensory level with a "+" in the five circled areas of the foot if the patient can feel the 5.07 (10-gram) Semme-Weinstein filament and "-" if the patient cannot feel the filament.

NOTES



Right Foot



Left Foot

5. Vibration Perception with 128-Hz tuning fork

Check appropriate box.

- ☐ Normal (+)
- ☐ Abnormal (-)

IV. Risk Categorization

Check appropriate box.

☐ Low Risk Patient

All of the following:

- ☐ Intact protective sensation
- ☐ Pedal pulses present
- ☐ No deformity
- ☐ No prior foot ulcer
- ☐ No amputation

☐ High Risk Patient

One or more of the following:

- ☐ Loss of protective sensation
- ☐ Absent pedal pulses
- ☐ Foot deformity
- ☐ History of foot ulcer
- ☐ Prior amputation

V. Footwear Assessment

Indicate yes or no.

1. Does the patient wear appropriate shoes? Y ___ N ___
2. Does the patient need inserts? Y ___ N ___
3. Should corrective footwear be prescribed? Y ___ N ___

VI. Education

Indicate yes or no.

1. Has the patient had prior foot care education? Y ___ N ___
2. Can the patient demonstrate appropriate foot care? Y ___ N ___
3. Does the patient need smoking cessation counseling?
Y ___ N ___
4. Does the patient need education about HbA1c or other diabetes self-care? Y ___ N ___

Provider Signature _____

VII. Management Plan

Check all that apply.

1. Self-management education:

Provide patient education for preventive foot care. Date: _____

Provide or refer for smoking cessation counseling. Date: _____

Provide patient education about HbA1c or other aspect of self-care. Date: _____

2. Diagnostic studies:

- ☐ Vascular Laboratory
- ☐ Hemoglobin A1c (at least twice per year)
- ☐ Other: _____

3. Footwear recommendations:

- ☐ None
- ☐ Athletic shoes
- ☐ Accommodative inserts
- ☐ Custom shoes
- ☐ Depth shoes
- ☐ Socks

4. Refer to:

- ☐ Primary Care Provider
- ☐ Diabetes Educator
- ☐ Podiatrist
- ☐ RN Foot Specialist
- ☐ Pedorthist
- ☐ Orthotist
- ☐ Endocrinologist
- ☐ Vascular Surgeon
- ☐ Foot Surgeon
- ☐ Rehab. Specialist
- ☐ Other: _____

5. Follow-up Care:

Schedule follow-up visit. Date: _____