# Comprehensive Diabetes Foot Examination Form

Adapted from the National Diabetes Education Program’s Foot Screening Form

**Name:** ___________________  **MRN/DOB:** ___________  **Date:** ___________  **Age:** ___________

**Age at Onset:** ___________  **Diabetes Type:** 1 2  
**Current Treatment:** [ ] Diet  [ ] Oral  [ ] Insulin

## I. Medical History

(Check all that apply.)
- [ ] Peripheral Neuropathy
- [ ] Cardiovascular Disease
- [ ] Nephropathy
- [ ] Retinopathy
- [ ] Peripheral Vascular Disease

## 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 “P” or an “A” to indicate present or absent)
   - Posterior tibial: [ ]  
   - Dorsalis pedis: [ ]
   - Left [ ]
   - Left [ ]
   - Right [ ]
   - Right [ ]

4. Skin Condition (Measure, draw in and label the patient’s skin condition using the key and foot diagram to the right.)
   - C = Callus  R = Redness  W = Warmth
   - F = Fissure  S = Swelling  U = Ulcer
   - M = Maceration  PU = Pre-ulcerative lesion  D = Dryness

## 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 filament and “-” if the patient cannot feel the filament.

## V. Risk Categorization

(Check appropriate item.)

**High-Risk Patient**
- One or more of the following:
  - [ ] Loss of protective sensation
  - [ ] Absent pedal pulses
  - [ ] Severe foot deformity
  - [ ] History of foot ulcer

**Low-Risk Patient**
- All of the following:
  - [ ] Intact protective sensation
  - [ ] No severe deformity
  - [ ] No prior foot ulcer
  - [ ] Pedal pulses present
  - [ ] No severe deformity
  - [ ] No amputation

## VI. Footwear Assessment

1. Does the patient wear appropriate shoes?
   - [ ] Yes  [ ] No

2. Does the patient need inserts/orthotics?
   - [ ] Yes  [ ] No

## VII. Education

1. Has the patient had prior foot care education?
   - [ ] Yes  [ ] No

2. Can the patient demonstrate appropriate self-care?
   - [ ] Yes  [ ] No

## VII. Management Plan

(Check all that apply.)

- [ ] Provide patient education for prevention foot care.
- [ ] Refer to appropriate physician: ________________________________

Date: ____________________  
Provider Signature: ____________________________________________

Provider Name (print): ____________________________________________

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