

DIABETES FOOT SCREEN

Patient's Name (Last, First, MI) _____ Date: _____
 Physician's Name _____ Sex: M F
 ID No: _____
 D.O.B. _____

Check (✓) the appropriate boxes below to indicate findings on the right or left foot:

	No findings	Yes Left	Yes Right
Is there a foot ulcer now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there a history of foot ulcer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there an abnormal shape of the foot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there toe deformity? (bunions, hammertoes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are the toenails thick or ingrown? (fungal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there a callus buildup?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there swelling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there elevated skin temperature?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there muscle weakness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there lower extremity pain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has there been a previous amputation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there a blister or laceration?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can the patient see the bottom of his/her feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient use footwear appropriate for his/her category?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Vascular Findings: (+) Present (-) Absent

	Left	Right
Dorsalis Pedis Pulse	_____	_____
Post Tibial Pulse	_____	_____
Foot Hair	_____	_____
Capillary Refill	_____	_____
Edema	_____	_____



Indicate the level of sensation in the circles on the foot diagram

- + = Can feel the 10 gram nylon filament
- = Cannot feel the 10 gram nylon filament

Skin conditions on the foot and between the toes:

- Label: Skin condition with:
R - Redness, **S** - Swelling, **W** - Warmth, **D** - Dryness, and/or **M** - Maceration
- Draw pattern where there is:

Callus  Pre-Ulcer  Ulcer  (note ulcer size in cm.)

Risk Category:

- 0 = No loss of protective sensation
- 1 = Loss of protective sensation with no weakness, deformity, callus, pre-ulcer or history of ulceration
- 2 = Loss of protective sensation with weakness, deformity, pre-ulcer or callus but no history of ulceration or poor circulation
- 3 = History of plantar ulceration or neuropathic fracture

Refer to:

____ Primary Care Provider ____ Endocrinologist ____ Certified Diabetes Educator ____ Vascular surgeon
 ____ Podiatrist ____ Orthotist ____ Other _____

Follow-up Care: Schedule follow-up visit. Date: _____

Signature: _____