

Annual Comprehensive Diabetes Foot Exam Form

Name: _____ Date: _____ ID#: _____

<p>I. Presence of Diabetes Complications <i>1. Check all that apply.</i></p> <p><input type="checkbox"/> Peripheral Neuropathy <input type="checkbox"/> Nephropathy <input type="checkbox"/> Retinopathy <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> Amputation (<i>Specify date, side, and level</i>)</p> <hr/> <p>Current ulcer or history of a foot ulcer? Y ___ N ___</p> <p><i>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.</i></p> <p>II. Current History 1. Is there pain in the calf muscles when walking that is relieved by rest? Y ___ N ___</p>	<p>2. Any change in the foot since the last evaluation? Y ___ N ___</p> <p>3. Any shoe problems? Y ___ N ___</p> <p>4. Any blood or discharge on socks or hose? Y ___ N ___</p> <p>5. Smoking history? Y ___ N ___</p> <p>6. Most recent hemoglobin A1c result _____% _____ date</p> <hr/> <p>III. Foot Exam 1. Skin, Hair, and Nail Condition Is the skin thin, fragile, shiny and hairless? Y ___ N ___</p> <p>Are the nails thick, too long, ingrown, or infected with fungal disease? Y ___ N ___</p>	<p><i>Measure, draw in, and label the patient's skin condition, using the key and the foot diagram below.</i></p> <p>C=Callus U=Ulcer PU=Pre-Ulcer F=Fissure M=Maceration R=Redness S=Swelling W=Warmth D=Dryness</p> <p>2. Note Musculoskeletal Deformities</p> <p><input type="checkbox"/> Toe deformities <input type="checkbox"/> Bunions (Hallus Valgus) <input type="checkbox"/> Charcot foot <input type="checkbox"/> Foot drop <input type="checkbox"/> Prominent Metatarsal Heads</p> <p>3. Pedal Pulses Fill in the blanks with a "P" or an "A" to indicate present or absent.</p> <p>Posterior tibial Left ___ Right ___ Dorsalis pedis Left ___ Right ___</p>
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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) Semmes-Weinstein nylon monofilament and "-" if the patient cannot feel the filament.

Notes



Right Foot



Left Foot

Notes

<p>IV. Risk Categorization Check appropriate box.</p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><input type="checkbox"/> Low Risk Patient All of the following:</p> <p><input type="checkbox"/> Intact protective sensation <input type="checkbox"/> Pedal pulses present <input type="checkbox"/> No deformity <input type="checkbox"/> No prior foot ulcer <input type="checkbox"/> No amputation</p> </td> <td style="width: 50%; vertical-align: top;"> <p><input type="checkbox"/> High Risk Patient One or more of the following:</p> <p><input type="checkbox"/> Loss of protective sensation <input type="checkbox"/> Absent pedal pulses <input type="checkbox"/> Foot deformity <input type="checkbox"/> History of foot ulcer <input type="checkbox"/> Prior amputation</p> </td> </tr> </table> <hr/> <p>V. Footwear Assessment Indicate yes or no.</p> <p>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 ___</p> <hr/> <p>VI. Education Indicate yes or no.</p> <p>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 ___</p>	<p><input type="checkbox"/> Low Risk Patient All of the following:</p> <p><input type="checkbox"/> Intact protective sensation <input type="checkbox"/> Pedal pulses present <input type="checkbox"/> No deformity <input type="checkbox"/> No prior foot ulcer <input type="checkbox"/> No amputation</p>	<p><input type="checkbox"/> High Risk Patient One or more of the following:</p> <p><input type="checkbox"/> Loss of protective sensation <input type="checkbox"/> Absent pedal pulses <input type="checkbox"/> Foot deformity <input type="checkbox"/> History of foot ulcer <input type="checkbox"/> Prior amputation</p>	<p>VII. Management Plan Check all that apply.</p> <p>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: _____</p> <p>2. Diagnostic studies:</p> <p><input type="checkbox"/> Vascular Laboratory <input type="checkbox"/> Hemoglobin A1c (at least twice per year) <input type="checkbox"/> Other: _____</p> <p>3. Footwear recommendations:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> None</td> <td><input type="checkbox"/> Custom shoes</td> </tr> <tr> <td><input type="checkbox"/> Athletic shoes</td> <td><input type="checkbox"/> Depth shoes</td> </tr> <tr> <td><input type="checkbox"/> Accommodative inserts</td> <td></td> </tr> </table> <p>4. Refer to:</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Primary Care Provider</td> <td><input type="checkbox"/> Endocrinologist</td> </tr> <tr> <td><input type="checkbox"/> Diabetes Educator</td> <td><input type="checkbox"/> Vascular Surgeon</td> </tr> <tr> <td><input type="checkbox"/> Podiatrist</td> <td><input type="checkbox"/> Foot Surgeon</td> </tr> <tr> <td><input type="checkbox"/> RN Foot Specialist</td> <td><input type="checkbox"/> Rehab. Specialist</td> </tr> <tr> <td><input type="checkbox"/> Pedorthist</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Orthotist</td> <td></td> </tr> </table> <p>5. Follow-up Care: Schedule follow-up visit. Date: _____</p>	<input type="checkbox"/> None	<input type="checkbox"/> Custom shoes	<input type="checkbox"/> Athletic shoes	<input type="checkbox"/> Depth shoes	<input type="checkbox"/> Accommodative inserts		<input type="checkbox"/> Primary Care Provider	<input type="checkbox"/> Endocrinologist	<input type="checkbox"/> Diabetes Educator	<input type="checkbox"/> Vascular Surgeon	<input type="checkbox"/> Podiatrist	<input type="checkbox"/> Foot Surgeon	<input type="checkbox"/> RN Foot Specialist	<input type="checkbox"/> Rehab. Specialist	<input type="checkbox"/> Pedorthist	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Orthotist	
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Provider Signature _____