Diabetic Foot Examination

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Gender: _____ Date of assessment: _____ dd / mm / yyyy

CHIEF COMPLAINT

Specify below

- [ ] Here for diabetic foot evaluation and counseling
- [ ] Additional question(s)/concern(s)
- [ ] Old chart not available

Specify additional question(s)/concern(s)

MEDICAL HISTORY

Diabetic? If yes, indicate number of years:

Are you on

- [ ] Oral agents
- [ ] Insulin
- [ ] Diet only
- [ ] Other

Checking glucose at home?

◯ Yes ◯ No

If yes, usual value is: _____

Taking medications regularly?

◯ Yes ◯ No

If no, indicate reason: _____

Frequency of checking glucose

◯ Once a day (morning) ◯ Once a day (evening) ◯ Twice a day ◯ More than twice a day

Problems with feet?

◯ Yes ◯ No

SYMPTOMS

Numbness?

◯ Yes ◯ No

Ulcers?

◯ Yes ◯ No

Thick toe nails?

◯ Yes ◯ No

Dryness of skin?

◯ Yes ◯ No

Pain?

◯ Yes ◯ No

Calluses?

◯ Yes ◯ No

Fungus?

◯ Yes ◯ No

PAST MEDICAL HISTORY

Check all that apply

- ☐ Hypertension (HTN)
- ☐ Coronary artery disease (CAD)
- ☐ Neuropathy
- ☐ Nephropathy
- ☐ Peripheral vascular disease

Other significant past medical history

Last LDL: _____ **Date:** _____ dd / mm / yyyy

MEDICATIONS

Select one

◯ Medication list reviewed; no changes ◯ Medication list reviewed and updated

PNEUMOCOCCAL AND INFLUENZA VACCINATIONS

Influenza vaccine received?

◯ Yes ◯ No

If yes, when: _____

Pneumococcal vaccine received?

◯ Yes ◯ No

If yes, when: _____

REVIEW OF SYSTEMS

Constitutional symptoms?

◯ Yes ◯ No

Claudication?

◯ Yes ◯ No

Foot ulcers?

◯ Yes ◯ No

Chest pain?

◯ Yes ◯ No

Edema?

◯ Yes ◯ No

Decreased vision?

◯ Yes ◯ No

Last eye exam (date): _____ dd / mm / yyyy

Last foot exam (date): _____ dd / mm / yyyy

Last creatinine (date): _____ dd / mm / yyyy

Last HbA1c (date): _____ dd / mm / yyyy

Last creatinine (value): _____

Last HbA1c (value): _____

PHYSICAL EXAM

Vital signs

Weight: _____

Blood pressure: _____

EXAMINATION OF FEET

Is there a foot ulcer now?

◯ Yes ◯ No

Is there an abnormal shape of foot?

◯ Yes ◯ No

Is there toe deformity?

◯ Yes ◯ No

Are the toenails thick or ingrown?

◯ Yes ◯ No

Is there callus buildup?

◯ Yes ◯ No

Is there elevated skin temperature?

◯ Yes ◯ No

Is the patient wearing improperly fitting shoes?

◯ Yes ◯ No

Does the patient use footwear inappropriate for category?

◯ Yes ◯ No

Can the patient see bottom of the feet?

◯ Yes ◯ No

Comments

Check if applicable

☐ No significant clinical findings

Indicate the level of sensation in the circle: + = Can feel the 10 gram nylon filament - = Cannot feel the 10 gram nylon filament

L1

◯ + ◯ -

L2

◯ + ◯ -

L3

◯ + ◯ -

L4

◯ + ◯ -

R1

◯ + ◯ -

R2

◯ + ◯ -

R3

◯ + ◯ -

R4

◯ + ◯ -

Skin conditions on the foot and between the toes

Draw a pattern where there is:

Specify below

Label: Skin condition with R-redness; W-warmth; D-drynes, and/or M-maceration

Specify below

IMPRESSION

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, pre-ulcer, or callus but no history of ulceration or poor circulation
◯ 3 - History of plantar ulceration or neuropathic fracture

PLAN

Specialty referral given

◯ Yes ◯ No ◯ Podiatry ◯ Other

Discussed routine foot care with patient?

◯ Yes ◯ No

Directed to Certified Diabetic Educator?

◯ Yes ◯ No

Pneumococcal vaccination ordered (0.5cc IM)

◯ Yes ◯ No

Influenza vaccination ordered (0.5cc IM)

◯ Yes ◯ No

Follow up: _____

Signature
Select one

◯ MD/DO ◯ NP ◯ PA

Date: _____ dd / mm / yyyy

Didactic education on foot care given?

◯ Yes ◯ No

Educational material given on foot care?

◯ Yes ◯ No

Signature
Select one

◯ Certified Diabetic Educator ◯ RN

Date: _____ dd / mm / yyyy