PATIENT FOOT EVALUATION

TODAYS DATE:_____ **PATIENT NAME:**_____ **DOB:**___/___/___/

HISTORY

	Yes	No
Has patient worn therapeutic footwear before		
History of diabetes?		
History of Amputation?		
History of Callus?		
History of Ulcers/Wounds?		
History of Vascular Disease?		

ASSESMENT: *Patient received a dermatologic, neurologic, musculoskeletal and vascular foot exam today including lpTT. Which feet does patient have?* __Both __Left __Right

DERMATOLOGIC: __Foot Discoloration __Callus evidence __Ulcer __Fungal infections
__Bluish Skin __Loss of Hair __Nail Deformity __Fissure

NEUROLOGICAL: __Right Foot checked __Left Foot checked
IS THERE A LOSS OF PROTECTIVE SENSATION? __*YES* __*NO*

VASCULAR:
__Normal Pulses
__Diminished Pulses
__Absent Pulses
__Edema/Swelling Present
__Loss of Hair

MUSCULAR:
__Normal Range of Motion
__Abnormal Range of Motion

NOTED DEFORMITIES:
__Bunion __Hammer toes __Clawing __Diminished Arch __Over Pronation
__ Charcot __Calcaneal Heel Spur __Prominent Metatarsal Heads __Pes Planus
Other deformity:_____.

FUNCTIONAL GOALS FOR PATIENT: (check all that apply) __Protection of sensation-compromised foot through daily inspections, cleanliness and care of feet
__Provision of therapeutic footwear/inserts for
__Protection
__Refer to specialist for follow-up
__Other:_____.

- ☐ Patient qualifies for diabetic shoes.
- ☐ Diabetic Shoes Ordered; Patient was measured with a Brannock Device
  Size:_____Width:_____Add'l Notes:_____.
- ☐ Diabetic Inserts Ordered: __Prefabricated 3 pairs __Custom 3 pairs
  __1 Toe Fill Insert for __RT __LT foot in lieu of 3 custom inserts for that foot

☐ Foam Impression Made; Reason: __Deformity __Amputation _Gait __Excess __Weight __Offloading

PROVIDER NAME (Print) _____.

PROVIDER SIGNATURE _____ DATE_____.