PATIENT NAME: _____ DOB: _____

EXAM DATE: _____

*Circle findings that apply				
HISTORY OF AMPUTATION	Yes	No	Right	Left
DATE OF AMPUTATION:				
HISTORY OF FOOT ULCERATION	Yes	No	Right	Left
DATE OF ULCERATION:				
ANY CHANGE IN FOOT SINCE LAST EVALUATION	Yes	No	Right	Left
PT WEARING PROPERLY FITTING SHOES	Yes	No	Right	Left
BLOODY DISCHARGE ON SOCKS OR HOSE	Yes	No	Right	Left
Peripheral Artery Disease (PAD) Screen				
HISTORY OF CLAUDICATION	Yes	No	Right	Left
ANKLE BRACHIAL INDEX (ABI)	Yes	No	Right	Left
PEDAL PULSE PRESENT	Yes	No	Right	Left
Foot Exam				
Foot Exam	WNL			
PAD Exam	WNL			

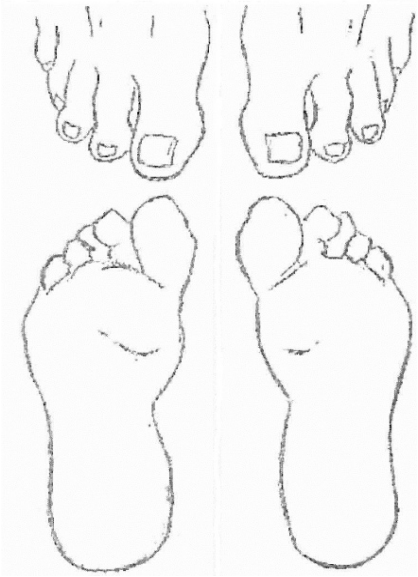
*If abnormal, circle findings that apply				
ABNORMAL SHAPE	Yes	No	Right	Left
ACUTE SWELLING	Yes	No	Right	Left
CALLUS BUILD-UP	Yes	No	Right	Left
CHARCOT FOOT	Yes	No	Right	Left
DECREASED CIRCULATION	Yes	No	Right	Left
DIGITAL DEFORMITY	Yes	No	Right	Left
DYSTROPHIC NAILS	Yes	No	Right	Left
EDEMA	Yes	No	Right	Left
ELEVATED SKIN TEMP.	Yes	No	Right	Left
FOOT ULCER	Yes	No	Right	Left
HIGH LEVEL OF DRY SKIN	Yes	No	Right	Left
LOSS OF SENSATION	Yes	No	Right	Left
MUSCLE WEAKNESS	Yes	No	Right	Left
THICK OR INGROWN TOENAILS	Yes	No	Right	Left
PT DEMONSTRATED PROPER FOOT CARE			Yes	No

DOCUMENT ANY AREAS OF CONCERN

NOTE LOCATION OF:

CALLUSES ULCERATION

PRE-ULCERATION DECREASED SENSATION



COMMENTS:

PHYSICIAN SIGNATURE: _____ DATE: _____