Podiatry Foot Screening Form

Name: ______________________ **DOB:** __________

Address: __________ **City:** __________ **State:** __________
Zip Code: __________

Phone Number: __________ **Primary Care Physician:** __________

Medications/Vitamins/Minerals: __________

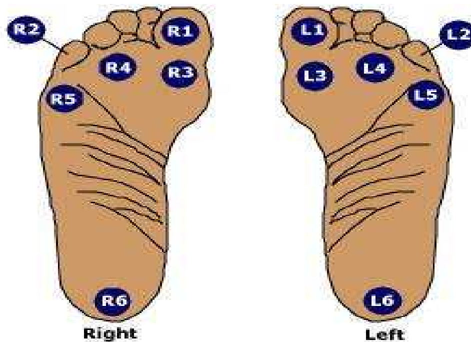
Have you ever seen a Podiatrist?	**Yes ______**	**No ______**
If yes, who did you see:		
If yes, was your last visit in 2010?	**Yes ______**	**No ______**

Do you have Diabetes?	**Yes ______**	**No ______**
Have you been diagnosed with PVD (Peripheral Vascular Disease)?	**Yes ______**	**No ______**
Do you have pain in your feet or ankles at rest or with exercise?	**Yes ______**	**No ______**
Do you have pain in your feet or ankles with sports activities?	**Yes ______**	**No ______**
Do you wear orthodics or special shoes?	**Yes ______**	**No ______**

INSPECTION

	Right			Left		
Bunion	Yes ______		No ______	Yes ______		No ______
Callus	Yes ______		No ______	Yes ______		No ______
Hammertoe	Yes ______		No ______	Yes ______		No ______
Skin Exam	Normal_____	Xirrosis______	Tinea_____	Normal_____	Xirrosis______	Tinea____
Pulses: Dorsalis Pedis	Normal____	Diminished ___	Absent___	Normal____	Diminished ___	Absent___
Pulses: Tibialis Posterior	Normal____	Diminished ___	Absent___	Normal____	Diminished ___	Absent___
Neurologic Exam	Normal____	Diminished ___		Normal____	Diminished ___	

NEUROLOGICAL EXAM



RISK CATEGORY

______ **No problems identified on exam**
______ **Refer to Podiatry**

Completed by: **Date:**