

My Personal Foot Evaluation



Date Completed: _____ My Name: _____

Check the box if you have or have had the following foot conditions:

- | | |
|---|--|
| <input type="checkbox"/> Amputations | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Hot Feet |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Pale Feet |
| <input type="checkbox"/> Bunions | <input type="checkbox"/> Red Feet |
| <input type="checkbox"/> Blisters | <input type="checkbox"/> Charcot Foot |
| <input type="checkbox"/> Ulcers/Wounds | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Hammer Toes |
| <input type="checkbox"/> Fungus | <input type="checkbox"/> Mallet Toes |
| <input type="checkbox"/> Warts | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Calluses | <input type="checkbox"/> Bruising |
| <input type="checkbox"/> Corns | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Flat Feet | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Foot Drop |
| <input type="checkbox"/> High Arch | <input type="checkbox"/> Toe Deformities |
| <input type="checkbox"/> Ingrown Toenails | <input type="checkbox"/> Prominent
Metatarsal Heads |

*** Remind your physician to review this self evaluation, evaluate your feet and document all findings in your medical record. If this is not done, you may not be eligible for certain benefits under your medical plan.

Patient Signature: _____

**** Take this form to my next Diabetic Appointment ****