

# Diabetes Foot Care Questionnaire

---

Patient Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Clinician: \_\_\_\_\_

## Prior Foot Problems

- Previous amputation of leg or portion of foot?  Yes  No
- Previous foot ulcer?  
If Yes, Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  Yes  No
- Have you been told that you have reduced sensation in your feet?  Yes  No

## Current Foot or Leg Problems

- Ulcer, sore, or blister on your foot at this time?  Yes  No
- Blood or discharge noted in your socks?  Yes  No
- Callus build-up on your feet?  Yes  No
- Pain or cramping in your feet, calves, thighs, or buttocks when you walk?  Yes  No
- Numbness or tingling sensation in your feet?  Yes  No

## Podiatry (Foot Specialist) Follow-Up

- Have you seen a podiatrist (foot specialist) in the past 6 months?  
If yes, date of last visit: \_\_\_\_/\_\_\_\_/\_\_\_\_  Yes  No

## Foot Care Education

- Have you been taught how to care for your feet?  Yes  No
- Have you read an educational handout about foot care?  Yes  No
- Have you read an educational handout about shoe selection?  Yes  No

## Ability to Care for Your Feet

- Can you reach and see the soles of your feet?  Yes  No

## How You Currently Care For Your Feet

- Do you (or an assistant) inspect your feet daily for problems?  Yes  No
- Do you know to report any sores or blisters immediately to your clinician?  Yes  No
- Do you wash your feet every day?  Yes  No
- Do you dry thoroughly between the toes?  Yes  No
- Do you put moisturizing lotion on your feet daily (but not between the toes)?  Yes  No
- Do you have another person cut your toenails and trim your calluses?  Yes  No
- Do you wear shoes at all times, outdoors and indoors?  
(Do you avoid walking stocking or bare-footed even at night or in the shower?)  Yes  No

- Do you always test water temperature with your hand before putting your foot in?  Yes  No
- Do you avoid the use of corn plasters on your feet?  Yes  No
- Do you check your shoes for any objects that may have fallen into them before you put them on?  Yes  No

### Your Current Footwear

- Do you wear special shoes and/or protective inserts in the shoes?  Yes  No
- If yes, do you wear them at all times?  Yes  No
- Check the appropriate box to describe any shoes that you wear at any time.
 

<input type="checkbox"/> Broad, round toes	<input type="checkbox"/> Laces, buckles, Velcro	<input type="checkbox"/> Pointed toes
<input type="checkbox"/> Slip-ons	<input type="checkbox"/> Open toes	<input type="checkbox"/> Athletic shoes
<input type="checkbox"/> Leather or canvas	<input type="checkbox"/> High heels	<input type="checkbox"/> Plastic
<input type="checkbox"/> Light color	<input type="checkbox"/> Cowboy boots	<input type="checkbox"/> Black color

### Your Current Physical Activity

- Check all boxes that describe how you currently exercise.
 

<input type="checkbox"/> Treadmill	<input type="checkbox"/> Jogging	<input type="checkbox"/> Walking
<input type="checkbox"/> Bicycling	<input type="checkbox"/> Stair-step	<input type="checkbox"/> Swimming
<input type="checkbox"/> No exercise		