



Diabetic Shoe Prescreening

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Weight: _____ Height: _____

- When were you diagnosed with diabetes? _____
- Which type of diabetes do you have? I II
- How are you managing it? Diet Oral Insulin
- Have you worn diabetic shoes before? Yes No
 If yes, have you received a pair of diabetic shoes from any provider in this calendar year? Yes No
 If yes, from which provider? _____

Medical History

- Do you have a history of any of the following?
 Peripheral Neuropathy Cardiovascular disease Nephropathy Retinopathy Peripheral Vascular disease

Current History

- Any change in the foot or feet since the last evaluation? Yes No
 If yes, please describe: _____
- Do you currently have any open ulcers, calluses, swelling and/or bunions on your feet?
Current: Yes No **History:** Yes No
 If yes, please describe: _____
- Have you had any amputations on your toes or part of your foot?
 If yes, please describe: _____
- Have you experienced any muscle weakness in your legs?
 If yes, please describe: _____
- Have you worn diabetic shoes before?
 Yes No If yes, please describe: _____
- What shoe size do you wear? _____
- What is the name of the doctor who monitors your diabetes?
 Name: _____ Phone number: _____

Websites of Diabetic Shoe Suppliers:

Apis Footwear
<https://apisfootwear.com>

Apex
<https://www.apexfoot.com>

Dr. Comfort
<https://www.drcomfort.com>