

Professional Medical Foot Assessment Worksheet

Patient Name	Phone
Prescribing Physician	Phone

Customer Medical Summary

<i>List Current Symptoms or Areas of Complaint</i>	
<i>List Pertinent Medical History</i>	
<i>List Previous Lower Extremity Conditions/Surgeries including ulceration</i>	
<i>Size of Current Footwear</i>	
<i>Note any abnormalities in current footwear (to small, short, not wide enough, to lrg)</i>	

Foot Assessment

Please note any areas of concern or location of conditions that apply:
Notes about conditions:

If ulceration exists refer patient to physician or otherwise qualified provider



Foot Shape <input type="checkbox"/> Chubby <input type="checkbox"/> Lean/bony/narrow	Temperature <input type="checkbox"/> Feverish (contact physician) <input type="checkbox"/> Cold <input type="checkbox"/> Normal	Activity Level <input type="checkbox"/> Ambulates with assistance <input type="checkbox"/> Moderate <input type="checkbox"/> Active <input type="checkbox"/> Non-Ambulatory
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Foot Measurements & Shoe Size

	<i>Measurement</i>			<input type="checkbox"/> <i>Check here if patient needs to be referred to a physician or another provider because the patient has a condition outside the scope of training of the fitter.</i>
	Length		Width	
	Toe to Heel	Ball to Heel		
Right Foot				<input type="checkbox"/> High <input type="checkbox"/> Flat <input type="checkbox"/> Normal
Left Foot				<input type="checkbox"/> High <input type="checkbox"/> Flat <input type="checkbox"/> Normal

Fitter Size and Style Recommendations	
Final Style Shoe Patient Fitted With:	Final Size Shoe Patient Fitted With:

Therapeutic Shoe Fitter Name _____ Date of Assessment: _____