

Foot Sensory Exam

Patient Name: _____ Birth Date: ____ - ____ - ____ Gender: M ___ F ___

Date: _____

Right Foot Left Foot

Date: _____

Right Foot Left Foot

Date: _____

Right Foot Left Foot

Date: _____

Right Foot Left Foot

Date: _____

Right Foot Left Foot

Date: _____

Right Foot Left Foot

Date: _____

Right Foot Left Foot

Date: _____

Right Foot Left Foot

Date: _____

Right Foot Left Foot

Date: _____

Right Foot Left Foot



⊕ = CAN feel the 10 gram nylon filament

⊖ = CanNOT feel the 10 gram nylon filament