

Patient Version

MICHIGAN NEUROPATHY SCREENING INSTRUMENT

A. History (To be completed by the person with diabetes)

Please take a few minutes to answer the following questions about the feeling in your legs and feet. Check yes or no based on how you usually feel. Thank you.

- | | | |
|--|------------------------------|-----------------------------|
| 1. Are your legs and/or feet numb? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Do you ever have any burning pain in your legs and/or feet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Are your feet too sensitive to touch? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Do you get muscle cramps in your legs and/or feet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Do you ever have any prickling feelings in your legs or feet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Does it hurt when the bed covers touch your skin? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. When you get into the tub or shower, are you able to tell the
hot water from the cold water? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Have you ever had an open sore on your foot? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Has your doctor ever told you that you have diabetic neuropathy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Do you feel weak all over most of the time? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Are your symptoms worse at night? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Do your legs hurt when you walk? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Are you able to sense your feet when you walk? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Is the skin on your feet so dry that it cracks open? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Have you ever had an amputation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Total: _____

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B. Physical Assessment (To be completed by health professional)

1. Appearance of Feet

Right
a. Normal ☐₀Yes ☐₁No

b. If no, check all that apply:

Deformities ☐

Dry skin, callus ☐

Infection ☐

Fissure ☐

Other ☐

Specify: _____

Left
Normal ☐₀Yes ☐₁No

If no, check all that apply:

Deformities ☐

Dry skin, callus ☐

Infection ☐

Fissure ☐

Other ☐

Specify: _____

Right
2. Ulceration Absent ☐₀ Present ☐₁

Present/

3. Ankle Reflexes Present ☐₀ Reinforcement ☐_{0.5} Absent ☐₁

4. Vibration perception at great toe Present ☐₀ Decreased ☐_{0.5} Absent ☐₁

5. Monofilament Normal ☐₀ Reduced ☐_{0.5} Absent ☐₁

Left
Absent ☐₀ Present ☐₁

Present/

Present ☐₀ Reinforcement ☐_{0.5} Absent ☐₁

Present ☐₀ Decreased ☐_{0.5} Absent ☐₁

Normal ☐₀ Reduced ☐_{0.5} Absent ☐₁

Signature: _____

Total Score _____/10 Points