



Patient ID Number	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Site	Sub-site		Sequential ID			

Patient Version

MICHIGAN NEUROPATHY SCREENING INSTRUMENT and 10-gram Filament Exam

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

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0904).

NEUROPATHY SCREENING INSTRUMENT

B. Physical Assessment (To be completed by the study personnel)

1. Appearance of Feet

Right Foot

a. Normal 1 No 2 Yes

b. If no, check all that apply:

Deformities 1

Dry skin, callus 1

Infection 1

Fissure 1

Other 1

specify: _____

Left Foot

Normal 1 No 2 Yes

If no, check all that apply:

Deformities 1

Dry skin, callus 1

Infection 1

Fissure 1

Other 1

specify: _____

2. Ulceration

Right Foot

Absent Present
 1 2

Left Foot

Absent Present
 1 2

3. Ankle Reflexes

Present Present/
 1 Reinforcement Absent
 2 3

Present Present/
 1 Reinforcement Absent
 2 3

4. Vibration perception at the great toe*

Present Reduced Absent
 1 2 3

Present Reduced Absent
 1 2 3

5. 10 gm filament (number of applications detected out of 10 applications):

Present (≥ 8) Reduced (1-7) Absent(0)
 1 2 3

Present (≥ 8) Reduced (1-7) Absent(0)
 1 2 3

*Vibration is Present if the examiner feels vibration on his finger joint for 10 seconds or less after the patient reports vibration at toe has stopped. Vibration is Reduced if examiner feels vibration for more than 10 seconds after patient reports vibration at toe has stopped. Vibration is Absent if patient does not perceive any vibration from the tuning fork.

FOR STUDY USE ONLY

Date
Completed

Month

Day

Year

Completed
by

Date
Reviewed

Month

Day

Year

Reviewer
Code

Date
Entered

Month

Day

Year

Data Entry
Code