



Where Medi meets Pedi®

Pedicure Information Form

Name: _____

Phone: _____

Email: _____

Please check the appropriate boxes below:

Question	Yes	No
• Are you a diabetic?	<input type="checkbox"/>	<input type="checkbox"/>
• Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>

Current medications: _____

With respect to your feet and legs, which of these conditions do you experience and how often?

CONDITION	NEVER	AT TIMES	FREQUENTLY
Cold Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cracked Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itchiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peeling Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweaty Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Fungus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nail Fungus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discoloured Nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thick Nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Sensation in Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy Sensation in Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot Odour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Callus Build-up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plantar Warts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What improvements would you like to see in your feet?

Signature: _____



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Email: _____

Please check the appropriate boxes below:

Question	Yes	No
• Are you a diabetic?	<input type="checkbox"/>	<input type="checkbox"/>
• Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>

Current medications: _____

With respect to your feet and legs, which of these conditions do you experience and how often?

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Pedicure Service History

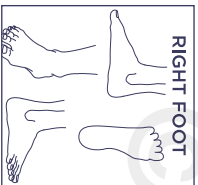
Date

Technician

Observations

Home Maintenance

1. Tinea Pedis
Peeling or Rough Skin



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2. Bunions
3. Calluses
4. Corns

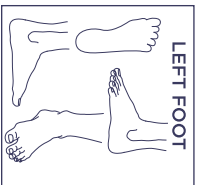
5. Discolouration
6. Dropped Metatarsal

7. Flat Foot

8. Hammer Toes

9. Ingrown Nails

10. Toenail Fungus



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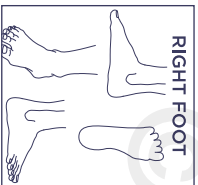
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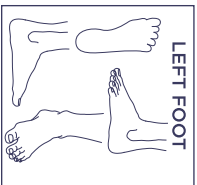
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