

HYPERHIDROSIS DIAGNOSIS FORM

Date: _____ Last name: _____ First name: _____

Age: _____ Gender: Male Female

1. Which areas of your body are affected by excessive sweating?

- Underarms Face/Head Hands
 Groin Feet Other _____

2. Are you right or left hand dominant?

- Left Right

3. Is the sweating the same on both sides of your body or worse on one side (e.g. do both armpits/hands sweat about the same)?

- Same on both Worse on right Worse on left

4. At what age did your excessive sweating become a problem? _____

5. Do any family members also suffer from excessive sweating? Yes No

6. Is the sweat triggered by anything specific such as:

- Food Stress Heat
 Exercise Other _____

Please check one of the boxes below:

Hyperhidrosis Disease Severity Scale (HDSS)

- | | |
|---|---------|
| <input type="checkbox"/> My sweating is never noticeable and never interferes with my daily activities | SCORE 1 |
| <input type="checkbox"/> My sweating is tolerable but sometimes interferes with my daily activities | SCORE 2 |
| <input type="checkbox"/> My sweating is barely tolerable and frequently interferes with my daily activities | SCORE 3 |
| <input type="checkbox"/> My sweating is intolerable and always interferes with my daily activities | SCORE 4 |

7. What therapies have you tried in the past for your excessive sweating?

- Aluminum chloride hexahydrate (Drysol®, Certain Dri®)
Reason for discontinuing therapy _____
- BOTOX®
Reason for discontinuing therapy _____
- Iontophoresis devices (Drionic®, Fischer, or other)
Reason for discontinuing therapy _____
- Oral medications (Glycopyrrolate, Ditropan®, or other)
Reason for discontinuing therapy _____
- Surgery (local excision of sweat glands, ETS, or other)
- None

8. Are you pregnant or breastfeeding? Yes No

9. Do you have any allergies (including allergies to medications)? Yes No

If yes, please specify: _____

10. Do you have any neurological disorders? Yes No

11. Do you have a private/extended healthcare plan? Yes No

HYPERHIDROSIS DIAGNOSIS FORM

(For Physician Use Only)

Physician name: _____

Patient medications: _____

Past medical history: _____

ROS: wt loss / weakness / fever / chills / N,V,D / neuro / CV, Resp / GU / Psych

Therapy outcomes:

Aluminum chloride _____

BOTOX® _____

Iontophoresis _____

Surgery _____

Other _____

Treatment recommended

- Aluminum chloride
- BOTOX®
- Iontophoresis
- Surgery
- None

Patient has been informed that the injection fee is not covered by OHIP

Dose: _____ Area injected: _____

Lot #: _____ Prep used: _____

Anesthetic used: _____

AE/Complications: _____

Follow-up recommendations: _____
