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)	
☐ My sweating is never noticeable and never interferes with my daily activities	SCORE 1
☐ My sweating is tolerable but sometimes interferes with my daily activities	SCORE 2
☐ My sweating is barely tolerable and frequently interferes with my daily activities	SCORE 3
☐ 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)

Referring physician: _____

Patient medications: _____

_____

_____

Past medical history: _____

_____

_____

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

Therapy outcomes:

Aluminum chloride _____

BOTOX® _____

Iontophoresis _____

Surgery _____

Other _____

Physical Exam: _____

_____

_____

Diagnosis: _____

Treatment recommended:

- ☐ Aluminum chloride
- ☐ BOTOX®
- ☐ Iontophoresis
- ☐ Oral Anticholinergics
- ☐ Surgery
- ☐ None

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

Dose: _____ Area[s] injected: _____

Lot #: _____ Reconstitution used: _____

Anesthetic used: _____

AE/Complications: _____

Follow-up recommendations: _____

_____

_____