FLORIDA HEART & LUNG INSTITUTE
NORTH FLORIDA REGIONAL HEALTHCARE

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Patient Hyperhidrosis Evaluation Form

Name: _____ Date: _____/_____/_____

Date of Birth _____/_____/_____ Age: _____

Please complete the following to the best of your knowledge:

1. Ethnicity (check box)
   - □ White □ African-American
   - □ Hispanic □ American Indian
   - □ Asian □ Other

2. Please check your main concern with today's visit:
   - □ Excessive sweating
   - □ Body odor
   - □ Other (specify) _____

3. Select the area(s) that has the worst Sweating:
   - □ Axilla/Underarms □ Face or scalp
   - □ Hands/Palms □ Groin
   - □ Feet/Soles
   - □ Other (specify): _____

4. Is the sweating problem on both sides of your body?
   - □ Yes
   - □ No:
     - □ RIGHT side sweats more
     - □ LEFT side sweats more

5. Other areas that also have a sweating
   - □ Axilla/Underarms
   - □ Hands/Palms
   - □ Feet/Soles
   - □ Face or scalp
   - □ Groin
   - □ Other (specify): _____

6. Factors that worsen or trigger the
   - □ Stress □ Heat □ Pregnancy
   - □ Anxiety □ Sleep □ Cole
   - □ Exercise □ Menstrual cycle
   - □ Other (specify): _____

7. Factors that improve sweating (list): _____

8. If you have ever been pregnant, how did this affect your sweating:
   - □ Not applicable □ Remained the same □ Sweating improved during pregnancy
   - □ Sweating worsened during pregnancy.

9. Have you had skin problems related to excessive sweating?
   - □ Macerated/peeling skin □ Bacterial infections □ Fungal infections
   - □ Blisters □ Other _____ □ None

10. Any relatives affected by excessive sweating (check box below)
    - □ Yes – a relative has excessive sweating. Relationship: _____

Check the area (s) of your relative's sweating:

- □ axilla/underarms □ face □ feet/soles □ hand/palm □ groin □ other
- □ No – no one else in my family has excessive sweating
- □ Unknown – don't know

11. Have you seen a medical provider about this problem in the past? (check all that apply)

□ Yes, please indicate who you saw:
□ Pediatrician □ Primary care physician □ Dermatologist □ Neurologist
□ Other (specify): _____
□ No, I have NOT seen a medical professional about this problem

12. Age when the sweating problem first began: _____ years
If unsure, estimate age range: □ 0-12 years □ 26-40 years □ over 40 years

13. Dominant hand: □ Right □ Left □ Both

14. How does sweating affect your daily living, at work, school, relationships?

□ carry extra clothes □ change clothes/shoes during the day □ affects work
□ smudge papers □ avoid shaking hands □ affects personal relationships
□ avoid holding hands or intimacy □ avoid meeting new people
□ affects the way you buy/wear clothes □ think about sweating often
□ other (specify): _____

15. List examples of how this sweating problem impacts your work, school, relationships:
_____

16. Please choose the number that best described you:

□ my sweating is NEVER noticeable and NEVER interferes with my daily activities
□ my sweating is tolerable, but SOMETIMES interferes with my daily activities
□ my sweating is BARELY tolerable & FREQUENATLY interferes with my daily activities
□ my sweating is INTOLERABLE & ALWAYS interferes with my daily activities

17. Have you been diagnosed with any of the following:

□ Diabetes mellitus □ cancer □ thyroid disease □ tuberculosis

18. Over the past few months have you experienced:

□ weight loss □ fever □ night sweats □ cough □ decreased appetite
□ weight gain □ increased appetite □ tachycardia □ palpitations
□ shortness of breath □ hot flashes □ flushing □ menopause symptoms
□ other (specify) _____ □ none of the above

19. Check if you have any of the following:

□ **metal** replacement joint/bone rod/plate/screw □ Pacemaker/defibrillator

20. Alcohol use: □ No □ Yes – amount (drinks/week) _____ how long? _____ years

21. Are you currently pregnant or planning to become pregnant soon? □ No □ Yes

22. Please note current: Weight _____ lbs Height _____ in

23. Do you have breast implants: □ Yes □ No

24. Please list your occupation: _____

25. Which best describes you □ single □ married □ divorced □ widowed

Past treatment of excessive sweating

Please note the example below and then complete the table below by placing a check mark in the left column for each past treatment used and fill in the remainder:

Example:

Check	*Past Treatments*	*Length of Time Used*	*Date Last Used*	*Results*	*Side Effects*
√	Drysol	10 months	March 2005	Fair	Irritation, redness

Check	Past Treatments	Length of time used	Date last used	Results (none, poor, fair, good, excellent)	Side effects (none, dryness, splits in skin etc)
	Over the counter antiperspirant				
	Drysol/aluminum chloride				
	Drionic				
	Iontophoresis				
	Oral anticholinergic (ex. Robinul)				
	Other oral drugs (clonidine, Inderal, anti-anxiety pills)				
	Botox				
	Surgery				
	Liposuction/Curettage				
	Hypnosis				
	Acupuncture				
	Diet/Fluid changes				
	Other (specify)				