Oregon Dermatology and Research Center
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Hyperhidrosis Evaluation Form

Name: ____ Age: ______ Sex: M or F   Date: _________________

How would you rate the severity of your hyperhidrosis? Check one response

a. sweating is never noticeable and never interferes with daily activities ____

b. sweating is tolerable but sometimes interferes with daily activities ____

c. sweating is barely tolerable and frequently interferes with daily activities ____

d. sweating is intolerable and frequently interferes with daily activities ____

What is the focal location of sweating? Axillae (under arms) __________ or other (if so where) ________________

Approximately how long have your symptoms been present? ________ years _________ months

Please specify if hyperhidrosis severely impairs the following daily activities:

a. occupational impairment ____

b.physical activity ____

c. psychosocial effect ____

d.other ____

Have you tried any over the counter antiperspirants? ________ If yes, for how long? _______________ Was the treatment effective, tolerable and did you have any side effects? ____

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Have you tried any prescription antiperspirants (like drysol)? _______ If yes, for how long? ___________ Was the treatment effective, tolerable and did you have any side effects? ____

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Have you ever treated your Hyperhidrosis with Botulinum Toxin Type A (Botox)? _________ If yes, for how long?__________ Was the treatment effective? ________ If yes, how long did the effects last? ______________

Did you experience any side effects? ____

____

Have you ever had surgery for your Hyperhidrosis? _______ If yes, what was the date of the procedure? ________ Was the procedure effective? _______ Did you experience any side effects? __________________________________

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Other treatments or medications ______________________________________ ***Was it effective?*** ______________

What was the length of treatment time? ______________ What was the length of effectiveness? ______________

Did you experience any side effects? ____

Additional Comments ____

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