SAINT LOUIS UNIVERSITY
DEPARTMENT OF DERMATOLOGY
Division of Cosmetic & Laser Surgery

Hyperhidrosis Evaluation Form

Des Peres Medical Arts Pavilion
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(314) 977-9666

Today's Date (mm/dd/yy): _____ / _____ / _____
Name: _____
Date of Birth (mm/dd/yy): _____ / _____ / _____
Age: _____
E-mail address, if interested in receiving email about hyperhidrosis opportunities: _____

Please complete the following to the best of your knowledge:

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

2. Please check your main concern with today's visit:
   □ Excessive Sweating or
   □ Body Odor
   □ Other, specify:_____

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

4. **Other** areas that **also** have a sweating problem:
   □ Axilla/Underarms
   □ Hands/ Palms
   □ Feet/Soles □ Face or scalp
   □ Groin □ Other, specify: _____

5. Is the sweating problem on both sides of your body?
   □ YES
   □ NO : □ RIGHT side sweats much more or
   □ LEFT side sweats much more

6. Factors that worsen or trigger the sweating problem:
   □Stress □Heat □Pregnancy
   □Anxiety □Sleep □Menstrual cycle
   □Exercise □Cold
   □Other, specify:_____

7. Factors that improve sweating (list): _____

8. Do your sweating symptoms stop while you sleep? □ Yes □ No □ Other: _____

9. Age when the sweating problem first began: _____ years old
   <u>If unsure</u>, estimate age range: □ 0 – 12 yrs □ 13 – 25 yrs □ 26 – 40 yrs □ >40 yrs

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

11. 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

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12. Which is your dominant hand? □ RIGHT-handed □ LEFT-handed □ BOTH- handed

13. Do you have any relatives affected by excessive sweating? (check the box below)
    □YES – a relative has excessive sweating
    If yes, please indicate their relationship to you: _____
    Check the area(s) of your relative's sweating:
    □axillary/underarm □face □feet/soles
    □hand/palm □groin □ other_____
    □NO – No one else in my family has excessive sweating □ UNKNOWN – Don't know

14. Have you seen someone 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

15. Is the diagnosis of hyperhidrosis or the treatment of sweat disorders EXCLUDED by your insurance policy?

□ Yes □ No □ Unknown

Past Treatment of Excessive Sweating

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

Past Treatments	*Length of Time Used*	*Date Last Used*	*Areas treated*	*Results*	*Side Effects*
Drysol	***10 months***	***March 2010***	***Hands, underarms***	***Fair***	***Irritation, redness***

Past Treatments	Length of Time Used (weeks, months, years)	Date Last Used	Areas Treated	Results (none, poor, fair, good, excellent)	Side Effects/ Problems (none, dryness, splits in skin, irritation, redness)
Over-the-counter Anti-perspirant					
Drysol/aluminum chloride					
Drionic					
Iontophoresis					
Oral Anticholinergic (ex. Robinul)					
Other Oral Drugs (clonidine, inderal, anti-anxiety pills)					
Botox					
Surgery					
Liposuction/ Curette					
Hypnosis					
Acupuncture					
Diet/ Fluid Changes					
Other, specify: _____					

16. Please indicate how this sweating problem has affected your daily living, at work, school, relationships:

□ carry extra clothes
□ avoid shaking hands
□ avoid meeting new people
□ change clothes/shoes during day
□ affects personal relationships
□ affects the way you buy or wear clothes (eg. Wear layers, only dark colors)
□ affects work
□ avoid holding hands or intimacy
□ think about sweating often
□ smudge papers
□ have difficulty using tools, instruments
□ impairs professional appearance or status
□ keep arms down to hide stains
□ damage electronic equipment
□ Other, specify:_____

17. Please list specific examples of how this sweating problem impacts your work, school and relationships:

_____

_____

_____

18. Using the table below please mark your areas of sweating and rate them using the following Hyperhidrosis Disease Severity Scale (HDSS):

1 – My sweating is NEVER noticeable and NEVER interferes with my daily activities
2 – My sweating is tolerable, but SOMETIMES interferes with my daily activities
3 – My sweating is BARELY tolerable and FREQUENTLY interferes with my daily activities
4 – My sweating is INTOLERABLE and ALWAYS interferes with my daily activities

Check Areas of Excessive Sweating:	**Rate Current HDSS per scale above (1-4)**	**Rate your satisfaction with current treatment : (scale of 1-5, 1=very satisfied)**
Underarms		
Palms		
Soles		
Face		
Scalp		
Chest		
Back		
Groin		
Other:		

19. Have you been diagnosed with any of the following:
□ Diabetes Mellitus □ Cancer
□ Thyroid Disease □ Tuberculosis □ None of these

20. Over the past months have you experienced?
□ weight loss
□ weight gain
□ shortness of breath
□ fever
□ decreased appetite
□ increased appetite
□ menopause symptoms
□ night sweats
□ tachycardia
□ hot flashes
□ cough
□ palpitations
□ flushing
□ Other, specify:_____
_____
□ No significant symptoms

21. Check if you have any of the following: □ metal replacement joint/bone rod/plate/screw □ Pacemaker/defibrillator

22. Alcohol use: □NO □YES – amount (drinks/ week) _____ how long? _____ years

22. Are you currently pregnant or planning to become pregnant soon? □NO □YES
(Please discuss pregnancy issues with provider before starting any medications)

23. Please note your current: Weight _____lbs Height _____ft _____in

24. Please list your occupation: _____

25. Which best describes you: □ Single □ Married □Divorced □Widowed

26. Do you participate in activities that require sweating? □ Working out □ Team Sports □ Running □ Outdoor Labor □ None □ Other _____

Other Medications

Certain prescription and non-prescription medications can cause excess sweating as a side effect. Below is a partial list of medicines associated with sweating. Please check any you are currently or have recently taken.

Pain Medications
___Celebrex
___Hydrocodone/Vicodin
___Toradol/ketoralac
___Morphine
___Relafen/Nabumetone
___Naproxen/Aleve
___Oxycodone/Roxicodone
___Ultram/Tramadol
___Duragesic/Fentanyl
___Marinol

Oncology/Cancer
___Aridimex/Anastozole
___Lupron/Leuprolide
___Tamoxifen/Nolvadex

Hormonal/Endocrine
___Calcitonin/Fortical
___Glucotrol/Glipizide
___Insulin/Humulin
___Synthroid/Thyroid
___Depo-Provera
___Prednisolone/Orapred
___Evista/Raloxifene
___Gentropin/Somatropin
___Testosterone/Androgel
___Antibodies/Tositumomab
___Vasopressin/Pitressin

Gastrointestinal
___Lomotil/Diphenoxylate
___Anzemet/Dolasetron
___Asacol/Mesalamine
___Prilosec/omeprazole
___Aciphex/Rabeprazole

Gental/Urinary
___Cialis/Tadalafil
___Levitra/Vardenafil

Antibiotics/Antivirals
___Acyclovir/Zovirax
___Rocephin/Ceftriaxone
___Cipro/Ciprofloxasin
___Sustiva/Efavirenz
___Foscavir/Foscarnet
___Tequin/Gatifloxacin
___Avelox/moxifloxacin
___Ketek/Telithromycin
___Ribavirin/Copegus
___Retrovir/AZT

Skin Medications
___Topical steroids
___Accutane/Isotretinoin
___Lidocaine/Carbocaine
___Selsun/Selenium Sulfide

Head & Neck Medications
___Aerobid/Nasarel
___Claritin/Loratadine
___Sudafed/psuedoephedrine
___Aristocort/Azmacort
___Afrin/Neo-synephrine
___Zinc tablets/Cold-Eeze

Blood/Immune System
___Neoral/Cyclosporine
___Ferrous Gluconate/Iron
___Remicade/Infliximab
___Cellcept/Mycopheolate
___Prograf/Tacrolimus

Eye Medications
___Phospholine Iodide
___Vasocon/Naphazoline
___Alcaine/Proparacaine

Heart/Blood Pressure
___Norvasc/Amlodipine
___Lotensin/Benazepril
___Bumex/Bumetamide
___Coreg/Carvedilol
___Digoxin/Lanoxin
___PersantineDipyridamole
___Cardura/Doxazosin
___Vasotec/Enalopril
___Hydralazine
___Prinivil/Zestril/Lisinopril
___Cozaar/Losartan
___Lopressor/metoprolol
___Nifedipine/Procardia
___Rythmol/Propafenone
___Altace/Ramipril
___Calan/Verapamil

Psychiatric/Neuro Medications
___Elavil/Amitriptyline
___Buspar/Buspirone
___Tegretol/carbamazepine
___Celexa/Citalopram
___Clozaril/Clozapine
___Norpramin/Desipramine
___Adderall/Amphetamine
___Migranal/ergotamine
___Aricept/Donepezil
___Cymbalta/Duloxetine
___Lexapro/Escitalopram
___Lunesta/Eszopiclone
___Prozac/Fluoxetine
___Haldol/Haloperidol
___Sinemet/Levodopa
___Provigil/Modafinil

Lung Medications
___Advair/Fluticasone
___Combivent/Ipratropium
___Xopenex/Levalbuterol
___Alupent/Metaproterenol

___None of the above

Thank you for assisting us with your care.