Synergycentre
Dental & Healthcare

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HYPERHIDROSIS HISTORY & ASSESSMENT FORM

Hyperhidrosis is a chronic disorder of excessive sweating that may affect any body part, particularly the underarm, palms, soles of the feet and face. This condition can cause significant problems in your personal and professional life and has been shown to have a negative impact on the emotional well-being of those suffering from the disease.

To treat hyperhidrosis, Botox is administered via tiny injections, within the skin of the affected area, to reduce excessive sweating by blocking the release of the chemical acetylcholine from the nerve fibres that stimulate overactive sweat glands.

PERSONAL HISTORY

Date: _____

Last Name: _____ First Name: _____

Date of Birth: D _____M _____YR _____ **Age**: _____ Height _____ Weight _____ Sex: M / F / Other

OHIP (health card) #: _____ **Version Code:** _____

Address: _____ City/Town:_____ Postal Code: _____

Telephone: (_____) _____ Cell: (_____) _____ Work: (_____) _____

Preference of which number to call you: *(please circle)* HOME / CELL / WORK May we leave a voicemail? YES / NO

*__Email:__ _____ Occupation: _____

How did you hear about us? (*please circle)*

Friend or Family Facebook/Instagram Website Advertisement Physician/Healthcare Professional

Signage on building/Driving by Email Google Search Other: _____

Do you have a private / extended healthcare plan? Y / N Name of provider: _____

MEDICAL HISTORY

Family Physician: _____ Address: _____

Are you currently **pregnant or breastfeeding**? **Y / N** Are you planning a **pregnancy** within the next year? **Y / N**

Major illnesses or Surgeries [PAST or PRESENT] (cancer, diabetes, surgery, etc.) _____

Do you have any **neurological** conditions? [i.e. myasthenia gravis, multiple sclerosis, ALS, Lambert-Eaton syndrome, Bells Palsy, etc.] **Y / N**

Current health conditions/diagnoses: _____

_____

Please list any **current medications** including vitamins, herbal supplements (dosage not required) _____

_____

Are you taking **blood thinners** [anti-coagulant or anti-platelet medications]? **Y / N** If yes, please explain: _____

Please list any **Allergies** [foods, medication, other]: _____

HYPERHIDROSIS HISTORY

At what age did your excessive sweating become a problem? Age: _____

Do any of your family members [parents, brothers, sisters, children] also suffer from excessive sweating? **Y / N**

Is the sweat triggered by anything specific such as (please check ✔): ____ Food ____ Stress ____ Heat ____ Exercise ____ Other

Are you right or left hand dominant? ____ Right ____ Left

Is the sweating the same on both sides of your body or worse on one side? ____ Same on both ____ Worse on right ____ Worse on left

When does your sweating usually occur? (check ✔ all that apply): ____ Throughout day ____ When sleeping ____ During/after specific activities ____ Other (please explain)

How often do you notice your sweating? ____ Daily ____ Most days ____ At least once a week ____ A few times a month ____ Occasionally

From which body region(s) do you sweat excessively? Rate the severity of the sweating for the affected region(s). (Please

	Mild	Moderate	Severe
Face			
Scalp			
Soles			
Palms			
Underarms			
Groin			
Other: _____			

Which treatment/therapy are you currently using or have tried in the past?

	Please indicate: **Current = C** **Past = P**	**Reason for discontinuing therapy/ unsatisfied with therapy****
Topical antiperspirant (aluminum chloride, Drysol, Certain Dri, etc.)		
Topical glycopyrrolate		
Iontophoresis (Drionic, Fischer, or other)		
Botox injections		
Alternative therapies (herbal, homeopathy, natural products)		
Oral medication (Glycopyrrolate, Ditropan, or other)		
Laser therapy		
Surgery (local excision of sweat glands, ETS, or other)		
Other: _____		

****Potential reasons for discontinuing any of the above treatments:** poor/lack of response, wore off too quickly, side effects/difficult to tolerate, too expensive, difficulty complying with demands of treatment, etc.

Hyperhidrosis Disease Severity Scale

(Please check ✔)	**"How would you rate the severity of your sweating?"**
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.

PLEASE SIGN - AUTHORIZATION OF INFORMATION

I have carefully read all 3 pages of this document and confirm that the above stated/written information and disclosure of my personal health information is correct to the best of my knowledge.

Patient Signature: _____

Print Name: _____

Thank you for trusting us with your care,

Dr. Maria Tetelbaum & Team