Stop Sweat Now™
RAISE YOUR ARMS WITH CONFIDENCE

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Patient Questionnaire

Patient Name: _____ Date: _____

Hyperhidrosis Disease Severity Scale

"How would you rate the severity of your hyperhidrosis?"

◯ 1	My underarm sweating is never noticeable and never interferes with my daily activities
◯ 2	My underarm sweating is tolerable but sometimes interferes with my daily activities
◯ 3	My underarm sweating is barely tolerable and frequently interferes with my daily activities
◯ 4	My underarm sweating is intolerable and always interferes with my daily activities

1. How many wetness outbreaks have you had in the last week? (Choose one)

o None o 1-2 o 3-5 o More than 5

2. How severe of a problem is your underarm wetness? (Circle one number)

1 2 3 4 5 6 7 8 9 10

1 = Not a problem 10 = Severe problem

Patient Signature: _____ Date: _____

For office use only:
Please specify at what point the questionnaire was provided to patient

o Baseline – Before procedure
o Post Treatment Follow up: Select one: o 30 days o 60 days o 90 days Other:_____

Treatment 1 Date:_____ Treatment 2 Date:_____