

Advanced Foot Care Center  
204 Grove Avenue  
Suite G  
Thorofare, NJ 08086  
856-579-8674

Hyperhidrosis/Excessive Sweating History Survey

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please answer the following questions to the best of your ability. The information given will be used to get gain reimbursement from your insurance company for your visit.

- |   |     |   |      |
|---|-----|---|------|
| 1. Is the excessive sweating on one side or both sides?   | R   | L | Both |
| 2. Does the excessive sweating interfere with your daily activities?  | Yes |   | No   |
| 3. Do you have a family history of excessive sweating? Does your Mother, Father, Brother, Sister, or grandparent have excessive sweating too? | Yes |   | No   |
| 4. Does the excessive sweating stop at night when you go to bed?  | Yes |   | No   |
| 5. Did the excessive sweating start on or before you turned 25 yrs old?   | Yes |   | No   |