

# SUBSTANCE SURVEY FORM

Name	Date
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Please list any prescription medications you are currently taking or have taken in the last year

Medications	Diagnosis

Please list any over-the-counter medications you are currently taking or have taken in the last year:

Product	Symptom	Quantity and Frequency

Please list any vitamins, supplements, herbs, or homeopathic medicines you are currently taking or have taken in the last year: (Use other side if needed.)

Product	Symptom	Quantity and Frequency

Check the following items which apply to you and *indicate the amount used*:

<input type="checkbox"/> Coffee	<input type="checkbox"/> Artificial Sweetener	<input type="checkbox"/> Ice cream
<input type="checkbox"/> Tea	<input type="checkbox"/> Antacids	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Soft Drinks	<input type="checkbox"/> Laxatives	<input type="checkbox"/> Cigarettes
<input type="checkbox"/> Diet Soft Drinks	<input type="checkbox"/> Candy	<input type="checkbox"/> Other Tobacco Products

How many desserts do you have in an average week? \_\_\_\_\_