

SUBSTANCE SURVEY FORM

Name _____

Date _____

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 & 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? _____