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:

Product	Symptom	Quantity & Frequency

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

Coffee _____	Artificial Sweetener _____	Ice Cream _____
Tea _____	Antacids _____	Alcohol _____
Soft Drinks _____	Laxatives _____	Cigarettes _____
Diet Soft Drinks _____	Candy _____	Other Tobacco _____
Energy Drinks _____		

How many desserts do you have in an average week?