SUBSTANCE SURVEY FORM

Name _____ Date _____

Please list prescription medications you are currently taking or have taken in the last year (continue on back of page if necessary):

Medication	Diagnosis
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

Product	Symptom	Quantity & Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list vitamins, supplements, herbs, or homeopathic medicines you are currently taking or have taken in the last year (continue on back of page if necessary):

Product	Symptom	Quantity & Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

- ☐ Coffee _____
- ☐ Tea _____
- ☐ Soft Drinks _____
- ☐ Diet Soft Drinks _____
- ☐ Protein Powders _____
- ☐ Artificial Sweeteners _____
- ☐ Antacids _____
- ☐ Laxatives _____
- ☐ Candy _____
- ☐ Ice Cream _____
- ☐ Alcohol _____
- ☐ Tobacco Products _____

How many desserts do you have in an average week? _____