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	Quality & 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	Quality & Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

❒ Coffee _____
❒ Tea _____
❒ Soft drinks _____
❒ Diet Soft Drinks _____
❒ Artificial Sweetener _____
❒ Antacids _____
❒ Laxatives _____
❒ Candy _____
❒ Ice cream _____
❒ Alcohol _____
❒ Cigarettes _____
❒ Other tobacco products _____

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