SUBSTANCE SURVEY FORM

NAME: ______________________________ DATE: ____________________

List any prescription medications you are currently taking or have taken in the last year.

Medication	Diagnosis

List any over-the-counter medications you are currently taking or have taken in the last year.

Product	Symptom	Quantity & Frequency

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

Product	Amount Taken Daily	How Long Taken

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

- ❑ Coffee __________
- ❑ Tea __________
- ❑ Soft Drinks __________
- ❑ Artificial Sweetener ____
- ❑ Antacids __________
- ❑ Laxatives __________
- ❑ Candy __________
- ❑ Ice Cream __________
- ❑ Alcohol __________
- ❑ Cigarettes __________
- ❑ Other Tobacco Products __________