SUBSTANCE SURVEY FORM

Name_____ Date_____

Prescription Meds Only

Please list any **PRESCRIPTION MEDICATION** you are currently taking or have taken in the last **2** years

Medication	Daily Dosage	Diagnosis or Symptom	Dates of Use
			From To
			From To
			From To
			From To
			From To
			From To

OTC'S Only

Please list any **OVER THE COUNTER MEDICATIONS** you are currently taking or have taken in the last **2** years

Medication	Daily Dosage	Diagnosis or Symptom	Dates of Use
			From To
			From To
			From To

Vitamins/Supplements Only

Please list any **VITAMINS, SUPPLEMENTS, OR HERBS** you are currently taking or have taken in the last **2** years

Product	Daily Dosage	Diagnosis or Symptom	Dates of Use
			From To
			From To
			From To
			From To
			From To
			From To
			From To
			From To

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

	Amount		Amount		Amount		Amount
☐ Coffee	____	☐ Candy	____	☐ Alcohol	____	☐ Antacids	____
☐ Tea	____	☐ Ice Cream	____	☐ Cigarettes	____	☐ Laxatives	____
☐ Soft Drinks	____	☐ Artificial Sweetener	____	☐ Other Tobacco Products	____		

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

Are you on any special diet?____If so, what?_____