



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

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 deserts do you have in an average week? _____