risa groux CN
nutritionist

Substance Survey Form

Name_____Date_____

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

Name	Daily Dosage	Diagnosis or symptom	Dates of use

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

Name	Daily Dosage	Diagnosis or symptom	Dates of use

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

Name	Daily Dosage	Diagnosis or symptom	Dates of use

Please list any ALLERGIES you may have:

_____

_____

_____

Please list all **SURGERIES** or **MEDICAL PROCEDURES:**

_____

_____

_____

Circle the following items that apply to you and indicate the amount used

Candy	Y/N_____	Antacids	Y/N_____
Ice cream	Y/N _____	Tea	Y/N_____
Artificial sweetener	Y/N _____	Laxatives	Y/N_____

How many desserts do you average in a week?

_____