Path to Health
Carrie Wojciechowski, C.N.

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:

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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?____