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**PATIENT HEALTH SURVEY**

1. Are you presently taking any type of nutritional supplements (such as vitamins, minerals, herbs, amino acids, fish oils, etc.)? _____Yes _____No
2. If you are taking supplements, which of the following are you currently taking:

| | | |
|---|---|---|
| _ Multivitamin | _ Vitamin B Complex | _ Multi-Minerals |
| _ Calcium | _ Vitamin C | _ Flaxseed |
| _ Omega 3 Fish Oils | _ Vitamin D | _ Hormone Therapy |
| _ Antioxidants | _ Joint Supplement | _ Allergy Aids |

   _ Other (*please specify*): _____
3. Who recommended you take these supplements?
   _ Family member or friend
   _ Advertisement
   _ Health professional
   _ Other (please specify): _____
4. Where did you purchase these supplements?

| | |
|---|---|
| _ Mail order | _ Nutrition or vitamin shop |
| _ Healthcare provider | _ Pharmacy |

   _ Other (please specify): _____
5. If this practice offered advanced, high quality supplements, would you consider purchasing them?
   _____ Yes _____ No
6. If this office offered a simple genetic test to determine what supplements are best for you, based on your genetics, would you consider doing it? _____ Yes _____ No
7. If this office offered a comprehensive weight management program, would you be interested in it?
   _____ Yes _____ No
8. Our practice is offering free nutritional education programs to improve your oral health and dietary habits. Would you like to find out more about these free programs? _____ Yes _____ No
9. Please note any comments or questions: _____

_____

_____

_____