

"Self-medication study questionnaire"

General Information Section

Surveyor Dialogue: Now I am going to ask you general information about you and your family members staying in this house.

1. Date of visit: ___/___/_____
(DD / MM / YYYY)

Who is answering this survey?

Self

Other family member (write the relation. If mother is answering for son then write mother)

2. Gender (Tick appropriate): Male Female Do not wish to specify

3. Date of Birth: ___/___/_____
(DD / MM / YYYY)

4. Occupation:

You can select multiple choices by crossing (x) the appropriate boxes below.

<input type="checkbox"/> Student	<input type="checkbox"/> Employee	<input type="checkbox"/> Business
<input type="checkbox"/> Housewife	<input type="checkbox"/> Retired	<input type="checkbox"/> Farmer
<input type="checkbox"/> Other. Explain		

5. Marital status: **Select only 1 choice by crossing (x) the appropriate box below.**

<input type="checkbox"/> Unmarried	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
<input type="checkbox"/> Widowed	<input type="checkbox"/> Separated	

6. Religion: **Select only 1 choice by crossing (x) the appropriate box below.**

<input type="checkbox"/> Hindu	<input type="checkbox"/> Muslim	<input type="checkbox"/> Sikh
<input type="checkbox"/> Christian	<input type="checkbox"/> Other. Explain	

7. Highest Qualification: **Select only 1 choice by crossing (x) the appropriate box below.**

<input type="checkbox"/> Illiterate	<input type="checkbox"/> Primary school	<input type="checkbox"/> High School
<input type="checkbox"/> College	<input type="checkbox"/> Diploma	<input type="checkbox"/> Graduate degree
<input type="checkbox"/> Post graduate degree	<input type="checkbox"/> PhD	<input type="checkbox"/> Other. Explain

8. Total number of family members staying with you in this house. _____

9. Total House income / month: Add all the income (in local currency) of family members staying in this house / month. _____

Self-Medication habits

Surveyor Dialogue: Now I am going to ask you questions regarding your health and self-medication habits.

10. Did you have any disease in last three months?

No, if answer is no, then go to health insurance question number 33.

Yes

Now let me define what is self-medication? –

• **Self-medication is the use of medicinal products by the consumer which is not prescribed by the physician.**

From now on to the next questions, your answers should be based on last 3 months experience, unless I specify the different time period.

11. Have you taken self-medication in last three months?

Select only 1 choice by crossing (x) the appropriate box below.

No

If your answer is no, then go to health insurance question number 33.

Yes

If your answer is yes, then continue with the rest of the questions.


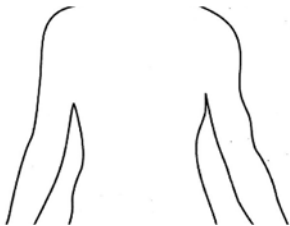
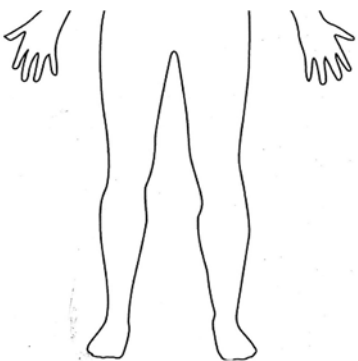
12. What was your reason for self-medication? (Self medication is the use of medicinal products by the consumer which is not prescribed by the physician.)

You can select multiple choices by crossing (x) the appropriate boxes below.

<input type="checkbox"/> Doctor / clinic far from home	<input type="checkbox"/> Saves time
<input type="checkbox"/> High fees of doctor	<input type="checkbox"/> I have old prescription
<input type="checkbox"/> Doctor is busy with many patients	<input type="checkbox"/> I have medicines of family members
<input type="checkbox"/> No trust in doctor	<input type="checkbox"/> Pharmacist advice
<input type="checkbox"/> Other. Explain	

13. For which disease you have taken self-medication in last 3 months?

You can select multiple choices by crossing (x) the appropriate boxes below.

	<input type="checkbox"/> Headache	<input type="checkbox"/> Eye infection
	<input type="checkbox"/> Dandruff	<input type="checkbox"/> Running nose
	<input type="checkbox"/> Hair fall	<input type="checkbox"/> Ear pain
	<input type="checkbox"/> Faints	<input type="checkbox"/> Mouth ulcer
	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Dental pain
	<input type="checkbox"/> Migraine	<input type="checkbox"/> Cough
	<input type="checkbox"/> Other. Specify	
	<input type="checkbox"/> Difficulty in swallowing	<input type="checkbox"/> Dysentery
	<input type="checkbox"/> Acidity	<input type="checkbox"/> Rash
	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Fever
	<input type="checkbox"/> Nausea	<input type="checkbox"/> Skin disease on open areas
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes
	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Hypertension
	<input type="checkbox"/> Body pain. Specify	
	<input type="checkbox"/> Other. Specify	
	<input type="checkbox"/> Pain in joints	<input type="checkbox"/> Sexually transmitted disease STD
	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Skin disease in covered areas
	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Impotency
	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Urination problems
	<input type="checkbox"/> Wounds	<input type="checkbox"/> Menstrual problems
	<input type="checkbox"/> Genital infection	<input type="checkbox"/> Birth control
	<input type="checkbox"/> Other. Specify	

14. What do you consider while selecting the drug for self-medication?

You can select multiple choices by crossing (x) the appropriate boxes below.

<input type="checkbox"/> Price
<input type="checkbox"/> Pharmaceutical Company
<input type="checkbox"/> Type of medicine Which type of medicine you select? <input type="checkbox"/> Ayurvedic <input type="checkbox"/> Allopathic <input type="checkbox"/> Homeopathic
<input type="checkbox"/> Brand. If you select any specific brand, then answer question 15, or else go to question 16.
<input type="checkbox"/> Other. Explain

15. Your selection of particular brand depends on which of the following choices?

You can select multiple choices by crossing (x) the appropriate boxes below.

<input type="checkbox"/> Recommended by pharmacist	<input type="checkbox"/> Old prescription of doctor
<input type="checkbox"/> Used by peers – friends / family	<input type="checkbox"/> Advertisement
<input type="checkbox"/> My previous experience	<input type="checkbox"/> Other. Explain

16. Where do you obtain your drugs for self-medication?

You can select multiple choices by crossing (x) the appropriate boxes below.

<input type="checkbox"/> Pharmacy shop	<input type="checkbox"/> Online shopping
<input type="checkbox"/> Primary health care center	<input type="checkbox"/> Medical representatives
<input type="checkbox"/> Friends / family	<input type="checkbox"/> Other. Explain

17. Do you check the prescribing information before self-medicating?

Select only 1 choice by crossing (x) the appropriate box below.

<input type="checkbox"/> Yes, always	<input type="checkbox"/> No, never	<input type="checkbox"/> Yes, sometimes
--------------------------------------	------------------------------------	---

If your answer to question 17 is Yes, always or Yes, sometimes then answer 18. If not go to question 19.

18. How much did you understand from the instructions of prescribing information?

Select only 1 choice by crossing (x) the appropriate box below.

Fully understood

Partially understood

Not at all

19. Have you ever experienced adverse events with self-medication?

No

Yes. Explain _____

If answer to question 19 is yes, then solve question 20. If not, then go to question 21.

20. What did you do for the adverse event you experienced? (the adverse event/s referred in question 19) You can select multiple choices by crossing (x) the appropriate boxes below.

Go to private doctor

Go to pharmacist

Go to primary health care center

Stop taking medication

Other. Explain

21. Are you taking self-medication for any chronic disease? (Chronic disease in this study is defined as a disease lasting three months or longer.)

No

Yes

If answer to question 21 is yes, then solve question 22. If not, then go to the next section of questionnaire on anti-infectives (question 23).

22. How long you have been taking self-medication for any chronic disease?

Name of disease	Time period in months

Self-Medication habits with Anti-infectives

Surveyor Dialogue: Now I am going to ask you questions regarding your use of anti-infectives for self-medication.

23. Did you have any infection in last three months?

No, if answer is no then, go to health insurance question number 33.

Yes, go to question number 24

24. Have you ever self-medicated yourself with anti-infectives?

<input type="checkbox"/> No	<input type="checkbox"/> Yes
-----------------------------	------------------------------

If answer to question 24 is yes, then go to question 25 or else go to the next section on Health insurance that is question 31.

25. For which of the following diseases did you self-medicate with anti-infectives?

You can select multiple choices by crossing (x) the appropriate boxes below.

Infection	Medicine name	Infection	Medicine name
<input type="checkbox"/> Eye infection		<input type="checkbox"/> Skin disease on open areas	
<input type="checkbox"/> Running nose		<input type="checkbox"/> Skin disease in covered areas	
<input type="checkbox"/> Ear pain		<input type="checkbox"/> Genital infection	
<input type="checkbox"/> Cough		<input type="checkbox"/> Sexually transmitted disease STD	
<input type="checkbox"/> Sore throat		<input type="checkbox"/> Urinary problems	
<input type="checkbox"/> Dental pain		<input type="checkbox"/> Menstrual problems	
<input type="checkbox"/> Vomiting		<input type="checkbox"/> Diarrhea	
<input type="checkbox"/> Fever		<input type="checkbox"/> Other. Explain	
<input type="checkbox"/> Wounds			

26. From the above which was the most recent infection for which you self medicated?

27. How did you know the dosage of anti-infectives?

You can select multiple choices by crossing (x) the appropriate boxes below.

<input type="checkbox"/> By checking the prescribing information	<input type="checkbox"/> Consulting pharmacist	<input type="checkbox"/> Internet
<input type="checkbox"/> Consulting doctor	<input type="checkbox"/> Consulting peers – friends / family	<input type="checkbox"/> Previous experience
<input type="checkbox"/> Consulting primary health care center	<input type="checkbox"/> Advertisements	<input type="checkbox"/> Guessing the dosage by myself
<input type="checkbox"/> Other. Explain		

28. Did you ever change the dosage of anti-infectives during the course of self-medication?

Select only 1 choice by crossing (x) the appropriate box below.

<input type="checkbox"/> Yes, always	<input type="checkbox"/> Yes, sometime	<input type="checkbox"/> No, never	<input type="checkbox"/> Do not know
--------------------------------------	--	------------------------------------	--------------------------------------

If your answer to question 28 is Yes, always or Yes, sometime then go to question 29. If answer is No, never or Do not know, then go to question 30.

29. Why did you change the dosage of anti-infectives during the course of self-medication?

You can select multiple choices by crossing (x) the appropriate boxes below.

<input type="checkbox"/> Health improved	<input type="checkbox"/> To reduce adverse events	Other. Explain _____ _____
<input type="checkbox"/> Disease worsened	<input type="checkbox"/> Drug insufficient for self-medication	

30. Last time when you used anti-infective, did you change that anti-infective/s during self-medication?

Select only 1 choice by crossing (x) the appropriate box below.

<input type="checkbox"/> Yes, always	<input type="checkbox"/> Yes, sometime	<input type="checkbox"/> No, never	<input type="checkbox"/> Do not know
--------------------------------------	--	------------------------------------	--------------------------------------

If your answer to question 30 is Yes, always or Yes, sometime then go to question 31. If your answer is No, never or Do not know, then go to question 32.

31. Why did you change anti-infectives during self-medication?

You can select multiple choices by crossing (x) the appropriate boxes below.

<input type="checkbox"/> The former anti-infective did not work	<input type="checkbox"/> The latter one was cheaper	<input type="checkbox"/> Pharmacy ran out of former anti-infective
<input type="checkbox"/> The former anti-infective got over	<input type="checkbox"/> To reduce adverse events	<input type="checkbox"/> Other. Explain _____ _____

32. When did you stop taking anti-infectives?

You can select multiple choices by crossing (x) the appropriate boxes below.

<input type="checkbox"/> After a few days regardless of the outcome	<input type="checkbox"/> After symptoms disappeared	<input type="checkbox"/> After anti-infective got over
<input type="checkbox"/> After complete course of anti-infective		
<p>If you select this choice then where did you get the knowledge about course of anti-infectives? You can select multiple choices by crossing (x) the appropriate boxes below.</p>		
<input type="checkbox"/> Prescribing information <input type="checkbox"/> Pharmacist <input type="checkbox"/> Primary health care center <input type="checkbox"/> Doctor <input type="checkbox"/> Peers- family / friends		
<input type="checkbox"/> Other. Explain		

Health insurance

Surveyor Dialogue: Now I am going to ask you question regarding health insurance.

33. What kind of health insurance do you have this year?

You can select multiple choices by crossing (x) the appropriate boxes below.

<input type="checkbox"/> No insurance	<input type="checkbox"/> Government sponsored insurance
<input type="checkbox"/> Rural insurance	<input type="checkbox"/> Private medical insurance
<input type="checkbox"/> Other. Explain	