OVER-THE-COUNTER (OTC) medicines & side effects

Hello All,

Hope you are doing well.
We are collecting information about OTC medicines for our research purpose. We would appreciate your feedback in our online survey.
All responses will remain confidential and secure.

In case if you're not aware about OTC medicines you can refer to the following URL:
Over the counter medicines: An over-the-counter medicine is a medicine that may be sold without a doctor's prescription.
You can buy over-the-counter medicines from a pharmacy or other shop without a doctor's prescription.
https://en.m.wikipedia.org/wiki/Over-the-counter_drug

*Required

1. Age *

Mark only one oval.

- 20-29
- 30-39
- 40-49
- 50 and above

2. Gender *

Mark only one oval.

- Male
- Female
- Not prefer to answer

3. Education *

Mark only one oval.

- ◯ Primary
- ◯ Secondary
- ◯ Higher secondary
- ◯ Graduation
- ◯ Post graduation
- ◯ Other: _____

4. Income *

Mark only one oval.

- ◯ Not prefer to answer
- ◯ 0 - 1 Lakh
- ◯ 1 Lakh- 5 Lakh
- ◯ 5 Lakh- 10 Lakh
- ◯ 10 Lakh+

5. Place of Residence *

Mark only one oval.

- ◯ Urban
- ◯ Rural
- ◯ Semi-Urban

6. Monthly expenditure on OTC medicines. *

Mark only one oval.

- ◯ Below Rs.200
- ◯ Rs.200- Rs.400
- ◯ Rs.401- Rs.600
- ◯ Rs.601- Rs.800
- ◯ Above Rs.800

Skip to question 7

OVER-THE-COUNTER (OTC) MEDICINES

7. Are you suffering from any common illness? *

Mark only one oval.

- ◯ Almost never
- ◯ Less than once a month
- ◯ About once a month
- ◯ Atleast one day a week
- ◯ Almost everyday

8. For what kind of common symptoms you ever worry? (You can select more than one option.) *

Tick all that apply.

- ☐ Headache and fever
- ☐ Backaches
- ☐ Joints and muscles pain
- ☐ Toothache
- ☐ Abdominal pain
- ☐ Cough and common cold
- ☐ Period cramps

Other: ☐ _____

9. Which category of OTC medicine you prefer to treat pain? (You can select more than one option.) *

Tick all that apply.

- [ ] Oral (tablet, syrup, capsule, powder, etc taken internally)
- [ ] Topical (ointments, cream, liquids that are applied to the skin)
- [ ] Others (such as eye drop and surgical dressings)

10. To which extent do the following factors influence your selection during the purchase of an over-the-counter medicines? For each statement please check whether you Fully agree, Agree, Neither agree/ Nor disagree, Disagree, Disagree completely. *

Mark only one oval per row.

	Fully Agree	Agree	Neither agree/ Nor disagree	Disagree	Disagree completely
Experience of previous use	◯	◯	◯	◯	◯
The medicine's advertisement	◯	◯	◯	◯	◯
Family's /friends' opinion	◯	◯	◯	◯	◯
Medicine's safety & effectivity	◯	◯	◯	◯	◯
OTC medicines are cheaper & convenient	◯	◯	◯	◯	◯
Medical advice	◯	◯	◯	◯	◯
Faster relief	◯	◯	◯	◯	◯
Availability of medicines	◯	◯	◯	◯	◯

Skip to question 11

Untitled section

11. Attitude & Practices regarding self medication and awareness. *

Mark only one oval per row.

	Never	Sometimes	Always
Do you take medicines for self medication for long period without any medical advice			
Have you given your prescription to someone who have similar symptoms			
Do you take self medication without reading instructions on medicine label			
Do you check the expiry date before using any medicine			

12. Do you suffer from any side effect of OTC medicine? *

Mark only one oval.

- Yes
- No
- Maybe

13. Which of the following side effect do you suffer? (You can select more than one option)

Tick all that apply.

- Burning sensation in tummy
- Sleepiness
- Abdominal problems
- Skin rash
- Nausea & Vomiting
- Loss of appetite
- Constipation

Other: _____

14. Have you used any vitamins or other dietary supplements in the past year? *

Mark only one oval.

- ◯ Yes
- ◯ No
- ◯ Not sure

15. Do you have any long-term disease (Diabetes, BP, Asthma) *

Mark only one oval.

- ◯ Yes
- ◯ No

16. If yes, what long term diseases do you have? (You can select more than one option.)

Tick all that apply.

- ☐ Diabetes
- ☐ High blood pressure
- ☐ Asthma
- ☐ Kidney disease

Other: ☐ _____

17. Apart from this, are you taking any treatment below? (you can select more than one option.) *

Tick all that apply.

- ☐ Not taking any treatment
- ☐ Ayurveda
- ☐ Homeopathy
- ☐ Home remedies

Other: ☐ _____