

AILMENTS/ REMEDIES	How treated in the last 12 months?					
	Used a prescription remedy		Used a non-prescription remedy	Used a home/herbal remedy	Have not treated	
	Branded	Generic				
107	1	2	3	4	5	6
<b>AILMENTS</b>						
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 01
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 02
Allergy/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 03
Anxiety/Panic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 04
Arthritis/Rheumatoid arthritis (RA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 05
Arthritis/Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 06
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 07
Athlete's Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 08
Backache/Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 09
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 10
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 11
Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 12
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 13
Dandruff/Dry Scalp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 14
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 15
Diabetes (Insulin Dependent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 16
Diabetes (Non-Insulin Dependent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 17
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 18
Eczema/Skin Itch/Rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 19
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 20
Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 21
Heart Attack/Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 22
Heartburn/Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 23
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 24
Hypertension/High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 25
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 26
Irritable Bowel Syndrome (IBS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 27
Kidney Ailments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 28
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 29
Menopause/Hormone Replacement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 30
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 31
Multiple Sclerosis (MS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 32
Muscle Strain/Sprain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 33
Nail Fungus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 34
Obesity/Overweight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 35
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 36
Overactive Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 37
Prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 38
Restless Legs Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 39
Rosacea or Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 40
Sexual/Erectile Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 41
Sinus Congestion/Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 42
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 43
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 44
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 45
Urinary Tract Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 46
Wrinkles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 47
Yeast Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> 48

  

**In the last 12 months, how did you obtain information about an ailment or prescription drug?** 15A-0

Advertisement	<input type="checkbox"/> 1	Pharmacist	<input type="checkbox"/> 6
Doctor or Health care professional	<input type="checkbox"/> 2	Pharmaceutical company	<input type="checkbox"/> 7
Friends/Family	<input type="checkbox"/> 3	Medical journals	<input type="checkbox"/> 8
Pamphlets/Brochures	<input type="checkbox"/> 4	Online/Internet site	<input type="checkbox"/> 9
Patient support group	<input type="checkbox"/> 5	Other	<input type="checkbox"/> 0

**In the last 12 months, have you asked your doctor about a prescription medication you saw advertised?** Yes  X

DOCTOR VISITS	You Personally:	
	Visited in last 12 months	Times/last 12 months
094		
<b>TOTAL:</b>	<input type="checkbox"/>	00
<b>TYPES:</b>		
Acupuncturist	<input type="checkbox"/>	01
Allergist	<input type="checkbox"/>	02
Cardiologist	<input type="checkbox"/>	03
Chiropractor	<input type="checkbox"/>	04
Dentist	<input type="checkbox"/>	05
Dermatologist	<input type="checkbox"/>	06
Ear, Nose & Throat	<input type="checkbox"/>	07
Eye Doctor	<input type="checkbox"/>	08
Gastroenterologist	<input type="checkbox"/>	09
General/Family Practitioner	<input type="checkbox"/>	10
Internist	<input type="checkbox"/>	11
Nurse Practitioner	<input type="checkbox"/>	12
OB/Gyn	<input type="checkbox"/>	13
Osteopath	<input type="checkbox"/>	14
Physical Therapist	<input type="checkbox"/>	15
Plastic Surgeon	<input type="checkbox"/>	16
Podiatrist	<input type="checkbox"/>	17
Psychiatrist	<input type="checkbox"/>	18
Urologist	<input type="checkbox"/>	19
OTHER (Write In)	<input type="checkbox"/>	999

  

CONTRACEPTION (Women)	You Personally: Used in last 12 months
15J-0	
Depo-Provera	<input type="checkbox"/> 1
Loestrin	<input type="checkbox"/> 2
NuvaRing	<input type="checkbox"/> 3
Ortho Evra	<input type="checkbox"/> 4
Ortho Tri-cyclen	<input type="checkbox"/> 5
Ortho Tri-cyclen Lo	<input type="checkbox"/> 6
Seasonale	<input type="checkbox"/> 7
Yasmin	<input type="checkbox"/> 8
IUD	<input type="checkbox"/> 9
Diaphragm or Cervical Cap	<input type="checkbox"/> 0
OTHER (Write In)	<input type="checkbox"/> X

  

CARETAKER/ CAREGIVER	
<b>Are you, personally, the primary caretaker for someone with a medical condition?</b> Yes <input type="checkbox"/> 1 15L-0	
<b>If yes, what services/support do you provide?</b> 15N-0	
Assist with chores	<input type="checkbox"/> 1
Assist with personal care	<input type="checkbox"/> 2
Give medication	<input type="checkbox"/> 3
Make doctor's appointments	<input type="checkbox"/> 4
Provide transportation	<input type="checkbox"/> 5
Research medical information	<input type="checkbox"/> 6
Other	<input type="checkbox"/> 7
<b>Age of patient(s):</b> 15W-0	
Less than 18 years old	<input type="checkbox"/> 1
18-64 years old	<input type="checkbox"/> 2
65 years or older	<input type="checkbox"/> 3
<b>Patient's relationship to you:</b> 15Y-0	
Relative	<input type="checkbox"/> 1
Friend	<input type="checkbox"/> 2
Other	<input type="checkbox"/> 3