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qg_B1_za-zd - B1 za-zd

B1 za-zd

Please indicate below if you have used any medicines (pills, syrups, inhalers, drops, sprays, suppositories, pessaries, ointments etc including homeopathic and herbal remedies) in the last 12 months.

Code List Dimension

1	Other condition (please tick & describe)
2	Other condition (please tick & describe)
3	Other condition (please tick & describe)
4	Other condition (please tick & describe)

Code List Dimension

1	Yes in past 12 months
2	If yes, give name of substance
3	How often did you take/use this?

Responses

Type

Text

Label

Generic text

Maximum Length

255

1	Yes
1	Every day
2	Most days
3	Sometimes
4	Once or twice

Type

Text

Label

Generic text

Maximum Length

255

1	Yes
1	Every day
2	Most days
3	Sometimes
4	Once or twice
1	Yes
1	Every day
2	Most days
3	Sometimes
4	Once or twice

Type

Text

Label

Generic text

Maximum Length

255