

Patient questionnaire

for Dr _____

Licensed doctors are expected to seek feedback from colleagues and patients and review and act upon that feedback where appropriate.

The purpose of this exercise is to provide doctors with information about their work through the eyes of those they work with and treat, and is intended to help inform their further development.

Please do not write your name on this questionnaire.

Please base your answers only on the consultation you have had today.

Please mark the box like this with a ball point pen. If you change your mind just cross out your old response and make your new choice.

Please write today's date here: / /

1 Are you filling in this questionnaire for:

- Yourself Your child Your spouse or partner Another relative or friend

If you are filling this in for someone else, please answer the following questions from the patient's point of view.

2 Which of the following best describes the reason you saw the doctor today? (Please tick all the boxes that apply)

- To ask for advice Because of an ongoing problem For treatment (including prescriptions)
 Because of a one-off problem For a routine check Other (please give details)

3 On a scale of 1 to 5, how important to your health and wellbeing was your reason for visiting the doctor today?

- Not very important Very important
 1 2 3 4 5

4 How good was your doctor today at each of the following? (Please tick one box in each line)

	Poor	Less than satisfactory	Satisfactory	Good	Very good	Does not apply
a Being polite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b Making you feel at ease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c Listening to you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d Assessing your medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e Explaining your condition and treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f Involving you in decisions about your treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g Providing or arranging treatment for you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5	Please decide how strongly you agree or disagree with the following statements by ticking <u>one</u> box in each line.					
	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Does not apply
a	This doctor will keep information about me confidential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b	This doctor is honest and trustworthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	I am confident about this doctor's ability to provide care			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7	I would be completely happy to see this doctor again			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8	Was this visit with your usual doctor?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
9	Please add any other comments you want to make about this doctor. Please note: No patients will be identified when this information is given to the doctor.					

The next questions will provide the doctor with some basic information about who took part in the survey. If you are filling this in on behalf of a child or a patient with a disability, please provide details about the patient.

10	Are you:	<input type="checkbox"/> Female	<input type="checkbox"/> Male						
11	Age:	<input type="checkbox"/> Under 15	<input type="checkbox"/> 15–20	<input type="checkbox"/> 21–40	<input type="checkbox"/> 40–60	<input type="checkbox"/> 60 or over			
12	What is your ethnic group? Please choose one section from A to E, and then tick the appropriate box to indicate your cultural background.								
A	White	B	Mixed	C	Asian or Asian British	D	Black or Black British	E	Chinese or other ethnic group
<input type="checkbox"/>	British	<input type="checkbox"/>	White and Black Caribbean	<input type="checkbox"/>	Indian	<input type="checkbox"/>	Caribbean	<input type="checkbox"/>	Chinese
<input type="checkbox"/>	Irish	<input type="checkbox"/>	White and Black African	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	African	<input type="checkbox"/>	Any other
<input type="checkbox"/>	Any other white background	<input type="checkbox"/>	White and Asian	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>	Any other Black background		
		<input type="checkbox"/>	Any other Mixed background	<input type="checkbox"/>	Any other Asian background				
	Please write in		Please write in		Please write in		Please write in		Please write in
	<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>