Patient questionnaire

for Dr _____

General Medical Council

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 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very important

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	☐	☐	☐	☐	☐	☐
b	Making you feel at ease	☐	☐	☐	☐	☐	☐
c	Listening to you	☐	☐	☐	☐	☐	☐
d	Assessing your medical condition	☐	☐	☐	☐	☐	☐
e	Explaining your condition and treatment	☐	☐	☐	☐	☐	☐
f	Involving you in decisions about your treatment	☐	☐	☐	☐	☐	☐
g	Providing or arranging treatment for you	☐	☐	☐	☐	☐	☐

5	Please decide how strongly you agree or disagree with the following statements by ticking one box in each line.	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Does not apply
a	This doctor will keep information about me confidential	☐	☐	☐	☐	☐	☐
b	This doctor is honest and trustworthy	☐	☐	☐	☐	☐	☐

6	I am confident about this doctor's ability to provide care	☐ Yes	☐ No

7	I would be completely happy to see this doctor again	☐ Yes	☐ No

8	Was this visit with your usual doctor?	☐ Yes	☐ 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:	☐ Female	☐ Male

11	Age:	☐ Under 15	☐ 15–20	☐ 21–40	☐ 40–60	☐ 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
☐ British	☐ White and Black Caribbean	☐ Indian	☐ Caribbean	☐ Chinese
☐ Irish	☐ White and Black African	☐ Pakistani	☐ African	☐ Any other
☐ Any other white background	☐ White and Asian	☐ Bangladeshi	☐ Any other Black background	
	☐ Any other Mixed background	☐ Any other Asian background		
Please write in	Please write in	Please write in	Please write in	Please write in