

GMC Patient Questionnaire

2.3 I am confident about this doctor's ability to provide care: (Please check one box)

- Yes No

2.4 I would be completely happy to see this doctor again: (Please check one box)

- Yes No

2.5 Was this visit with your usual doctor? (Please check one box)

- Yes No

3 Any other comments

3.1 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.

4 Demographics

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.

4.1 Are you?

- Male Female

4.2 Your age?

- Under 15 15 to 20 21 to 40 40 to 60 60 or over

4.3 What is your ethnic group? Tick the appropriate box to indicate your cultural background.

- | | | | | |
|--|--|--------------------------------------|---|--|
| <input type="checkbox"/> British | <input type="checkbox"/> White and Black
Carribbean | <input type="checkbox"/> Indian | <input type="checkbox"/> Carribbean | <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 ethnic
group |
| <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 | | | |



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