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.**

This questionnaire is automatically read by a computer program.
**Please make sure you use a black pen for filling in your answers**

## 1 About your consultation

1.1 **Are you filling in this questionnaire for:** (Please check one box)

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

1.2 **Which of the following best describes the reason you saw the doctor today?** (Please check 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 problem
☐ Other

1.3 **How important to your health and wellbeing was your reason for visiting the doctor today?** (Please check one box)

Not very important ○ ○ ○ ○ ○ Very important

## 2 About the doctor

2.1 **How good was your doctor today at each of the following?** (Please check one box in each line)

| | Very good | Good | Satisfactory | Poor | Very poor | Doesn't 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 | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

2.2 **Please decide how strongly you agree or disagree with the following statements:** (Please check one box in each line)

| | Strongly agree | Agree | Neutral | Disagree | Strongly disagree | Doesn't apply |
|---|---|---|---|---|---|---|
| a) This doctor will keep information about me confidential | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| b) This doctor is honest and trustworthy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

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.

☐ British ☐ White & Black Carribbean ☐ Indian ☐ Carribbean ☐ Chinese

☐ Irish ☐ White & Black African ☐ Pakistani ☐ African ☐ Any other ethnic group

☐ Any other white background ☐ White & Asian ☐ Bangladeshi ☐ Any other Black background

☐ Any other Mixed background ☐ Any other Asian background