

# Patient Feedback Questionnaire

The team at Southampton would be very grateful for your feedback on the doctor you saw today. Please give us your honest answers and additional comments, your feedback is completely anonymous. Thank you for helping us.

## How was your doctor at the following:

**Making you feel at ease?**  
(Introducing him/herself, being warm and friendly, treating you with respect, not being abrupt).

Poor	Fair	Good	Excellent
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Listening?**  
(Paying close attention without rushing you. Listening, not looking at the notes as you were talking).

Poor	Fair	Good	Excellent
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Understanding your concerns?**  
(Making it clear to you he or she has accurately understood your anxieties or concerns, not dismissing anything).

Poor	Fair	Good	Excellent
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Explaining things clearly?**  
(Fully answering any questions, giving you adequate information, not being vague).

Poor	Fair	Good	Excellent
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Showing care and compassion?**  
(Showed genuine concern, not being indifferent or detached).

Poor	Fair	Good	Excellent
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Making a plan with you?**  
(Weighing up the risks and benefits with you. Involving you in decision making when there are choices).

Poor	Fair	Good	Excellent
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Would you be happy to see this doctor again?**

Yes	No
<input type="text"/>	<input type="text"/>

**How old are you?**

25 or under	26-65	Over 65
<input type="text"/>	<input type="text"/>	<input type="text"/>

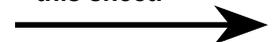
**Please could you indicate your ethnic group**

White British	White Irish	White Other	Chinese	Caribbean
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Indian	Pakistani	Bangladeshi	African	Mixed race
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other ethnic group - please let us know				
<input type="text"/>				

**Is English your first language?**

Yes	No
<input type="text"/>	<input type="text"/>

**Please write any comments about the visit on the reverse of this sheet.**



Date:

Doctor identifier:

Outpatient clinic / clinical area: