**Patient Feedback Form for Doctor**

**Patient Information**

* **Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Doctor's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date of Consultation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Doctor's Service Feedback**

1. **Satisfaction with diagnosis and treatment:**
   * **( ) Highly Satisfied**
   * **( ) Satisfied**
   * **( ) Neutral**
   * **( ) Dissatisfied**
2. **Doctor's listening skills and empathy:**
   * **( ) Excellent**
   * **( ) Good**
   * **( ) Average**
   * **( ) Poor**
3. **Explanation of medical condition and treatment options:**
   * **( ) Very Thorough**
   * **( ) Thorough**
   * **( ) Basic**
   * **( ) Inadequate**

**General Comments**

* **What did you find most helpful during your visit?**
* **Any recommendations for improving the consultation experience?**

**Follow-Up**

* **( ) I would like to schedule a follow-up consultation.**
* **Preferred Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**