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?**

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- **Any recommendations for improving the consultation experience?**

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Follow-Up

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

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