**Patient Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Title | Mr / Mrs / Miss / Ms / Other (delete as appropriate) |  | Address |  |
| First Name |  |  |  | |
| Middle Name |  |  |
| Surname |  |  | Tel. No |  |
| Date of Birth |  |  | Email address |  |

**Gender Identity –** delete/circle as appropriate

|  |  |
| --- | --- |
| Which of the following best describes your sexual orientation? | Heterosexual or Straight / Gay or Lesbian / Bisexual / Other |
| Which of the following best describes your Gender identity? | Woman [including trans woman] / Man [including trans man] / Non-Binary / Other |
| Is your gender identity the same as the gender you were assigned at birth? | Yes / No |
|  | I do not wish to specify my gender identity |

**Ethnic Origin –** delete/circle as appropriate

|  |  |
| --- | --- |
| White | British / Irish / Other |
| Mixed | White & Black Caribbean / White & Black African / White & Asian / Other |
| Asian or Asian British | Indian / Pakistani / Bangladeshi / Other |
| Black or Black British | Caribbean / African / Other |
| Chinese or other Ethnic Group | Chinese / Other |
|  | I do not wish to specify my ethnic origin |

**How often do you attend the practice? –** please tick correct option

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Regularly |  | Occasionally |  | Very Rarely |  |

The information above will help us to understand if the feedback we receive is from a representative sample of the patients registered at this practice.

Updated: January 2023