Appendix 1. Patient questionnaire.

Please complete the following for you (if you are the patient) or your child (if your child is the patient):

1. Age: Under 6 ❑ 6-25 ❑ 26-55 ❑ 56-70 ❑ Over 70 ❑

2. Gender: Male ❑ Female ❑

3. Medical card: Yes ❑ No ❑

4. Is it your first consultation with a GP or Shannondoc for this complaint? Yes ❑ No ❑

5. Do you expect to receive antibiotics for this illness? Yes ❑ No ❑ Unsure❑

6. Reasons for seeing the doctor (please tick all that apply):	
Ear ache or discharge	
Complaints of nose/sinuses	
Common cold	
Throat ache	
Cough	
Other (please specify): *e.g. flu like symptoms*	

7. Do you expect to receive from the doctor (please tick all that apply):	
Further examination	
Information	
Reassurance	
Medication for pain relief	
Nose drops	
Medication for cough	
Referral to hospital or specialist	
Other (please specify):	

8. We may wish to contact you to discuss your experience in more detail as part of a follow up study. If you are happy to be contacted for this purpose then please provide your details below (please print):

Name: ______________________________

Address: ______________________________

Contact Telephone Number/Email:

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Please hand your completed questionnaire to the receptionist