

Patient Experience and Healthcare Satisfaction Survey

Please print and complete this survey to help us improve our healthcare services. Use a pen to fill in the text fields.

1. General Information

Patient Full Name:

Date of Visit (MM/DD/YYYY):

Doctor / Healthcare Provider Name:

Department / Clinic Visited:

2. Appointment and Arrival

How easy was it to schedule your appointment? (Excellent / Good / Fair / Poor):

How long did you wait in the reception area past your scheduled time? (e.g., 15 minutes):

Rate the friendliness of the reception staff (Excellent / Good / Fair / Poor):

3. Care and Communication

Did the healthcare provider listen carefully to your concerns? (Yes / No / Somewhat):

Did the provider explain your treatment plan in a way you could understand? (Yes / No / Somewhat):

Rate the courtesy and respect shown by the nursing staff (Excellent / Good / Fair / Poor):

4. Facility and Overall Satisfaction

Rate the cleanliness of our facility (Excellent / Good / Fair / Poor):

On a scale of 1 to 10, how likely are you to recommend this facility to friends and family?:

5. Additional Comments

Please share any specific feedback, compliments, or areas where we can improve: