

Patient Satisfaction Survey

Survey Instructions: Answer each question by marking the to the left of your answer.

Communication

1. Did your doctor give you an easy to understand explanation about the next steps for any health questions or concerns?
 Yes No I don't have any questions.
2. Did this doctor use pictures, drawings, or videos to explain things to you?
 Yes No It would be helpful.
3. At today's visit, did the clerks and receptionists treat you with courtesy and respect?
 Yes No

Self Management: Health Promotion

4. Did anyone talk to you about specific things you could do to prevent illness?
 Never Sometimes Usually Always
5. Did anyone ask you if there are things that make it hard for you to take care of your health?
 Never Sometimes Usually Always
6. Did anyone talk to you about all the prescription medicines you were taking?
 Never Sometimes Usually Always

Access

7. In the last 12 months, when you phoned this office to get an emergency appointment for care you needed right away, how often did you get an appointment as soon as you needed?
 Never Sometimes Usually Always
8. Did you get information about what to do if you needed care during the evenings, weekends, or holidays?
 Yes No It would be helpful.
9. In the last 12 months, when you phoned this doctor's office during regular office hours, how often did you get any answer to your medical question that same day or in a reasonable amount of time?
 Never Sometimes Usually Always

Shared Decision Making

10. When you talked about starting or stopping a prescription medicine, did this doctor ask you what you thought was best for you?

Never Sometimes Usually Always

11. When you and this doctor talked about a procedure (CT Scan, MRI, etc.), did the doctor ask what you thought was best for you?

Never Sometimes Usually Always

Care Coordination

12. In the last 3 months when this doctor ordered a blood test, x-ray, or other test for you, did someone from this doctor's office follow up to give you those results?

Never Sometimes Usually Always

13. In the last 6 months, have you been a patient in a hospital overnight or longer?

Yes No If yes, how many times? _____ Why? _____

14. In the last 6 months, have you been to the emergency room?

Yes No If yes, how many times? _____ Why? _____

PLEASE CHECK ALL BELOW THAT DESCRIBE YOU:

Your Gender Male Female

Your Age 18-39 40-49 50-64 65 or older

Who was your doctor/clinician today?

THIS INFORMATION WILL BE KEPT CONFIDENTIAL AND USED TO BETTER SERVE YOU.

THANK YOU FOR YOUR FEEDBACK!