Patient Satisfaction Questionnaire

Name: _____ Date: _____

Thank you for taking the time to complete this questionnaire. Your feedback is vital as we strive to provide the best possible care. Please indicate your level of satisfaction with the following aspects of your recent visit by checking the appropriate number:

1 = Very Dissatisfied, 2 = Dissatisfied, 3 = Neutral, 4 = Satisfied, 5 = Very Satisfied

Quality of Care:

Overall satisfaction with the medical treatment received:

☐	1	☐	2	☐	3	☐	4	☐	5

Satisfaction with the effectiveness of the treatment:

☐	1	☐	2	☐	3	☐	4	☐	5

Satisfaction with the explanation of your medical condition and treatment plan:

☐	1	☐	2	☐	3	☐	4	☐	5

Communication with Medical Staff:

Satisfaction with the way the medical staff communicated with you:

☐	1	☐	2	☐	3	☐	4	☐	5

Satisfaction with the time the medical staff spent with you:

☐	1	☐	2	☐	3	☐	4	☐	5

Satisfaction with the respect and empathy shown by the medical staff:

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Facilities:

Satisfaction with the cleanliness and comfort of the facility:

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Satisfaction with the accessibility and convenience of the facility:

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Waiting Times:

Satisfaction with the waiting time for your appointment:

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Satisfaction with the waiting time in the reception area:

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Overall Experience:

Overall satisfaction with your experience at our healthcare facility:

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Optional: Comments or Suggestions

Please share any additional comments, concerns, or suggestions that might help us improve our services:

Thank you for your feedback! Your responses will help us to improve our services continually.