**Patient Questionnaire**

As a valued patient, we respect your opinion on how well we are delivering that care. We would like you to take a few minutes to share your opinion with us on how your care today with  
Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ met your needs. This survey is anonymous and your name will not be noted on this document. Please leave this form with your nurse before you leave the exam room or with the staff at the front desk. Thank you for helping us to identify ways that we can better serve you!

1. Do you feel that the doctor really Yes \_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_  
   understood and addressed the main   
   purpose of your visit today?
2. If additional tests were ordered today, Yes \_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_  
   do you understand what the tests are  
   and why the doctor felt it was needed?
3. If you received prescriptions, do you Yes \_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_  
   understand what the medicine is for, how  
   and when to take it, and any problems that  
   you should report to your doctor?
4. Do you understand the details of your plan Yes \_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_  
   of care and follow-up?
5. Did your doctor conduct himself/herself Yes \_\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_  
   in a professional manner?

**FAX COMPLETED FORM TO 504-568-6127**