**Patient Information:**

1. **Full Name (Optional):** [Patient's Full Name]
2. **Date of Birth:** [Patient's Date of Birth]
3. **Date of Visit:** [Date of the Patient's Visit]

**1. General Information:**

**a. How did you hear about our clinic/hospital?**

* Referral from a friend or family member
* Online search
* Advertisement
* Other (please specify): \_\_\_\_\_\_\_\_\_\_\_

**b. Was this your first visit to our clinic/hospital?**

* Yes
* No

**c. How would you rate the ease of scheduling an appointment?**

* Excellent
* Good
* Fair
* Poor

**2. Waiting Room Experience:**

**a. Waiting Time:**

* Less than 15 minutes
* 15-30 minutes
* 30-45 minutes
* More than 45 minutes

**b. Comfort of the Waiting Area:**

* Excellent
* Good
* Fair
* Poor

**c. Cleanliness of the Waiting Area:**

* Excellent
* Good
* Fair
* Poor

**3. Interaction with Staff:**

**a. Courtesy and Friendliness:**

* Excellent
* Good
* Fair
* Poor

**b. Professionalism:**

* Excellent
* Good
* Fair
* Poor

**c. Communication Skills:**

* Excellent
* Good
* Fair
* Poor

**4. Healthcare Provider:**

**a. Quality of Care Provided:**

* Excellent
* Good
* Fair
* Poor

**b. Explanation of Diagnosis and Treatment:**

* Excellent
* Good
* Fair
* Poor

**c. Availability for Questions:**

* Excellent
* Good
* Fair
* Poor

**5. Facilities and Amenities:**

**a. Cleanliness of Examination Rooms:**

* Excellent
* Good
* Fair
* Poor

**b. Availability of Amenities (e.g., Wi-Fi, reading materials):**

* Excellent
* Good
* Fair
* Poor

**6. Overall Experience:**

**a. How would you rate your overall experience at our clinic/hospital?**

* Excellent
* Good
* Fair
* Poor

**b. Would you recommend our clinic/hospital to friends or family?**

* Yes
* No

**7. Additional Comments:**

[Provide a space for patients to provide additional comments or suggestions.]

**Thank you for taking the time to complete our Patient Satisfaction Survey! Your feedback is important to us.**