Resident Patient Survey

Physician's name _____

BACKGROUND QUESTIONS (Please complete)

Date of visit _____
(month/day/year)

Is this your first visit here? _____

Sex: Male____ Female____

Age _____

PLEASE EVALUATE THE CARE YOU RECEIVED (Circle the number that best represents your experience with your doctor. Space is also provided for your comments.)

	very poor	poor	fair	good	very good
1. Courtesy of your doctor.	1	2	3	4	5
2. Explanations of your problem given by your doctor.	1	2	3	4	5
3. Concern your doctor showed for your questions.	1	2	3	4	5
4. Efforts made by your doctor to include you in decisions.	1	2	3	4	5
5. Information your doctor gave you about your treatment.	1	2	3	4	5
6. Instructions your doctor gave you about the need for follow-up.	1	2	3	4	5
7. Degree to which your doctor used words you could understand.	1	2	3	4	5
8. Amount of time your doctor spent with you.	1	2	3	4	5
9. Your confidence in your doctor.	1	2	3	4	5
10. Likelihood of your recommending your doctor to others.	1	2	3	4	5

Comments:

Your name (optional) _____ Your phone number (optional)_____

Thank you.

Adapted 2002