



Surgical Patient Survey

Thank you for choosing Eastside Gynecology for you and your healthcare needs. In an effort to continue providing excellent care for all of our patients, we ask that you take a moment to complete this survey.

Name: _____ Date: _____

How did you find out about us?

Physician referral/ faculty referred me

Dr. or Facility name: _____

Radio/ Advertisement

address: _____

radio bing google citysearch facebook other _____

Patient Friend

name: _____

Would you recommend our services to others? why or why not?

please answer the following questions about your receptionist(s)/ medical assistant(s):

Was the receptionist courteous and professional during your visit? yes no n/a

Did your medical assistant smile and introduce herself? yes no n/a

Was she courteous and professional? yes no n/a

Where you able to make a follow up appointment with ease? yes no n/a

What could be done to improve our services:

please rate your surgical experience:

	<i>poor</i>				<i>excellent</i>	
	1	2	3	4	5	n / a
The person who booked your appointment	1	2	3	4	5	n / a
Office receptionist	1	2	3	4	5	n / a
Sonogram technician	1	2	3	4	5	n / a
Laboratory technician/ blood drawing	1	2	3	4	5	n / a
Medical assistant	1	2	3	4	5	n / a
Operating room staff	1	2	3	4	5	n / a
Anesthetist	1	2	3	4	5	n / a
Recovery room nurse	1	2	3	4	5	n / a
Recovery room staff	1	2	3	4	5	n / a
Health care provider	1	2	3	4	5	n / a
Overall rating	1	2	3	4	5	n / a

Yes, i would like to be on your email list.

email address: _____

please answer the following questions about your provider?

Who was your provider today? _____

Was he/she courteous and professional during your visit? yes no n/a

Were tests, exams, and/or procedures explained to you? yes no n/a

Was follow-up or future plan of care discussed? yes no n/a

please not that your survey information may be shared on our promotional materials without the use of your name.

Office use only: date entered into database _____