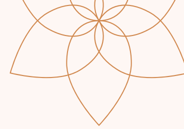
HELEN HUNT
MEDICAL AESTHETICS

Patient Follow up Survey

Dear Patient: According to our records, you recently visited Helen Hunt Aesthetics & Skin Care. Please tell us your opinion about the service you received. Your responses will be kept strictly confidential. Thank you in advance for your help.

A. APPOINTMENT	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
Ease of making an appointment	5	4	3	2	1	N/A
Appointment available within a reasonable amount of time	5	4	3	2	1	N/A
Were you given an appointment as soon as you wanted it	YES				NO	
Did you get the after-hours care when you needed it	YES				NO	
Did you wait long before you were seen	YES				NO	
Were you kept informed if your appointment was delayed	YES				NO	
B. OUR STAFF						
The courtesy of the person who greeted you	5	4	3	2	1	N/A
The friendliness and courtesy of the receptionist	5	4	3	2	1	N/A
The caring concern of our nurses/medic	5	4	3	2	1	N/A
C. OUR COMMUNICATION WITH YOU						
Your phone calls answered promptly when/ if You called the clinic	5	4	3	2	1	N/A
Getting advice or help when needed during opening hours	5	4	3	2	1	N/A
Explanation of your procedure (if applicable)	5	4	3	2	1	N/A
Your test results reported in a reasonable amount of time	5	4	3	2	1	N/A
Effectiveness of information relating to your treat-ment/ health	5	4	3	2	1	N/A
Timeless of our staff returning your calls in a timely manner	5	4	3	2	1	N/A
Your ability to contact us after hours	5	4	3	2	1	N/A
D. YOUR VISIT WITH THE HEALTH PROFESSIONAL: (DOCTOR, NURSE PRACTITIONER)						
Listened carefully to you	5	4	3	2	1	N/A
Took time to answer your questions	5	4	3	2	1	N/A
Spent sufficient time with you	5	4	3	2	1	N/A
Explained things in a way you could understand	5	4	3	2	1	N/A
Instructions regarding medication/follow-up care	5	4	3	2	1	N/A
Happy with the consultation/ examination/ treatment	5	4	3	2	1	N/A
Advice given to you on ways to stay healthy	5	4	3	2	1	N/A



E. TREATMENT	Excellent	Very Good	Good	Fair	Poor	Does Not Apply
Are you happy with your treatment	YES				NO	
Did the area where you received treatment bruise	YES				NO	
Did you experience excessive bleeding	YES				NO	
Did you seek medical help 24 hours after treatment	YES				NO	
Did you seek medical help during the last 6 weeks	YES				NO	
Were you kept informed if your appointment was Have you received any antibiotics post treatment	YES				NO	
F. OUR FACILITY						
Hours of operation convenient for you	5	4	3	2	1	N/A
Overall comfort	5	4	3	2	1	N/A
Adequate parking	5	4	3	2	1	N/A
Signage and directions easy to follow	5	4	3	2	1	N/A
C. YOUR OVERALL SATISFACTION WITH:						
Our practice	5	4	3	2	1	N/A
The quality of your medical carehours	5	4	3	2	1	N/A
Overall rating of care from your provider or nurse	5	4	3	2	1	N/A

Would you recommend us to others?	YES			NO	

If no, please tell us why? ______________________

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If there is any way we can improve our service to you please tell us: ______________________

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Some information about you

Gender

☐ Male

☐ Female

Your age

☐ 18-30

☐ 31-40

☐ 41-51

☐ 51-60

☐ Over 60

Are you

☐ A new patient

☐ A returning patient