



Anchorage Women's Clinic values your input. In order to make our clinic better for you, our valued patient, we ask that you take a minute to answer a few quick questions and tell us what you think. Each quarter, we review this information and try to make positive changes. Thank you for your participation!

Patient Age: _____ After check in, how long did you wait to be seen? _____

Who is your provider? _____ How did you select your provider? _____

Did someone refer you to our clinic? Y / N

If so, will you let us know who it was so we can thank him/her? _____

Please circle the number that best represents your experience.

REGISTRATION	Very Poor	Poor	Fair	Good	Very Good
Were we professional on the telephone?	1	2	3	4	5
Did we answer the phone promptly?	1	2	3	4	5
Were we helpful when you checked in?	1	2	3	4	5
Was the registration process easy?	1	2	3	4	5
Were you informed of delays?	1	2	3	4	5
Amount of time you had to wait	1	2	3	4	5
Comments: _____					

FACILITY	Very Poor	Poor	Fair	Good	Very Good
How comfortable was the waiting room?	1	2	3	4	5
How clean was the clinic?	1	2	3	4	5
How was the decor?	1	2	3	4	5
Comments: _____					

VISIT/TEST/TREATMENT	Very Poor	Poor	Fair	Good	Very Good	
Was your clinician or provider friendly/pleasant?	1	2	3	4	5	
Did your provider answer your concerns/questions?	1	2	3	4	5	
Was your input was included in your treatment?	1	2	3	4	5	
If you had lab work, was the experience comfortable?	1	2	3	4	5	
Do you feel your condition has improved?	1	2	3	4	5	
Did you find OB education informative?	N/A	1	2	3	4	5
Were you offered educational materials pertinent to your condition or treatment?	N/A	1	2	3	4	5
Comments: _____						

-Over-



AWWC
Anchorage Women's Clinic
You take care of everyone else, let us take care of you.

WEBSITE	Yes	No
Were you aware Anchorage Women's Clinic has a website?		
Have you ever visited our website?		
Was our site easy to navigate?		
Did you find the information you were looking for?		
Did you find the site visually appealing?		
Did you pre-register or print necessary forms via our website?		
Comments: _____		

Reason for visit: Please check those that apply.	
GYN Issues	
Massage	
OB	
Preventative care: (Annual Exam/PAP/Birth Control/Vaccines)	
Ultrasound	
Other	

What is important to you? Please check appropriate box.	Not Important	Somewhat Important	Important	Most Important
I can get appointments promptly				
Location of the office				
My provider's personality				
Office helps with my insurance				
Office provides me with educational materials or pertinent information				
Pleasant staff				
The knowledge my provider has				
Warm/friendly environment				
Other – please list				

Was there anything we forgot to ask about that you'd like to share with us?

Would you like us to contact you regarding anything in this survey or about your recent visit? Y / N

Name: _____

Phone: _____