VIRGINIA BEACH OBSTETRICS & GYNECOLOGY
A Division of Mid-Atlantic Women's Care, P.L.C.

IN-OFFICE PROCEDURE PATIENT SATISFACTION SURVEY

At Virginia Beach Obstetrics and Gynecology, our goal is to make your experience with our practice as pleasant as possible. We value your insight with regard to how well we accomplished that goal during your recent office surgery in our surgical suite.

1. When your surgery was scheduled:

   Were you contacted in a timely manner by the surgery scheduler? ____Yes____ No
   Was the surgery scheduling done in an efficient manner? ____Yes____ No____N/A
   Do you feel that you were adequately prepared for the procedure, and understood the risks and benefits and expected outcome of the procedure? ____Yes____ No
   Were all of your questions answered satisfactorily? ____Yes____ No

2. At the time of your surgery, were you greeted promptly and courteously upon arrival? ____Yes____ No
   Did you find the waiting time acceptable? ____Yes____ No

3. Did you find surgery suite to be acceptable (i.e. comfort, cleanliness, temperature)? ____Yes____ No

4. Were you greeted appropriately by the nursing staff? ____Yes____ No
   Did you find that the nurse or medical assistant prepared you for the procedure appropriately (i.e. directing you to the restroom, exam room, etc., instructing you on gowns, drapes, starting your IV, etc.? ____Yes____ No

5. Did your procedure start on time? ____Yes____ No

6. Were you satisfied with your postoperative care/recovery? ____Yes____ No
   Did you find your postoperative instructions to be adequate? ____Yes____ No
   Did you have any postop problems or complications (excessive pain, bleeding, infection, fever)? If yes, comment _____ ____Yes____ No

7. Overall, are you happy with the outcome? ____Yes____ No

8. Do you feel that your problem was helped or resolved by this procedure? ____Yes____ No

9. Please rate your pain during the procedure on a scale of 1-10:

   1 2 3 4 5 6 7 8 9 10
   (No Pain Some Pain Moderate Pain A lot of Pain Severe Pain)

10. Please rate your pain 15 minute-1 hour after the procedure on a scale of 1-10:

    1 2 3 4 5 6 7 8 9 10
    (No Pain Some Pain Moderate Pain A lot of Pain Severe Pain)

11. Please rate your pain on the 12 hour following your procedure on a scale of 1-10:

    1 2 3 4 5 6 7 8 9 10
    (No Pain Some Pain Moderate Pain A lot of Pain Severe Pain)

12. Please rate your pain on the 24th hour after your procedure on a scale of 1-10:

1 2 3 4 5 6 7 8 9 10

(No Pain Some Pain Moderate Pain A lot of Pain Severe Pain)

13. Please rate your overall experience on a scale of 1-10

1 2 3 4 5 6 7 8 9 10

(Poor Below Average Average Above Average Excellent)

14. Would you do this procedure again in-office at Virginia Beach OB/GYN if surgery were needed? ____Yes____ No

Please comment on any "No" Answers, or provide feedback (please use other side for additional room):

_____

_____

Your Name (Optional) _____ Doctor_____ _____

Would you like to be contacted by our practice manager? _____ If yes, phone number _____