**Optometry Customer Service Questionnaire**

1. **During your last visit, do you feel your eye doctor listened to your concerns?**

Strongly Agree Agree Neutral Disagree Strongly Disagree

1. **During your last visit, did your eye doctor provide you with their full attention?**

Strongly Agree Agree Neutral Disagree Strongly Disagree

1. **During your last visit, do you feel your care was up-to-date with respect to modern Eye Care standards?**

Strongly Agree Agree Neutral Disagree Strongly Disagree

1. **During your last visit, do you feel your time with the Optometry Department Staff was well spent?**

Strongly Agree Agree Neutral Disagree Strongly Disagree

1. **During your last visit, did you see your doctor wash their hands (i.e. use soap and water and/or use hand sanitizer)?**

Yes No I Don’t Remember

1. **(Optional)**

**If you would like to provide additional comments about your last visit to the Optometry Department, please do so in the space provided.**

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