

Attachment U - Patient Toolkit Survey - Patient

Patient Survey

Please complete this survey about your recent visit. It should take no longer than 5 minutes. Your responses will help us improve the quality of communication in our practice.

Please complete this survey now, before you leave our office. You can scan the QR code below to access the survey on your smartphone or you can complete this paper survey and hand it to us before you leave.



Thank you for your help!

This survey is authorized under 42 U.S.C. 299a. This information collection is voluntary and the confidentiality of your responses to this survey is protected by Sections 944(c) and 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 42 U.S.C. 242m(d)]. Information that could identify you will not be disclosed unless you have consented to that disclosure. Public reporting burden for this collection of information is estimated to average 5 minutes per response, the estimated time required to complete the survey. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The data you provide will help AHRQ's mission to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer Attention: PRA, Paperwork Reduction Project (0935-xxxx) AHRQ, 5600 Fishers Lane, Room #07W42, Rockville, MD 20857, or by email to the AHRQ MEPS Project Director at MEPSPROJECTDIRECTOR@ahrq.hhs.gov.

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	No	Possibly No	Possibly Yes	Yes
	1	2	3	4
Did the provider listen to you carefully during the visit?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the provider allow you to talk without interrupting you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the provider encourage you to express yourself/talk?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the provider examine you thoroughly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel like the provider listened to me attentively.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel like the provider addressed my main concerns.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel like the Be The Expert On You note sheet helped my communication with my provider.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ABOUT YOU

What is your age?

- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or older

Do you currently describe yourself as male, female or transgender?

- ☐ Male
- ☐ Female
- ☐ Transgender
- ☐ None of these

What is the highest grade or level of school that you have completed?

- ☐ 8th grade or less
- ☐ Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

Are you of Hispanic or Latino/Latina?

- ☐ Yes
- ☐ No

What is your race? Select one or more.

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐

Would you be interested in participating in an interview about your experience?

- ☐ No → Thank for completing this survey.
- ☐ Yes → Please provide your name, phone number and email address so we can contact you about the interview.

Name: _____

Telephone number: _____

Email address: _____