Hospital Client Satisfaction Questionnaire Form

Patient Information

- **Patient Name: _____**
- **Age: _____ Gender: ☐ Male ☐ Female**
- **Hospital ID: _____**
- **Date of Visit: _____**

Service Quality Evaluation

Criteria	Excellent ☐	Good ☐	Fair ☐	Poor ☐
Cleanliness of Facility				
Courtesy of Medical Staff				
Explanation of Treatment				
Comfort During Stay				
Wait Time				
Overall Experience				

Open-Ended Questions

- **What did you appreciate most during your visit?**

_____

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- **What could we improve?**

Patient Consent

I, _____, consent to the use of my feedback for improving hospital services.

Signature

- **Patient Signature: _____**
- **Date: _____**

For Hospital Use Only

Verified By	Date	Comments

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