

Pharmacy Patient Survey

Thank you for choosing our pharmacy. Please take a moment to tell us about your experience. Fill the checkboxes completely using a blue or black pen. Your answers are anonymous.

Your experience today

How satisfied were you with each of the following?

Please cross one in each line

Waiting time for prescriptions
Helpfulness of the pharmacy staff
Clarity of medication advice
Availability of the products you need
Privacy when discussing your health
Value for money

Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
☐	☐	☐	☐	☐
☐	☐	☐	☐	☐
☐	☐	☐	☐	☐
☐	☐	☐	☐	☐
☐	☐	☐	☐	☐
☐	☐	☐	☐	☐

Recommending us

How likely are you to recommend our pharmacy?

(Please cross one)

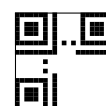
- ☐ Very likely
☐ Likely
☐ Neutral
☐ Unlikely
☐ Very unlikely

Your comments

Any comments or suggestions?

Thank you for your feedback. Please return this form to the counter or the drop box.

To respond ☒ or ☐



DRFT 0001