

**Patient diabetes review**

Dear Patient

We are now offering an alternative way to review your diabetes. You are still welcome to book an appointment with a practice nurse for a diabetes review if you would prefer. However, you may wish to fill in our questionnaire below instead. By completing a questionnaire and returning it to us we are able to review your symptoms and it may save you coming in to the surgery unnecessarily.

If your symptoms are deteriorating or you have any concerns, then please book a phone appointment with our diabetic nurse to review the management of your diabetes and medication.

Please complete the form overleaf and answer ALL the questions, then scan and email it to us at reception.harbourside@nhs.net. If you prefer a paper copy then please print it out, or request a paper copy to be sent to you, and post it to us at Harbourside Family Practice, Marina Healthcare Centre, 2 Haven View, Portishead BS20 7QA. We also have a post box on the outside of the building to the left of the main reception doors that you could put your completed questionnaire in.

**Note:** If you choose to send us this form by email you will be sending information about yourself across the internet. We use a secure email service. Whilst every effort is made to keep this information secure, you should be aware that we cannot offer any guarantee of absolute privacy. If this matter concerns you then please print off the form, complete it and return to the surgery.

**Personal Information:** Personal information retained on this system is stored in a secure data centre located in the UK and is treated as confidential.

|  |  |  |  |
| --- | --- | --- | --- |
| Name:  |  |  | Date of birth:  |
| **Home Phone:**  |  | **Mobile phone:** |
| Email address:  |
| Address: |  | Postcode:  |  |
|  |
| Please complete with as much detail as possible |
|  What is your most recent blood glucose level? |  |
|  |
|  |
|  **What is your total cholesterol level, if known?** |  |
|  |
|  |
|  **Height:** | **Weight:** |
|  |
|  |
|  **Blood pressure** | Heart rate / pulse: |
| Systolic ‘higher’: Diastolic ‘lower’: |
|  |
|

|  |
| --- |
| Left eye Date: |
| Right eye Date: |

**Date of your last retinal screening?** |
|  |
| **Please let us know any issues you have with your diabetes or health in general:** |  |  |
|  |  |
|  |
|  |
| Have you ever smoked and are you exposed to smoke or a passive smoker? | [ ]  No | [ ]  Yes |
| If yes, please answer the following: |
|  | Do you smoke now? | [ ]  No | [ ]  Yes |
| If yes, how many do you smoke each day?       |
| If no, when did you quit?       |
| There are plenty of options available to help you quit. Is this something you would like us to contact you about?Are you exposed to smoke, or a passive smoker? | [ ]  Yes[ ]  Yes | [ ]  No[ ]  No |

#### **DIABETES REVIEW QUESTIONNAIRE**

#### All questions contained in this questionnaire are strictly confidential and will become part of your medical record.