



CONFIDENTIAL POST HERPETIC NEURALGIA (PHN) ENHANCED SURVEILLANCE QUESTIONNAIRE: request for information

Case definition: Nerve pain which persists for 3 months following the resolution of the shingles cutaneous eruption

A. PATIENT DETAILS	
Your Patient ID: (e.g. hospital no)	NHS No: Full name code: (see below*)
* Full name code is the first two letters of the first name and the first two letters of the surname i.e. John Smith is JOSM, Ian DE Souza is IADE	
Date of Birth: (dd/mm/yyyy) ____/____/____	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Not Stated <input type="checkbox"/>
Ethnic Group: White <input type="checkbox"/> Black/Caribbean/Black British <input type="checkbox"/> Asian/Asian British <input type="checkbox"/> Mixed <input type="checkbox"/> Other <input type="checkbox"/>	
GP Surgery name: _____ GP Telephone Number: _____	
B. CLINICAL HISTORY	
Date of Shingles onset (dd/mm/yyyy) ____/____/____	Episode of shingles: First Episode <input type="checkbox"/> Recurrent <input type="checkbox"/>
Site of shingles infection: Face <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Arm <input type="checkbox"/> Leg <input type="checkbox"/> Other: (please specify) _____	
Extent of shingles: Localised (1-2 dermatomes) <input type="checkbox"/> Disseminated (3 or more dermatomes) <input type="checkbox"/>	
Laboratory Confirmed: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes: Serology <input type="checkbox"/> Oral Fluid <input type="checkbox"/> Vesicular Fluid/Swab <input type="checkbox"/>	
Antivirals given at time of shingles diagnosis: Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated <input type="checkbox"/>	
C. POST HERPETIC NEURALGIA (PHN)	
Date of onset of PHN: (dd/mm/yyyy) ____/____/____	Date of referral to pain clinic: (dd/mm/yyyy) ____/____/____
Date first seen in pain clinic: (dd/mm/yyyy) ____/____/____	
Reason for referral to pain clinic: _____	
Severity of PHN Pain (please circle): 1 2 3 4 5 6 7 8 9 10	
Treatments for PHN: 1 _____ Date (dd/mm/yyyy) ____/____/____ GP <input type="checkbox"/> or Pain Clinic <input type="checkbox"/>	
2 _____ Date (dd/mm/yyyy) ____/____/____ GP <input type="checkbox"/> or Pain Clinic <input type="checkbox"/>	
3 _____ Date (dd/mm/yyyy) ____/____/____ GP <input type="checkbox"/> or Pain Clinic <input type="checkbox"/>	
4 _____ Date (dd/mm/yyyy) ____/____/____ GP <input type="checkbox"/> or Pain Clinic <input type="checkbox"/>	
5 _____ Date (dd/mm/yyyy) ____/____/____ GP <input type="checkbox"/> or Pain Clinic <input type="checkbox"/>	
D. CO-MORBIDITIES	
Immunosuppression <input type="checkbox"/>	Reason for Immunosuppression: _____
Malignancy <input type="checkbox"/>	Diabetes <input type="checkbox"/> Chronic Lung Disease <input type="checkbox"/>
Chronic Heart Disease <input type="checkbox"/>	Chronic Heart Disease <input type="checkbox"/> Chronic Renal Disease <input type="checkbox"/>
Chronic Liver Disease <input type="checkbox"/>	Auto-immune Disease <input type="checkbox"/>
E. VACCINATION HISTORY	
Shingles Vaccine: Yes <input type="checkbox"/> Date given (dd/mm/yyyy) ____/____/____ No <input type="checkbox"/> Not Stated/Unknown <input type="checkbox"/>	
F. REPORTING	
Name of completing staff: _____	Pain Clinic Name _____
Phone Number: _____	Date: (dd/mm/yyyy) ____/____/____

Thank you for your help
Please return completed form by fax to 0208 327 7404 or by post:
Shingles (PHN), Immunisation and Blood Safety Department, Public Health England,
61 Colindale Avenue, London, NW9 5EQ
Contact 020 8327 6933 / 020 8327 6434 or email shingles@phe.gov.uk