Public Health England

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

Withdrawn November 2024

CONFIDENTIAL

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 ☐ Female ☐ Not Stated ☐

Ethnic Group: White ☐ Black/Caribbean/Black British ☐ Asian/Asian British ☐ Mixed ☐ Other ☐

GP Surgery name: ______________________________ GP Telephone Number: ______________________________

B. CLINICAL HISTORY

Date of Shingles onset *(dd/mm/yyyy)* ____/____/____ Episode of shingles: First Episode ☐ Recurrent ☐

Site of shingles infection: Face ☐ Chest ☐ Abdomen ☐ Arm ☐ Leg ☐

Other: (please specify) ______________________________

Extent of shingles: Localised (1-2 dermatomes) ☐ Disseminated (3 or more dermatomes) ☐

Laboratory Confirmed: Yes ☐ No ☐ If yes: Serology ☐ Oral Fluid ☐ Vesicular Fluid/Swab ☐

Antivirals given at time of shingles diagnosis: Yes ☐ No ☐ Not Stated ☐

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 ☐ *or* Pain Clinic ☐

2 ______________________ Date *(dd/mm/yyyy)* ____/____/____ GP ☐ *or* Pain Clinic ☐

3 ______________________ Date *(dd/mm/yyyy)* ____/____/____ GP ☐ *or* Pain Clinic ☐

4 ______________________ Date *(dd/mm/yyyy)* ____/____/____ GP ☐ *or* Pain Clinic ☐

5 ______________________ Date *(dd/mm/yyyy)* ____/____/____ GP ☐ *or* Pain Clinic ☐

D. CO-MORBIDITIES

Immunosuppression ☐ Reason for Immunosuppression: ______________________________

Malignancy ☐ Diabetes ☐ Chronic Lung Disease ☐

Chronic Heart Disease ☐ Chronic Heart Disease ☐ Chronic Renal Disease ☐

Chronic Liver Disease ☐ Auto-immune Disease ☐

E. VACCINATION HISTORY

Shingles Vaccine: Yes ☐ Date given *(dd/mm/yyyy)* ___/___/_____ No ☐ Not Stated/Unknown ☐

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