

# VIRAL HEPATITIS CASE REPORT



The following questions should be asked for every case of viral hepatitis

Form Approved OMB No. 0920-0728 Exp. Date 02/28/2021

Prefix: (Mr. Mrs. Miss Ms. etc) \_\_\_\_\_ Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
 Preferred Name (nickname): \_\_\_\_\_ Maiden: \_\_\_\_\_  
 Address: Street: \_\_\_\_\_  
 City: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Zip Code: \_\_\_\_\_ - \_\_\_\_\_  
 SSN # (optional) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **Only data from lower portion of form will be transmitted to CDC** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 State: \_\_\_\_\_ County: \_\_\_\_\_ Date of Public Health Report MM / DD / YYYY  
 Case ID: \_\_\_\_\_  
 Legacy Case ID: \_\_\_\_\_

## DEMOGRAPHIC INFORMATION

<b>RACE: (check all that apply)</b> <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other Race, specify _____		<b>ETHNICITY:</b> Hispanic..... <input type="checkbox"/> Non-hispanic ..... <input type="checkbox"/> Other/Unknown..... <input type="checkbox"/>
<b>SEX:</b> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk <input type="checkbox"/> <b>PLACE OF BIRTH:</b> <input type="checkbox"/> USA <input type="checkbox"/> Other: _____ <b>DATE OF BIRTH:</b> <u>MM / DD / YYYY</u> <b>AGE:</b> ____ (years) (00 = <1yr , 999 = Unk)		

## CLINICAL & DIAGNOSTIC DATA

**REASON FOR TESTING: (check all that apply)**

<input type="checkbox"/> Year of birth (1945-1965)	<input type="checkbox"/> Symptoms of acute hepatitis	<input type="checkbox"/> Prenatal screening
<input type="checkbox"/> Screening of asymptomatic patient with reported risk factors	<input type="checkbox"/> Blood/organ donor screening	<input type="checkbox"/> Unknown
<input type="checkbox"/> Screening of asymptomatic patient with no risk factors (e.g., patient requested)	<input type="checkbox"/> Evaluation of elevated liver enzymes	
<input type="checkbox"/> Follow-up testing for previous marker of viral hepatitis	<input type="checkbox"/> Other: specify: _____	

CLINICAL DATA:	DIAGNOSTIC TESTS: (CHECK ALL THAT APPLY)																																																				
Diagnosis date: <u>MM / DD / YYYY</u> Yes    No    Unk Is patient symptomatic? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> if yes, onset date: <u>MM / DD / YYYY</u> At diagnosis, was the patient • Jaundiced? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Hospitalized for hepatitis? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Was the patient pregnant? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Due date: <u>MM / DD / YYYY</u> Did the patient die from hepatitis? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Date of death: <u>MM / DD / YYYY</u> Was the patient aware they had viral hepatitis prior to lab testing? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does the patient have a provider of care for hepatitis?... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does the patient have diabetes? ..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetes diagnosis date: <u>MM / DD / YYYY</u>	<table> <thead> <tr> <th></th> <th>Pos</th> <th>Neg</th> <th>Unk</th> </tr> </thead> <tbody> <tr> <td>• Total antibody to hepatitis A virus [total anti-HAV].....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• IgM antibody to hepatitis A virus [IgM anti-HAV].....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• Hepatitis B surface antigen [HBsAg].....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• Total antibody to hepatitis B core antigen [total anti-HBc].....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• Hepatitis B “e” antigen [HBeAg].....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• IgM antibody to hepatitis B core antigen [IgM anti-HBc].....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• Nucleic Acid Testing for hepatitis B [Hep B NAT].....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• Antibody to hepatitis C virus [anti-HCV].....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>    – anti-HCV signal to cut-off ratio _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td>• Supplemental anti-HCV assay [e.g., RIBA].....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• Antibody to hepatitis D virus [anti-HDV].....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• Antibody to hepatitis E virus [IgM anti-HEV].....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>		Pos	Neg	Unk	• Total antibody to hepatitis A virus [total anti-HAV].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• IgM antibody to hepatitis A virus [IgM anti-HAV].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Hepatitis B surface antigen [HBsAg].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Total antibody to hepatitis B core antigen [total anti-HBc].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Hepatitis B “e” antigen [HBeAg].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• IgM antibody to hepatitis B core antigen [IgM anti-HBc].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Nucleic Acid Testing for hepatitis B [Hep B NAT].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Antibody to hepatitis C virus [anti-HCV].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	– anti-HCV signal to cut-off ratio _____				• Supplemental anti-HCV assay [e.g., RIBA].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Antibody to hepatitis D virus [anti-HDV].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Antibody to hepatitis E virus [IgM anti-HEV].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<b>LIVER ENZYME LEVELS AT TIME OF DIAGNOSIS</b> • ALT [SGPT] Result _____ Upper limit normal _____ • Date of ALT result <u>MM / DD / YYYY</u> • AST [SGOT] Result _____ Upper limit normal _____ • Date of AST result <u>MM / DD / YYYY</u>	If this case has a diagnosis of hepatitis A that has not been serologically confirmed, is there an epidemiologic link between this patient and a laboratory-confirmed hepatitis A case? Yes    No    Unk <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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**DIAGNOSIS: (check all that apply)**

<input type="checkbox"/> Acute hepatitis A	<input type="checkbox"/> Acute hepatitis C	<input type="checkbox"/> Chronic HBV infection	<input type="checkbox"/> Perinatal HBV infection
<input type="checkbox"/> Acute hepatitis B	<input type="checkbox"/> Acute hepatitis E	<input type="checkbox"/> HCV infection (Past or Present)	

# Patient History — Acute Hepatitis A

Case ID: \_\_\_\_\_

During the <b>2-6 weeks</b> prior to onset of symptoms-	Yes	No	Unk		
Was the patient a contact of a person with confirmed or suspected hepatitis A virus infection? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
If yes, was the contact (check one)					
• household member (non-sexual) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• sex partner .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• child cared for by this patient .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• babysitter of this patient .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• playmate .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• other _____					
Was the patient					
• a child or employee in a day care center, nursery, or preschool? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• a household contact of a child or employee in a day care center, nursery or preschool? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
If yes for either of these, was there an identified hepatitis A case in the child care facility? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
What is the sexual preference of the patient?					
<input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Unknown					
<b>Please ask both of the following questions regardless of the patient's gender.</b>					
In the <b>2-6 weeks</b> before symptom onset how many	<b>0</b>	<b>1</b>	<b>2-5</b>	<b>&gt;5</b>	<b>Unk</b>
male sex partners did the patient have? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
female sex partners did the patient have? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the <b>2-6 weeks</b> before symptom onset	<b>Yes</b>	<b>No</b>	<b>Unk</b>		
Did the patient inject drugs not prescribed by a doctor? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Did the patient use street drugs but not inject? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Did the patient <b>travel or live</b> outside of the U.S.A. or Canada? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
If yes, where?    1) _____ 2) _____					
(Country)      3) _____					
What was the principle reason for travel? <input type="checkbox"/> Business <input type="checkbox"/> New Immigrant <input type="checkbox"/> Other					
<input type="checkbox"/> Tourism <input type="checkbox"/> Visiting relatives/friends <input type="checkbox"/> Adoption <input type="checkbox"/> Unknown					
In the <b>3 months</b> prior to symptom onset did anyone in the patient's household travel outside of the U.S.A. or Canada? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
If yes, where?    1) _____ 2) _____					
(Country)      3) _____					
Is the patient suspected as being part of a common-source outbreak? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
If yes, was the outbreak					
Foodborne — associated with an infected food handler .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Foodborne — <b>NOT</b> associated with an infected food handler .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Specify food item _____					
Waterborne .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Source not identified .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Was the patient employed as a food handler during the <b>TWO WEEKS</b> prior to onset of symptoms or while ill? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

<b>VACCINATION HISTORY</b>					
	Yes	No	Unk		
• Has the patient ever received the hepatitis A vaccine? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
If yes, how many doses? .....	<b>1</b>	<b>&gt;2</b>			
<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		• In what year was the last dose received? .....	<u>  </u> <u>  </u> <u>  </u> <u>  </u> (year)
• Has the patient ever received immune globulin? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• If yes, when was the last dose received? .....	<u>  </u> <u>  </u> / <u>  </u> <u>  </u> <u>  </u> <u>  </u> (mo/year)
	<b>Yes</b>	<b>No</b>	<b>Unk</b>		

# Patient History — Acute Hepatitis B

Case ID: \_\_\_\_\_

<p>During the <b>6 weeks – 6 months</b> prior to onset of symptoms was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis B virus infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>If yes, type of contact</p> <p>Sexual ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Household (non-sexual)..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Other: _____</p>	<p>What is the sexual preference of the patient?</p> <p><input type="checkbox"/> Heterosexual    <input type="checkbox"/> Homosexual</p> <p><input type="checkbox"/> Bisexual        <input type="checkbox"/> Unknown</p> <p>Ask both of the following questions regardless of the patient's gender.</p> <p>In the <b>6 months</b> before symptom onset, how many</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"></td> <td style="text-align: center;"><b>0</b></td> <td style="text-align: center;"><b>1</b></td> <td style="text-align: center;"><b>2-5</b></td> <td style="text-align: center;"><b>&gt;5</b></td> <td style="text-align: center;"><b>Unk</b></td> </tr> <tr> <td>• male sex partners did the patient have? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>• female sex partners did the patient have? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>Was the patient <b>EVER</b> treated for a sexually-transmitted disease? .....</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"></td> <td style="text-align: center;"><b>Yes</b></td> <td style="text-align: center;"><b>No</b></td> <td style="text-align: center;"><b>Unk</b></td> </tr> <tr> <td>• If yes, in what year was the most recent treatment? <u>Y Y Y Y</u></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<b>0</b>	<b>1</b>	<b>2-5</b>	<b>&gt;5</b>	<b>Unk</b>	• male sex partners did the patient have? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• female sex partners did the patient have? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<b>Yes</b>	<b>No</b>	<b>Unk</b>	• If yes, in what year was the most recent treatment? <u>Y Y Y Y</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<p>During the <b>6 weeks – 6 months</b> prior to onset of symptoms</p> <p><b>Did the patient:</b></p> <ul style="list-style-type: none"> <li>• undergo hemodialysis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>• have an accidental stick or puncture with a needle or other object contaminated with blood?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>• receive blood or blood products [transfusion] ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> </ul> <p style="margin-left: 20px;">If yes, when? <u>MM / DD / YYYY</u></p> <ul style="list-style-type: none"> <li>• receive any IV infusions and/or injections in the outpatient setting ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>• have other exposure to someone else's blood..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> </ul> <p style="margin-left: 20px;">specify: _____</p> <p>During the <b>6 weeks – 6 months</b> prior to onset of symptoms</p> <ul style="list-style-type: none"> <li>• Was the patient employed in a medical or dental field involving direct contact with human blood? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> </ul> <p style="margin-left: 20px;">If yes, frequency of direct blood contact?</p> <p><input type="checkbox"/> Frequent (several times weekly)    <input type="checkbox"/> Infrequent</p> <ul style="list-style-type: none"> <li>• Was the patient employed as a public safety worker (fire fighter, law enforcement or correctional officer) having direct contact with human blood?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> </ul> <p style="margin-left: 20px;">If yes, frequency of direct blood contact?</p> <p><input type="checkbox"/> Frequent (several times weekly)    <input type="checkbox"/> Infrequent</p> <ul style="list-style-type: none"> <li>• Did the patient receive a tattoo?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> </ul> <p style="margin-left: 20px;">Where was the tattooing performed? (select all that apply)</p> <p><input type="checkbox"/> commercial parlor/shop</p> <p><input type="checkbox"/> correctional facility    <input type="checkbox"/> other _____</p>	<p>During the <b>6 weeks – 6 months</b> prior to onset of symptoms</p> <ul style="list-style-type: none"> <li>• inject drugs not prescribed by a doctor? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>• use street drugs but not inject?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>• Did the patient have any part of their body pierced (other than ear)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> </ul> <p style="margin-left: 20px;">Where was the piercing performed? (select all that apply)</p> <p><input type="checkbox"/> commercial parlor/shop</p> <p><input type="checkbox"/> correctional facility    <input type="checkbox"/> other _____</p> <ul style="list-style-type: none"> <li>• Did the patient have dental work or oral surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>• Did the patient have surgery ? (other than oral surgery)..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> </ul> <p>Was the patient: (check all that apply)</p> <ul style="list-style-type: none"> <li>• hospitalized?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>• a resident of a long term care facility?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>• incarcerated for longer than 24 hours..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> </ul> <p style="margin-left: 20px;">if yes, what type of facility (check all that apply)</p> <p>prison ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>jail ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>juvenile facility ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>																										
<p>Did the patient ever receive hepatitis B vaccine?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p style="margin-left: 20px;"><b>1</b>    <b>2</b>    <b>3+</b></p> <p>If yes, how many shots? .....</p> <p style="margin-left: 20px;">• In what year was the last shot received? _____</p> <p>Was the patient tested for antibody to HBsAg (anti-HBs) within 1-2 months after the last dose ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <ul style="list-style-type: none"> <li>• If yes, was the serum anti-HBs ≥ 10mIU/ml?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> </ul> <p style="margin-left: 20px;">(answer 'yes' if the laboratory result was reported as 'positive' or 'reactive')</p>	<p>During his/her lifetime, was the patient <b>EVER</b> incarcerated for longer than 6 months? .....</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"></td> <td style="text-align: center;"><b>Yes</b></td> <td style="text-align: center;"><b>No</b></td> <td style="text-align: center;"><b>Unk</b></td> </tr> <tr> <td>• If yes, what year was the most recent incarceration? <u>Y Y Y Y</u></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>for how long? <u>MM M</u> (mos)</td> <td></td> <td></td> <td></td> </tr> </table> <p>Did patient have a negative HBsAg test within 6 months prior to positive test?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p style="margin-left: 20px;">Verified test date: <u>MM / DD / YYYY</u></p> <p>Was the patient tested for hepatitis D? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Did patient have a co-infection with hepatitis D?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>		<b>Yes</b>	<b>No</b>	<b>Unk</b>	• If yes, what year was the most recent incarceration? <u>Y Y Y Y</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	for how long? <u>MM M</u> (mos)																	
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# Perinatal Hepatitis B Virus Infection

Case ID: \_\_\_\_\_

<p><b>RACE OF MOTHER:</b></p> <p><input type="checkbox"/> Amer Ind or Alaska Native    <input type="checkbox"/> Black or African American    <input type="checkbox"/> White    <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Asian    <input type="checkbox"/> Native Hawaiian or Pacific Islander</p> <p><input type="checkbox"/> Other Race, specify: _____</p>	<p><b>ETHNICITY OF MOTHER:</b></p> <p>Hispanic.....<input type="checkbox"/></p> <p>Non-hispanic .....<input type="checkbox"/></p> <p>Other/Unknown.....<input type="checkbox"/></p>
<p>Was <b>Mother</b> born outside of United States?..... <input type="checkbox"/> <b>Yes</b>    <input type="checkbox"/> <b>No</b>    <input type="checkbox"/> <b>Unk</b></p> <p>Was the <b>Mother</b> confirmed HBsAg positive prior to or at time of delivery?.. <input type="checkbox"/> <b>Yes</b>    <input type="checkbox"/> <b>No</b>    <input type="checkbox"/> <b>Unk</b></p> <p>    • If no, was the mother confirmed HBsAg positive after delivery? ..... <input type="checkbox"/> <b>Yes</b>    <input type="checkbox"/> <b>No</b>    <input type="checkbox"/> <b>Unk</b></p> <p>Date of earliest HBsAg positive test result..... <u>MM</u>/<u>DD</u>/<u>YYYY</u></p>	<p>If yes, what country? _____</p>
<p>How many doses of hepatitis B vaccine did the child receive ?..... <input type="checkbox"/> <b>0</b>    <input type="checkbox"/> <b>1</b>    <input type="checkbox"/> <b>2</b>    <input type="checkbox"/> <b>3+</b></p> <p>    • When?</p> <p>        • Dose 1 <u>MM</u>/<u>DD</u>/<u>YYYY</u></p> <p>        • Dose 2 <u>MM</u>/<u>DD</u>/<u>YYYY</u></p> <p>        • Dose 3 <u>MM</u>/<u>DD</u>/<u>YYYY</u></p>	
<p>Did the child receive hepatitis B immune globulin (HBIG)?..... <input type="checkbox"/> <b>Yes</b>    <input type="checkbox"/> <b>No</b>    <input type="checkbox"/> <b>Unk</b></p> <p>    • If yes, on what date did the child receive HBIG? ..... <u>MM</u>/<u>DD</u>/<u>YYYY</u></p>	

# Patient History — Acute Hepatitis C

Case ID: \_\_\_\_\_

	Yes	No	Unk							
During the <b>2 weeks – 6 months</b> prior to onset of symptoms was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis C virus infection?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		What is the sexual preference of the patient?					
If yes, type of contact					<input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual					
Sexual.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Bisexual <input type="checkbox"/> Unknown					
Household (non-sexual).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Ask both of the following questions regardless of the patient's gender.					
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		In the <b>6 months</b> before symptom onset, how many	<b>0</b>	<b>1</b>	<b>2-5</b>	<b>&gt;5</b>	<b>Unk</b>
					• male sex partners did the patient have? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					• female sex partners did the patient have? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Was the patient EVER treated for a sexually-transmitted disease? .....	<b>Yes</b>	<b>No</b>	<b>Unk</b>		
					• If yes, in what year was the most recent treatment? <u>Y Y Y Y</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
During the <b>2 weeks – 6 months</b> prior to onset of symptoms					During the <b>2 weeks – 6 months</b> prior to onset of symptoms					
<b>Did the patient:</b>					• inject drugs not prescribed by a doctor? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• undergo hemodialysis?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		• use street drugs but not inject?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• have an accidental stick or puncture with a needle or other object contaminated with blood? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Did the patient have a negative HCV antibody test within 6 months to a positive test? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• receive blood or blood products [transfusion].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Verified test date <u>MM / DD / YYYY</u>					
If yes, when?					During the <b>2 weeks – 6 months</b> prior to onset of symptoms					
• receive any IV infusions and/or injections in the outpatient setting .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		• Did the patient have any part of their body pierced (other than ear)? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• have other exposure to someone else's blood .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Where was the piercing performed? (select all that apply)					
specify: _____					<input type="checkbox"/> commercial parlor/shop					
During the <b>2 weeks – 6 months</b> prior to onset of symptoms					<input type="checkbox"/> correctional facility					
• Was the patient employed in a medical or dental field involving direct contact with human blood ? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> other _____					
If yes, frequency of direct blood contact?					• Did the patient have dental work or oral surgery? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Frequent (several times weekly) <input type="checkbox"/> Infrequent					• Did the patient have surgery ? (other than oral surgery).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• Was the patient employed as a public safety worker (fire fighter, law enforcement or correctional officer) having direct contact with human blood?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Was the patient – (check all that apply)					
If yes, frequency of direct blood contact?					• hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> Frequent (several times weekly) <input type="checkbox"/> Infrequent					• a resident of a long term care facility? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
• Did the patient receive a tattoo? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		• incarcerated for longer than 24 hours .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Where was the tattooing performed? (select all that apply)					If yes, what type of facility (check all that apply)					
<input type="checkbox"/> commercial parlor/shop					prison .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/> correctional facility <input type="checkbox"/> other _____					jail .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					juvenile facility .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
						<b>Yes</b>	<b>No</b>	<b>Unk</b>		
					During his/her lifetime, was the patient EVER incarcerated for longer than 6 months? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
					• If yes,					
					what year was the most recent incarceration? <u>Y Y Y Y</u>					
					for how long? <u>M M M</u> (mos)					
					Has the patient received medication for the type of hepatitis being reported? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

## Patient History — Chronic Hepatitis B Infection

Case ID: \_\_\_\_\_

The following questions are provided as a guide for the investigation of lifetime risk factors for HBV infection. Routine collection of risk factor information for persons who test HBV positive is not required. However, collection of risk factor information for such persons may provide useful information for the development and evaluation of programs to identify and counsel HBV-infected persons.

	Yes	No	Unk		Yes	No	Unk
Did the patient receive clotting factor concentrates produced prior to 1987?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was the patient ever employed in a medical or dental field involving direct contact with human blood?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the patient ever on long-term hemodialysis?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What is the birth country of the mother ? _____			
Has the patient ever injected drugs not prescribed by a doctor even if only once or a few times?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has the patient recieved medication for the type of hepatitis being reported? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How many sex partners has the patient had (approximate lifetime)? _____							
Was the patient ever incarcerated?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Was the patient ever treated for a sexually transmitted disease? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Was the patient ever a contact of a person who had hepatitis?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
If yes, type of contact							
• Sexual.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
• Household [Non-sexual].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
• Other.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

**Patient History — Hepatitis C Infection (past or present)**

Case ID: \_\_\_\_\_

The following questions are provided as a guide for the investigation of lifetime risk factors for HCV infection. Routine collection of risk factor information for persons who test HCV positive is not required. However, collection of risk factor information for such persons may provide useful information for the development and evaluation of programs to identify and counsel HCV-infected persons.

	Yes	No	Unk		Yes	No	Unk
Did the patient receive a blood transfusion prior to 1992? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was the patient ever employed in a medical or dental field involving direct contact with human blood? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the patient receive an organ transplant prior to 1992? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Has the patient recieved medication for the type of hepatitis being reported? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did the patient receive clotting factor concentrates produced prior to 1987? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Was the patient ever on long-term hemodialysis? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Has the patient ever injected drugs not prescribed by a doctor even if only once or a few times? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
How many sex partners has the patient had (approximate lifetime)? _____							
Was the patient ever incarcerated? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Was the patient ever treated for a sexually transmitted disease? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Was the patient ever a contact of a person who had hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
If yes, type of contact							
• Sexual .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
• Household [Non-sexual] .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
• Other .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				