

COLORADO DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT
Acute Hepatitis B Questionnaire

For confirmed, probable & suspected cases of acute hepatitis B
{Questions marked with a * are those that must be entered into the CEDRS record}

*Patient Name _____ CEDRS # _____
*Address _____ *Phone (hm) _____
*City _____ *County _____ *ZIP _____ *Phone (wk) _____
*DOB _____ *Age (years) _____ *Sex: M F
*Date reported to public health ___/___/___

***CONSENT:** "All of your responses will be handled in a confidential manner to the extent allowed by the law" **Date this statement was verbally told to the patient:** ___/___/___

***DEMOGRAPHIC INFORMATION:**

*Race: (check all that apply) American Indian/Alaska Native Asian Black
 Native Hawaiian/Pacific Islander White Other race
If other, please specify _____
*Ethnicity: Hispanic Non-Hispanic Other/Unknown
*Place of birth: USA Other country: _____
*Physician: (name, address, and phone number) _____

***CLINICAL AND DIAGNOSTIC DATA:**

*Reason for testing: (check all that apply)
 Asymptomatic patient with no risk factors Prenatal
 Asymptomatic patient with risk factors Symptoms of acute hepatitis
 Blood/organ donor screening Unknown
 Evaluation of elevated liver enzymes Other (specify) _____
 Follow-up testing for previous marker of viral hepatitis

***CLINICAL DATA / SYMPTOMS:**

*Diagnosis date: ___/___/___
*Is or was patient symptomatic? Yes No Unknown
*If yes, onset date: ___/___/___
*Did the patient experience? (answer for each symptom below)
Abdominal Pain Yes No Unk Fever Yes No Unk
Arthralgia Yes No Unk Jaundice Yes No Unk
Clay Colored Stool Yes No Unk Loss of Appetite Yes No Unk
Dark Urine Yes No Unk Nausea Yes No Unk
Diarrhea Yes No Unk Vomiting Yes No Unk
Fatigue Yes No Unk
* Patient hospitalized for hepatitis? Yes No Unknown

* Patient currently pregnant? Yes No Unknown

Due date: ___/___/___

*Did the patient die from hepatitis? Yes No Unknown Date of death ___/___/___

***DIAGNOSTIC TESTS:**

*Date when (1st) blood drawn for hepatitis B testing? ___/___/___

*Reporting Laboratory _____

*HAV/HBV/HCV serology results: start below (check all that apply)

*Total antibody to hepatitis A virus [total anti-HAV]

Positive Negative Unknown Not done

*IgM antibody to hepatitis A virus [IgM anti-HAV]

Positive Negative Unknown Not done

*Hepatitis B surface antigen [HBsAg]

Positive Negative Unknown Not done

*Total antibody to hepatitis B core antigen [total anti-HBc]

Positive Negative Unknown Not done

*IgM antibody to hepatitis B core antigen [IgM anti-HBc]

Positive Negative Unknown Borderline Not done

* Antibody to hepatitis C virus [anti-HCV]

Positive Negative Unknown Not done

*anti - HCV signal to cut-off ratio _____

*Supplemental anti-HCV assay [e.g., RIBA]

Positive Negative Unknown Not done

*HCV RNA [e.g., PCR]

Positive Negative Unknown Not done

*Liver enzyme values:

*SGPT (ALT) _____ Test date: ___/___/___ Upper limit normal: _____

*SGOT (AST) _____ Test date: ___/___/___ Upper limit normal: _____

Other tests _____

***VACCINATION HISTORY:**

*Has the patient ever received hepatitis A vaccine? Yes No Unk

If yes, how many doses? 1 ≥ 2

Year of the last Hepatitis A dose: _____

*Has the patient ever received hepatitis B vaccine? Yes No Unk

(If yes, record vaccine history below)

Hepatitis B Vaccination Date (Month, Day and Year):

Dose 1: Vaccine Type: _____ Brand Name: _____

Manufacturer: _____ Date Given: ___/___/___ Lot #: _____

Dose 2: Vaccine Type: _____ Brand Name: _____
Manufacturer: _____ Date Given: ___/___/___ Lot #: _____

Dose 3: Vaccine Type: _____ Brand Name: _____
Manufacturer: _____ Date Given: ___/___/___ Lot #: _____

*Was the patient ever given Immune Globulin? Yes No Unk
If yes, what month/year was the last dose received? ___/___.

***PATIENT INFORMATION/HISTORY:**

***During the 6 weeks – 6 months prior to onset of symptoms, was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis B virus infection?**

Yes No Unk

If yes, was the contact: (check all that apply)

Donor Household Member (non-sexual) IDU Nosocomial Occupational
 Other Perinatal Sex Partner Unknown

If other, please specify _____

***In the 6 months before symptom onset,**
(Ask both of the following questions regardless of the patient's gender)

	0	1	2-5	>5	Unk
How many male sex partners did the patient have?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How many female sex partners did the patient have?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Of the sex partners you had during the last 6 months how many did you find through the intranet? _____ Total #

***Was the patient *EVER* treated for a sexually transmitted disease?**

Yes No Unk

If yes, which disease(s): _____

What was the year of most recent treatment: _____

***During the 6 weeks – 6 months prior to onset of symptoms,**

1. *Did the patient inject drugs not prescribed by a doctor? Yes No Unk
If yes, what was patient's drug of choice? _____

2. *Did the patient use street drugs (not injected)? Yes No Unk
If yes, what was patient's drug of choice? _____

3. *Undergo hemodialysis? Yes No Unk
If yes, month and year of hemodialysis _____

4. * Did the patient have an accidental stick or puncture with a needle or other object contaminated with blood? Yes No Unk

5. *Did the patient receive blood or blood products [transfusion]? Yes No Unk
If yes, date of transfusion? (___/___/___)

6. *Did the patient receive any outpatient IV infusions and/or injections?
 Yes No Unk

7. Patient diabetic? Yes No Unk
If yes, has patient shared diabetic supplies? Yes No Unk

If yes, Family Friend Roommate Other

If other, please specify _____

8. Have you ever been told by a doctor that you have diabetes? Yes Yes, pregnancy related No No, pre-diabetes or borderline diabetes Don't know

If yes, when were you first told by a doctor that you have diabetes? < 6 months prior to symptom onset ≥ 6 months prior to symptom onset Don't know

9. *Did the patient have other exposure to someone else's blood? Yes No Unk

If yes, please specify _____

10. *Was the patient employed in a medical or dental field involving direct contact with human blood? Yes No Unk If yes, what was the frequency of the direct blood contact?

Frequent (several times weekly) Infrequent

11. *Was the patient employed as a public safety worker having direct contact with human blood? Yes No Unk

If yes, please specify Correctional Office Fire Fighter Law Enforcement Officer Other

What was the frequency of the direct blood contact?

Frequent (several times weekly) Infrequent

12. *Did the patient receive a tattoo? Yes No Unk

If yes, where was the tattooing performed? (check all that apply)

Commercial Parlor/Shop Correctional Facility Other

If other, please list _____

13. *Did the patient have any part of their body pierced (other than ear)?

Yes No Unk

If yes, where was the piercing performed? (check all that apply)

Commercial Parlor/Shop Correctional Facility Other

If other, please list _____

14. *Did the patient have dental work or oral surgery? Yes No Unk

15. *Did the patient have surgery (other than oral)? Yes No Unk

16. * Was the patient hospitalized during the incubation period? Yes No Unk

17. *Was the patient a resident of a long-term care facility (i.e., Nursing Home)?

Yes No Unk

18. *Was the patient a resident of an inpatient drug treatment program? Yes No Unk

19. *Was the patient a resident of a half-way house? Yes No Unk

20. *Was the patient incarcerated for longer than 24 hours? Yes No Unk

If yes, what type of facility? Jail Juvenile Facility Prison

21. * During his/her lifetime, was the patient **ever** incarcerated for longer than 6 months?

Yes No Unk

If yes, what year was the most recent incarceration? _____ For how long? _____

22. *Patient **EVER** have clotting factor? _____(enter year)

23. *Patient **EVER** have an organ transplant (any type)? _____(enter year)

◆ *Information from questions marked with a * should be entered into CEDRS. If unable to enter record into CEDRS surveillance form can be faxed to Sandy Rios at 303-759-5257. ◆ Questions contact Candace Vonderwahl (303.692.2687) or Sandy Rios (303.692.2965).*

Please complete CASE MANAGEMENT (page 6) and fax to Sandy Rios at 303-759-5257

HEPATITIS B / CASE MANAGEMENT:

Case Name: _____ CEDRS#: _____

1. **Patient** referred for HIV testing? Yes No
2. **Patient** referred for anti-HBs (surface antibody) & HBsAg testing 6 months after symptoms?
 Yes No *(VHP Staff will follow up with patient in 6 months to confirm HBsAb & HBsAg testing)*
3. **Patient** referred for hepatitis A vaccine? Yes No
4. Total number of **contacts** referred for hepatitis B vaccine. _____
5. Total number of **contacts** referred for hepatitis A vaccine. _____

CONTACTS							
Name of Contact	Age/ DOB	Locating Information Phone/address	Type of Exposure (IVDU, blood exposure, sex)	Exposure Date (m/d/yr)	HBsAg test? Y/N & where?	Lab Date & Result	Vaccinated? Y/N Date & where?
1.							
2.							
3.							
4.							

NOTES:

Interviewer Name: _____ **Interview Date:** ___/___/___

Agency: _____

Fax page 6 to Sandy Rios, Viral Hepatitis Program 303-759-5257