

**COLORADO DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT**  
**Acute Hepatitis C Questionnaire**

For confirmed, probable & suspected cases of acute hepatitis C  
{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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Arthralgia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Clay Colored Stool	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Loss of Appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Dark Urine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Nausea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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   $\geq 2$

Year of the last Hepatitis A dose: \_\_\_\_\_

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

If yes, how many doses?  1  2  3+

Year of the last Hepatitis B dose: \_\_\_\_\_

\*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 2 weeks – 6 months prior to onset of symptoms, was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis C 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 2 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

8. **\*Did the patient have other exposure to someone else's blood?**  Yes  No  Unk  
**If yes**, please specify \_\_\_\_\_

9. **\*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

10. \*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

11. \*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 \_\_\_\_\_

12. \*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 \_\_\_\_\_

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

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

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

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

Yes  No  Unk

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

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

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

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

20. \* 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? \_\_\_\_\_

21. \*Patient **EVER** have clotting factor? (enter year) \_\_\_\_\_

22.\*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 303-691-7753. ◆ Questions contact Candace Vonderwahl (303.692.2687) or Sandy Rios (303.692.2965).*

**Additionally, please complete CASE MANAGEMENT page (page 5) and fax to Sandy Rios at 303-691-7753.**

**HEPATITIS C / CASE MANAGEMENT:**

Case Name: \_\_\_\_\_ CEDRS#: \_\_\_\_\_

1. **Patient** referred for HIV testing?  Yes  No
2. **Patient** referred for hepatitis A & B vaccine (if not vaccinated)? Yes  No
3. Total number of **contacts** referred for hepatitis C testing. \_\_\_\_\_
4. Total number of **contacts** referred for hepatitis A and B vaccine. \_\_\_\_\_

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

**NOTES:**

*Interviewer Name:* \_\_\_\_\_ *Interview Date:* \_\_\_/\_\_\_/\_\_\_

*Agency:* \_\_\_\_\_

*Fax page 5 to Sandy Rios, Viral Hepatitis Program 303-691-7753*