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)***

<u>Hepatitis B Vaccination Date (Month, Day and Year):</u>

Dose 1:Vaccine Type:_____Brand Name:_____
Manufactor:_____Date Given:___/___/___Lot #:_____

Dose 2:Vaccine Type:_____Brand Name: _____
Manufactor:_____Date Given:___/___/___Lot #:_____

Dose 3:Vaccine Type:_____Brand Name: _____
Manufactor:_____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?	☐	☐	☐	☐	☐
How many female sex partners did the patient have?	☐	☐	☐	☐	☐

*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 hemodialyisis? ☐ 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).

Please complete CASE MANAGEMENT page (page 5) and fax to Sandy Rios at 303-691-7753

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