

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES PUBLIC HEALTH SERVICE

VIRAL HEPATITIS CASE REPORT

CDC Centers for Disease Control and Prevention Hepatitis Branch, (G37) Atlanta, Georgia 30333

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

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 Was this record submitted to CDC through the NETSS system? If yes, please enter NETSS ID NO. If no, please enter STATE CASE NO.

DEMOGRAPHIC INFORMATION

RACE (check all that apply): Amer Indian or Alaska Native, Black or African American, White, Asian, Native Hawaiian or Pacific Islander, Other Race, specify: ETHNICITY: Hispanic, Non-hispanic, Other/Unknown SEX: Male, Female, Unk PLACE OF BIRTH: USA, Other DATE OF BIRTH: AGE: (years)

CLINICAL & DIAGNOSTIC DATA

REASON FOR TESTING: (Check all that apply) Symptoms of acute hepatitis, Evaluation of elevated liver enzymes, Screening of asymptomatic patient with reported risk factors, Blood / organ donor screening, Screening of asymptomatic patient with no risk factors (e.g., patient requested), Follow-up testing for previous marker of viral hepatitis, Prenatal screening, Unknown, Other: specify:

CLINICAL DATA: Diagnosis date, Is patient symptomatic?, Was the patient Jaundiced?, Hospitalized for hepatitis?, Was the patient pregnant?, Did the patient die from hepatitis? LIVER ENZYME LEVELS AT TIME OF DIAGNOSIS: ALT [SGPT] Result, AST [SGOT] Result, Date of ALT result, Date of AST result DIAGNOSTIC TESTS: CHECK ALL THAT APPLY: Total antibody to hepatitis A virus, IgM antibody to hepatitis A virus, Hepatitis B surface antigen [HBsAg], Total antibody to hepatitis B core antigen [total anti-HBc], IgM antibody to hepatitis B core antigen [IgM anti-HBc], Antibody to hepatitis C virus [anti-HCV], Supplemental anti-HCV assay [e.g., RIBA], HCV RNA [e.g., PCR], Antibody to hepatitis D virus [anti-HDV], Antibody to hepatitis E virus [anti-HEV]

DIAGNOSIS: (Check all that apply) Acute hepatitis A, Acute hepatitis B, Acute hepatitis C, Acute hepatitis E, Chronic HBV infection, HCV infection (chronic or resolved), Acute non-ABCD hepatitis, Perinatal HBV infection, Hepatitis Delta (co- or super-infection)

## Hepatitis A

During the **2-6 weeks** 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 .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>

**Please ask both of the following questions regardless of the patient's gender.**

	0	1	2-5	>5	Unk
In the <b>2- 6 weeks</b> before symptom onset how many					
• male sex partners did the patient have? .....	<input type="checkbox"/>				
• female sex partners did the patient have? .....	<input type="checkbox"/>				

	Yes	No	Unk
In the <b>2- 6 weeks</b> before symptom onset			
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</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) _____			
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"/>

In the 2-6 weeks prior to symptom onset:  
Did the patient consume raw or undercooked shellfish? **Yes No Unk**  
**If yes,**

Type: \_\_\_\_\_

Where: \_\_\_\_\_

Date/time: \_\_\_\_\_

In the 2-6 weeks prior to symptom onset:  
Did the patient consume fresh or frozen berries? **Yes No Unk**  
**If yes,**

Fresh or Frozen: \_\_\_\_\_

Type: \_\_\_\_\_

Brand: \_\_\_\_\_

<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? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• In what year was the last dose received? .....	<input type="text" value="Y"/>	<input type="text" value="Y"/>	<input type="text" value="Y"/>
Has the patient ever received immune globulin ? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• If yes, when was the last dose received? .....	mo	/	yr

# DRAFT COPY

STATE CASE NO. \_\_\_\_\_

NETSS ID NO. \_\_\_\_\_

## Patient History- Acute Hepatitis B

<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? <b>Yes No Unk</b></p> <p><b>If yes, type of contact</b></p> <ul style="list-style-type: none"> <li>• Sexual ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li>• Household [Non-sexual] ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li>• Other: _____ <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> </ul>	<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 <b>0 1 2-5 &gt;5 Unk</b></p> <ul style="list-style-type: none"> <li>• male sex partners did the patient have? ..... <input type="checkbox"/> <b>0</b> <input type="checkbox"/> <b>1</b> <input type="checkbox"/> <b>2-5</b> <input type="checkbox"/> <b>&gt;5</b> <input type="checkbox"/> <b>Unk</b></li> <li>• female sex partners did the patient have? ..... <input type="checkbox"/> <b>0</b> <input type="checkbox"/> <b>1</b> <input type="checkbox"/> <b>2-5</b> <input type="checkbox"/> <b>&gt;5</b> <input type="checkbox"/> <b>Unk</b></li> </ul> <p>Was the patient <i>EVER</i> treated for a sexually-transmitted disease? <b>Yes No Unk</b></p> <p>..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></p> <ul style="list-style-type: none"> <li>• If yes, in what year was the most recent treatment? <u>YYYY</u></li> </ul> <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"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li>• use street drugs but not inject? ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> </ul>
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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> <b>Yes No Unk</b></p> <ul style="list-style-type: none"> <li>• undergo hemodialysis? ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li>• have an accidental stick or puncture with a needle or other object contaminated with blood? ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li>• receive blood or blood products [transfusion] ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li style="padding-left: 20px;">• if yes, when? <u>MM/DD/YYYY</u></li> <li>• receive any IV infusions and/or injections in the outpatient setting... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li>• have other exposure to someone else's blood ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li style="padding-left: 20px;">specify: _____</li> </ul> <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"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li style="padding-left: 20px;">If yes, frequency of direct blood contact?</li> <li style="padding-left: 40px;">Frequent (several times weekly) <input type="checkbox"/> Infrequent <input type="checkbox"/></li> <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"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li style="padding-left: 20px;">If yes, frequency of direct blood contact?</li> <li style="padding-left: 40px;">Frequent (several times weekly) <input type="checkbox"/> Infrequent <input type="checkbox"/></li> <li>• Did the patient receive a tattoo? ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li style="padding-left: 20px;">where was the tattooing performed? (select all that apply)</li> <li style="padding-left: 40px;"><input type="checkbox"/> commercial <input type="checkbox"/> correctional <input type="checkbox"/> other _____</li> <li style="padding-left: 40px;">parlor / shop facility</li> </ul>	<p>During the <b>6 weeks- 6 months</b> prior to onset of symptoms</p> <ul style="list-style-type: none"> <li>• Did the patient have any part of their body pierced (other than ear)?</li> <li style="padding-left: 20px;">where was the piercing performed? (select all that apply)</li> <li style="padding-left: 40px;"><input type="checkbox"/> commercial <input type="checkbox"/> correctional <input type="checkbox"/> other _____</li> <li style="padding-left: 40px;">parlor / shop facility <b>Yes No Unk</b></li> <li>• Did the patient have dental work or oral surgery? ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li>• Did the patient have surgery? (other than oral surgery) .. <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li>• Was the patient- <i>Check all that apply</i></li> <li style="padding-left: 20px;">• hospitalized? ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li style="padding-left: 20px;">• a resident of a long term care facility? ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li style="padding-left: 20px;">• incarcerated for longer than 24 hours? ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li style="padding-left: 40px;">if yes, what type of facility (check all that apply)</li> <li style="padding-left: 60px;">prison ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li style="padding-left: 60px;">jail ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li style="padding-left: 60px;">juvenile facility ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> </ul> <hr style="border-top: 1px dashed black;"/> <p>During his/her lifetime, was the patient <i>EVER</i></p> <ul style="list-style-type: none"> <li>• incarcerated for longer than 6 months? ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li>• If yes,</li> <li style="padding-left: 20px;">what year was the most recent incarceration? ..... <u>YYYY</u></li> <li style="padding-left: 20px;">for how long? ..... _____ <b>mos</b></li> </ul>
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<p><b>Did the patient ever receive hepatitis B vaccine?</b> <b>Yes No Unk</b></p> <p><b>If yes, how many shots?.....</b> <b>1 2 3+</b></p> <p>..... <input type="checkbox"/> <b>1</b> <input type="checkbox"/> <b>2</b> <input type="checkbox"/> <b>3+</b></p> <ul style="list-style-type: none"> <li>• In what year was the last shot received? ..... <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>Y</b> <input type="checkbox"/> <b>Y</b></li> </ul>	<p><b>Was the patient tested for antibody to HBsAg (anti-HBs) within 1-2 months after the last dose? .....</b> <b>Yes No Unk</b></p> <p>..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></p> <ul style="list-style-type: none"> <li>• If yes, was the serum anti-HBs <math>\geq</math> 10mIU/ml? ..... <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Unk</b></li> <li style="padding-left: 20px;">(answer 'yes' if the laboratory result was reported as .... 'positive' or 'reactive')</li> </ul>
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## Perinatal Hepatitis B Virus Infection

NETSS ID NO. 

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STATE CASE NO. \_\_\_\_\_

### RACE OF MOTHER:

- Amer Ind or Alaska Native     Black or African American     White     Unknown  
 Asian     Native Hawaiian or Pacific Islander     Other Race, specify: \_\_\_\_\_

### ETHNICITY OF MOTHER:

- Hispanic .....   
Non-hispanic .....   
Other/Unknown .....

Was **Mother** born outside of United States? .....  Yes     No     Unk    If yes, what country? \_\_\_\_\_

Was the **Mother** confirmed HBsAg positive prior to or at time of delivery ? ...  Yes     No     Unk

• If no, was the mother confirmed HBsAg positive after delivery? .....  Yes     No     Unk

Date of HBsAg positive test result ..... MM/DD/YYYY

How many doses of hepatitis B vaccine did the child receive ? .....  0     1     2     3

• When?

• Dose 1- MM/DD/YYYY

• Dose 2- MM/DD/YYYY

• Dose 3- MM/DD/YYYY

Yes    No    Unk

Did the child receive hepatitis B immune globulin (HBIG)? .....  Yes     No     Unk

• If yes, on what date did the child receive HBIG? ..... MM/DD/YYYY

# DRAFT COPY

NETSS ID NO.

STATE CASE NO. \_\_\_\_\_

## Patient History- Acute Hepatitis C

<p>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? <span style="float: right;">Yes    No    Unk</span></p> <p><b>If yes, type of contact</b></p> <ul style="list-style-type: none"> <li>• Sexual ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>• Household [Non-sexual] ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>• Other: _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> </ul>	<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 <span style="margin-left: 20px;">0    1    2-5    &gt;5    Unk</span></p> <ul style="list-style-type: none"> <li>• male sex partners did the patient have? ..... <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> &gt;5 <input type="checkbox"/> Unk</li> <li>• female sex partners did the patient have? ..... <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2-5 <input type="checkbox"/> &gt;5 <input type="checkbox"/> Unk</li> </ul> <p>Was the patient <i>EVER</i> treated for a sexually transmitted disease? ..... <span style="float: right;">Yes    No    Unk</span></p> <ul style="list-style-type: none"> <li>• If yes, in what year was the most recent treatment? <u>YYYY</u></li> </ul> <p>During the <b>2 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> </ul>
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<p>During the <b>2 weeks- 6 months</b> prior to onset of symptoms</p> <p><b>Did the patient-</b> <span style="float: right;">Yes    No    Unk</span></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             <ul style="list-style-type: none"> <li>• if yes, when? <u>MM/DD/YYYY</u></li> </ul> </li> <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             <ul style="list-style-type: none"> <li>specify: _____</li> </ul> </li> </ul> <p>During the <b>2 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             <ul style="list-style-type: none"> <li>If yes, frequency of direct blood contact?</li> <li>Frequent (several times weekly) <input type="checkbox"/> Infrequent <input type="checkbox"/></li> </ul> </li> <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             <ul style="list-style-type: none"> <li>If yes, frequency of direct blood contact?</li> <li>Frequent (several times weekly) <input type="checkbox"/> Infrequent <input type="checkbox"/></li> </ul> </li> <li>• Did the patient receive a tattoo? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk             <ul style="list-style-type: none"> <li>where was the tattooing performed? (select all that apply)</li> <li><input type="checkbox"/> commercial <input type="checkbox"/> correctional <input type="checkbox"/> other _____</li> <li>parlor / shop facility</li> </ul> </li> </ul>	<p>During the <b>2 weeks- 6 months</b> prior to onset of symptoms</p> <ul style="list-style-type: none"> <li>• Did the patient have any part of their body pierced (other than ear)?             <ul style="list-style-type: none"> <li>where was the piercing performed? (select all that apply)</li> <li><input type="checkbox"/> commercial <input type="checkbox"/> correctional <input type="checkbox"/> other _____</li> <li>parlor / shop facility</li> </ul> </li> <li>• Did the patient have dental work or oral surgery? ..... <span style="float: right;">Yes    No    Unk</span></li> <li>• Did the patient have surgery ? (other than oral surgery) .. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>• Was the patient- <i>Check all that apply</i> <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                 <ul style="list-style-type: none"> <li>if yes, what type of facility (check all that apply)</li> <li>prison ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>jail ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>juvenile facility ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> </ul> </li> </ul> </li> </ul> <hr style="border-top: 1px dashed black;"/> <p>During his/her lifetime, was the patient <i>EVER</i></p> <ul style="list-style-type: none"> <li>• incarcerated for longer than 6 months ? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</li> <li>• If yes,             <ul style="list-style-type: none"> <li>what year was the most recent incarceration ? ..... <u>YYYY</u></li> <li>for how long ? ..... _____ mos</li> </ul> </li> </ul>
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NETSS ID NO.

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**Patient History- Hepatitis C Virus Infection (chronic or resolved)**

STATE CASE NO. \_\_\_\_\_

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"/>				
• 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"/>				