Hepatitis D Questionnaire

Division of Viral Hepatitis, Centers for Disease Control and Prevention

Type of specimen: serum/plasma/other (specify):________
Date specimen collected: _____ / _____ / ______

Requesting Physician/Healthcare Provider/Public Health Department Contact

Name of requesting physician/healthcare provider: ________________________________________________
Phone: (_____) ____-_____ Fax: (_____) ____-_____ E-mail: __________________@_______________
Facility or practice name: ________________________________________________________________
Phone: (_____) ____-_____ Fax: (_____) ____-_____ E-mail: __________________@_______________

Patient Information

Medical Record #:________________________ Last name:________________________ First name: ____________________________
City: __________________________ State: ____ Postal Code: _______-__________
DOB: _____ / _____ / _____ or Age: _____ (years)  Sex: ☐ Male ☐ Female

If born outside of US, state country of birth:________________________ What year did patient move to US: ________

Ethnicity/race:
☐ White ☐ Black ☐ Hispanic ☐ East Asian ☐ Alaskan Native ☐ American Indian ☐ Native Hawaiian ☐ Mongolian
☐ South Asian ☐ Middle Eastern ☐ South American ☐ Pacific Islander ☐ Other (specify) __________________________

Hepatitis B vaccination: ☐ Yes ☐ No ☐ Not known If vaccinated, approximate year: _________________________

Results from viral hepatitis serologic and NAT testing

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<thead>
<tr>
<th></th>
<th>Result</th>
<th>Sample date</th>
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<tbody>
<tr>
<td>HBsAg (pos/neg)</td>
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<tr>
<td>HBeAg (pos/neg)</td>
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<tr>
<td>Anti-HBe (pos/neg)</td>
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<tr>
<td>Total anti-HBc (pos/neg)</td>
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<td>Anti-HBc IgM (pos/neg)</td>
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<td>Anti-HBs (pos/neg)</td>
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<td>Anti-HBs IgM (IU/ml)</td>
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<td>HBV DNA (IU/mL)</td>
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<td>Anti-HCV IgG (pos/neg)</td>
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<td>HCV RNA (IU/mL)</td>
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Liver Function Tests

Most recent values known of: ALT (SGPT) ______U/L  AST (SGOT) ______U/L  Bilirubin ______mg/dL

Sample date: _____ / _____ / _____  _____ / _____ / _____  _____ / _____ / _____  _____ / _____ / _____
Details of current illness

Date of onset of illness: _____ /_____ /______

Signs and Symptoms (check all that apply):
☐ Scleral icterus ☐ Dark urine ☐ Hepatomegaly ☐ Abdominal pain ☐ Diarrhea ☐ Fever ☐ Arthralgia ☐ Rash ☐ Other (specify) ________________________________

Has patient been previously diagnosed with hepatitis B: ☐ Yes ☐ No ☐ Not known

If yes: date of diagnosis? _____ /_____ /_____ 

Has patient a liver biopsy: ☐ Yes ☐ No ☐ Not known

If Yes: stage:__________ grade: _________ when: _____ /_____ /_____ 

Did patient have cirrhosis by imaging or laboratory testing? ☐ Yes ☐ No ☐ Not known 

Did patient have liver cancer by imaging tests or biopsy? ☐ Yes ☐ No ☐ Not known 

Was patient hospitalized? ☐ Yes ☐ No 

If Yes: what was duration of hospitalization (in days)?______________________________

Did patient develop liver failure? ☐ Yes ☐ No 

Did patient die? ☐ Yes ☐ No 

If Yes: what was date of death? _____ /_____ /_____ 

If No: what was the cause of death?__________________________

Has patient ever received an organ/tissue transplant? ☐ Yes ☐ No ☐ Not known 

If Yes: what organ/tissue? __________________________ Date of transplant: _____ /_____ /_____ ☐ Not known

Is patient on immunosuppressive therapy? ☐ Yes ☐ No ☐ Not known

If Yes: specify medications _________________________________________________________________________

Has patient ever received blood transfusion? ☐ Yes ☐ No ☐ Not known

If Yes: date of last transfusion: _____ /_____ /_____ 

Has patient ever received blood product(s)? ☐ Yes ☐ No ☐ Not known

If Yes: what product(s)?_________________________________ Date received: _____ /_____ /_____ ☐ Not known

Additional Patient History

What is patient’s primary occupation?_____________________________________________________________

Have any family members been diagnosed with chronic hepatitis B and/or hepatitis D? ☐ Yes ☐ No ☐ Not known 

During the 3 months prior to illness, did patient receive any:

prescribed injection ☐ Yes ☐ No ☐ Not known surgery ☐ Yes ☐ No ☐ Not known

hemodialysis ☐ Yes ☐ No ☐ Not known dental procedure ☐ Yes ☐ No ☐ Not known

During the 3 months prior to illness, did patient inject drugs not prescribed by a doctor? ☐ Yes ☐ No ☐ Not known 

If Yes: was needle sharing involved? ☐ Yes ☐ No ☐ Not known 

During the patient’s lifetime, did patient inject drugs not prescribed by a doctor? ☐ Yes ☐ No ☐ Not known