

VIRAL HEPATITIS CASE REPORT



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

Form Approved OMB No. 0920-0728 Exp. Date 01/31/2014

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 MM / DD / YYYY
 Case ID: _____
 Legacy Case ID: _____

DEMOGRAPHIC INFORMATION

RACE: (check all that apply) <input type="checkbox"/> Amer Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other Race, specify _____		ETHNICITY: Hispanic..... <input type="checkbox"/> Non-hispanic <input type="checkbox"/> Other/Unknown..... <input type="checkbox"/>
SEX: Male <input type="checkbox"/> Female <input type="checkbox"/> Unk <input type="checkbox"/> PLACE OF BIRTH: <input type="checkbox"/> USA <input type="checkbox"/> Other: _____ DATE OF BIRTH: <u>MM / DD / YYYY</u> AGE: ____ (years) (00 = <1yr , 999 = Unk)		

CLINICAL & DIAGNOSTIC DATA

REASON FOR TESTING: (check all that apply)

<input type="checkbox"/> Year of birth (1945-1965)	<input type="checkbox"/> Symptoms of acute hepatitis	<input type="checkbox"/> Prenatal screening
<input type="checkbox"/> Screening of asymptomatic patient with reported risk factors	<input type="checkbox"/> Blood/organ donor screening	<input type="checkbox"/> Unknown
<input type="checkbox"/> Screening of asymptomatic patient with no risk factors (e.g., patient requested)	<input type="checkbox"/> Evaluation of elevated liver enzymes	
<input type="checkbox"/> Follow-up testing for previous marker of viral hepatitis	<input type="checkbox"/> Other: specify: _____	

CLINICAL DATA:	DIAGNOSTIC TESTS: (CHECK ALL THAT APPLY)																																																				
Diagnosis date: <u>MM / DD / YYYY</u> Yes No Unk Is patient symptomatic? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> if yes, onset date: <u>MM / DD / YYYY</u> At diagnosis, was the patient • Jaundiced? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Hospitalized for hepatitis? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Was the patient pregnant? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Due date: <u>MM / DD / YYYY</u> Did the patient die from hepatitis? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Date of death: <u>MM / DD / YYYY</u> Was the patient aware they had viral hepatitis prior to lab testing? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does the patient have a provider of care for hepatitis?... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Does the patient have diabetes?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diabetes diagnosis date: <u>MM / DD / YYYY</u>	<table> <thead> <tr> <th></th> <th>Pos</th> <th>Neg</th> <th>Unk</th> </tr> </thead> <tbody> <tr> <td>• Total antibody to hepatitis A virus [total anti-HAV].....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• IgM antibody to hepatitis A virus [IgM anti-HAV].....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• Hepatitis B surface antigen [HBsAg]</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• Total antibody to hepatitis B core antigen [total anti-HBc].....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• Hepatitis B “e” antigen [HBeAg]</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• IgM antibody to hepatitis B core antigen [IgM anti-HBc]</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• Nucleic Acid Testing for hepatitis B [Hep B NAT].....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• Antibody to hepatitis C virus [anti-HCV]</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td> – anti-HCV signal to cut-off ratio _____</td> <td></td> <td></td> <td></td> </tr> <tr> <td>• Supplemental anti-HCV assay [e.g., RIBA]</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• Antibody to hepatitis D virus [anti-HDV]</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>• Antibody to hepatitis E virus [IgM anti-HEV].....</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>		Pos	Neg	Unk	• Total antibody to hepatitis A virus [total anti-HAV].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• IgM antibody to hepatitis A virus [IgM anti-HAV].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Hepatitis B surface antigen [HBsAg]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Total antibody to hepatitis B core antigen [total anti-HBc].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Hepatitis B “e” antigen [HBeAg]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• IgM antibody to hepatitis B core antigen [IgM anti-HBc]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Nucleic Acid Testing for hepatitis B [Hep B NAT].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Antibody to hepatitis C virus [anti-HCV]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	– anti-HCV signal to cut-off ratio _____				• Supplemental anti-HCV assay [e.g., RIBA]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Antibody to hepatitis D virus [anti-HDV]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• Antibody to hepatitis E virus [IgM anti-HEV].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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• Antibody to hepatitis D virus [anti-HDV]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																		
• Antibody to hepatitis E virus [IgM anti-HEV].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																																		

LIVER ENZYME LEVELS AT TIME OF DIAGNOSIS • ALT [SGPT] Result _____ Upper limit normal _____ • Date of ALT result <u>MM / DD / YYYY</u> • AST [SGOT] Result _____ Upper limit normal _____ • Date of AST result <u>MM / DD / YYYY</u>	If this case has a diagnosis of hepatitis A that has not been serologically confirmed, is there an epidemiologic link between this patient and a laboratory-confirmed hepatitis A case? Yes No Unk <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
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DIAGNOSIS: (check all that apply)

<input type="checkbox"/> Acute hepatitis A	<input type="checkbox"/> Acute hepatitis C	<input type="checkbox"/> Chronic HBV infection	<input type="checkbox"/> Perinatal HBV infection
<input type="checkbox"/> Acute hepatitis B	<input type="checkbox"/> Acute hepatitis E	<input type="checkbox"/> HCV infection (Past or Present)	

Patient History — Acute Hepatitis B

Case ID: _____

<p>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?</p> <p style="text-align: right;">Yes No Unk</p> <p style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, type of contact</p> <p>Sexual..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Household (non-sexual)..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Other: _____</p>	<p>What is the sexual preference of the patient?</p> <p><input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual</p> <p><input type="checkbox"/> Bisexual <input type="checkbox"/> Unknown</p> <p>Ask both of the following questions regardless of the patient's gender.</p> <p>In the 6 months before symptom onset, how many</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;"></td> <td style="width: 5%; text-align: center;">0</td> <td style="width: 5%; text-align: center;">1</td> <td style="width: 5%; text-align: center;">2-5</td> <td style="width: 5%; text-align: center;">>5</td> <td style="width: 5%; text-align: center;">Unk</td> </tr> <tr> <td>• male sex partners did the patient have?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>• female sex partners did the patient have?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>Was the patient EVER treated for a sexually-transmitted disease?</p> <p style="text-align: right;">Yes No Unk</p> <p style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>• If yes, in what year was the most recent treatment? <u>Y Y Y Y</u></p>		0	1	2-5	>5	Unk	• male sex partners did the patient have?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	• female sex partners did the patient have?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<p>During the 6 weeks – 6 months prior to onset of symptoms</p> <p>Did the patient:</p> <ul style="list-style-type: none"> • undergo hemodialysis?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • have an accidental stick or puncture with a needle or other object contaminated with blood?..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • receive blood or blood products [transfusion] <p style="padding-left: 20px;">If yes, when? <u>MM / DD / YYYY</u></p> <ul style="list-style-type: none"> • receive any IV infusions and/or injections in the outpatient setting • have other exposure to someone else's blood..... <p style="padding-left: 20px;">specify: _____</p> <p>During the 6 weeks – 6 months prior to onset of symptoms</p> <ul style="list-style-type: none"> • Was the patient employed in a medical or dental field involving direct contact with human blood? <p style="padding-left: 20px;">If yes, frequency of direct blood contact?</p> <p style="padding-left: 40px;"><input type="checkbox"/> Frequent (several times weekly) <input type="checkbox"/> Infrequent</p> <ul style="list-style-type: none"> • Was the patient employed as a public safety worker (fire fighter, law enforcement or correctional officer) having direct contact with human blood?..... <p style="padding-left: 20px;">If yes, frequency of direct blood contact?</p> <p style="padding-left: 40px;"><input type="checkbox"/> Frequent (several times weekly) <input type="checkbox"/> Infrequent</p> <ul style="list-style-type: none"> • Did the patient receive a tattoo?..... <p style="padding-left: 20px;">Where was the tattooing performed? (select all that apply)</p> <p style="padding-left: 40px;"><input type="checkbox"/> commercial parlor/shop</p> <p style="padding-left: 40px;"><input type="checkbox"/> correctional facility <input type="checkbox"/> other _____</p>	<p>During the 6 weeks – 6 months prior to onset of symptoms</p> <ul style="list-style-type: none"> • inject drugs not prescribed by a doctor? • use street drugs but not inject?..... • Did the patient have any part of their body pierced (other than ear)? <p style="padding-left: 20px;">Where was the piercing performed? (select all that apply)</p> <p style="padding-left: 40px;"><input type="checkbox"/> commercial parlor/shop</p> <p style="padding-left: 40px;"><input type="checkbox"/> correctional facility <input type="checkbox"/> other _____</p> <ul style="list-style-type: none"> • Did the patient have dental work or oral surgery? • Did the patient have surgery ? (other than oral surgery)..... <p>Was the patient: (check all that apply)</p> <ul style="list-style-type: none"> • hospitalized?..... • a resident of a long term care facility?..... • incarcerated for longer than 24 hours <p style="padding-left: 20px;">if yes, what type of facility (check all that apply)</p> <p style="padding-left: 40px;">prison</p> <p style="padding-left: 40px;">jail</p> <p style="padding-left: 40px;">juvenile facility</p>																		
<p>Did the patient ever receive hepatitis B vaccine?.....</p> <p style="text-align: right;">Yes No Unk</p> <p style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p style="text-align: center;">1 2 3+</p> <p>If yes, how many shots?</p> <p style="padding-left: 20px;">• In what year was the last shot received? _____</p> <p>Was the patient tested for antibody to HBsAg (anti-HBs) within 1-2 months after the last dose</p> <p style="text-align: right;">Yes No Unk</p> <p style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>• If yes, was the serum anti-HBs ≥ 10mIU/ml?.....</p> <p style="padding-left: 20px;">(answer 'yes' if the laboratory result was reported as 'positive' or 'reactive')</p>	<p style="text-align: right;">Yes No Unk</p> <p>During his/her lifetime, was the patient EVER incarcerated for longer than 6 months?</p> <p style="text-align: center;"><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>• If yes,</p> <p style="padding-left: 20px;">what year was the most recent incarceration? <u>Y Y Y Y</u></p> <p style="padding-left: 20px;">for how long? <u>MM M</u> (mos)</p> <p>Did patient have a negative HBsAg test within 6 months prior to positive test?.....</p> <p style="padding-left: 20px;">Verified test date: <u>MM / DD / YYYY</u></p> <p>Was the patient tested for hepatitis D?</p> <p>Did patient have a co-infection with hepatitis D?.....</p>																		

Perinatal Hepatitis B Virus Infection

Case ID: _____

<p>RACE OF MOTHER:</p> <p><input type="checkbox"/> Amer Ind or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Pacific Islander</p> <p><input type="checkbox"/> Other Race, specify: _____</p>	<p>ETHNICITY OF MOTHER:</p> <p>Hispanic.....<input type="checkbox"/></p> <p>Non-hispanic<input type="checkbox"/></p> <p>Other/Unknown.....<input type="checkbox"/></p>
<p>Was Mother born outside of United States?.....<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Was the Mother confirmed HBsAg positive prior to or at time of delivery? .. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p> • If no, was the mother confirmed HBsAg positive after delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p>Date of earliest HBsAg positive test result <u>MM</u> / <u>DD</u> / <u>YYYY</u></p>	<p>If yes, what country? _____</p>
<p>How many doses of hepatitis B vaccine did the child receive ? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+</p> <p> • When?</p> <p> • Dose 1 <u>MM</u> / <u>DD</u> / <u>YYYY</u></p> <p> • Dose 2 <u>MM</u> / <u>DD</u> / <u>YYYY</u></p> <p> • Dose 3 <u>MM</u> / <u>DD</u> / <u>YYYY</u></p>	
<p>Did the child receive hepatitis B immune globulin (HBIG)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p> <p> • If yes, on what date did the child receive HBIG? <u>MM</u> / <u>DD</u> / <u>YYYY</u></p>	

Patient History — Acute Hepatitis C

Case ID: _____

	Yes	No	Unk					
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?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		What is the sexual preference of the patient?			
If yes, type of contact					<input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual			
Sexual.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Bisexual <input type="checkbox"/> Unknown			
Household (non-sexual).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Ask both of the following questions regardless of the patient's gender.			
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		In the 6 months before symptom onset, how many	0	1	2-5
					• male sex partners did the patient have?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					• female sex partners did the patient have?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Was the patient EVER treated for a sexually-transmitted disease?	Yes	No	Unk
					• If yes, in what year was the most recent treatment? <u>Y Y Y Y</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
During the 2 weeks – 6 months prior to onset of symptoms					During the 2 weeks – 6 months prior to onset of symptoms			
Did the patient:					• inject drugs not prescribed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• undergo hemodialysis?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		• use street drugs but not inject?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• have an accidental stick or puncture with a needle or other object contaminated with blood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Did the patient have a negative HCV antibody test within 6 months to a positive test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• receive blood or blood products [transfusion].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Verified test date <u>MM / DD / YYYY</u>			
If yes, when?					During the 2 weeks – 6 months prior to onset of symptoms			
• receive any IV infusions and/or injections in the outpatient setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		• Did the patient have any part of their body pierced (other than ear)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• have other exposure to someone else's blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		Where was the piercing performed? (select all that apply)			
specify: _____					<input type="checkbox"/> commercial parlor/shop			
During the 2 weeks – 6 months prior to onset of symptoms					<input type="checkbox"/> correctional facility			
• Was the patient employed in a medical or dental field involving direct contact with human blood ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> other _____			
If yes, frequency of direct blood contact?					• Did the patient have dental work or oral surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Frequent (several times weekly) <input type="checkbox"/> Infrequent					• Did the patient have surgery ? (other than oral surgery).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• 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"/>	<input type="checkbox"/>	<input type="checkbox"/>		Was the patient – (check all that apply)			
If yes, frequency of direct blood contact?					• hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Frequent (several times weekly) <input type="checkbox"/> Infrequent					• a resident of a long term care facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Did the patient receive a tattoo?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		• incarcerated for longer than 24 hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where was the tattooing performed? (select all that apply)					If yes, what type of facility (check all that apply)			
<input type="checkbox"/> commercial parlor/shop					prison	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> correctional facility <input type="checkbox"/> other _____					jail	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					juvenile facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Yes	No	Unk
					During his/her lifetime, was the patient EVER incarcerated for longer than 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					• If yes,			
					what year was the most recent incarceration? <u>Y Y Y Y</u>			
					for how long? <u>MM M</u> (mos)			
					Has the patient received medication for the type of hepatitis being reported?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient History — Chronic Hepatitis B Infection

Case ID: _____

The following questions are provided as a guide for the investigation of lifetime risk factors for HBV infection. Routine collection of risk factor information for persons who test HBV 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 HBV-infected persons.

	Yes	No	Unk		Yes	No	Unk
Did the patient receive clotting factor concentrates produced prior to 1987?	<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"/>
Was the patient ever on long-term hemodialysis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What is the birth country of the mother ? _____			
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"/>	Has the patient recieved medication for the type of hepatitis being reported?	<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"/>				

Patient History — Hepatitis C Infection (past or present)

Case ID: _____

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"/>	Has the patient recieved medication for the type of hepatitis being reported?	<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"/>				