<table>
<thead>
<tr>
<th>AGE (yrs) (41-42)</th>
<th>DATE OF BIRTH (Mo-Day-Yr)</th>
<th>SEX (49)</th>
<th>RACE (50)</th>
<th>ETHNICITY (51)</th>
<th>OCCUPATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>00 &lt; 1yr</td>
<td>10/01/1948</td>
<td>Male</td>
<td>American Indian or Alaskan Native</td>
<td>Hispanic</td>
<td>Unk</td>
</tr>
<tr>
<td>99 = Unk</td>
<td></td>
<td>Female</td>
<td>Asian or Pacific Islander</td>
<td>Non-Hispanic</td>
<td>Unk</td>
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<td>Black</td>
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<td>White</td>
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<td></td>
<td>Unk</td>
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</tbody>
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**Clinical Data**

<table>
<thead>
<tr>
<th>Date of diagnosis (54-59)</th>
<th>IgM Hepatitis A antibody (IgM anti-HAV) (69)</th>
<th>Hepatitis B surface antigen (HBsAg) (70)</th>
<th>Antibody to Delta (anti-HDV) (72)</th>
</tr>
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**Laboratory Results**

<table>
<thead>
<tr>
<th>Pos</th>
<th>Neg</th>
<th>Not Tested/Unk</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
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**For purposes of National Surveillance, Ask ALL OF THE FOLLOWING QUESTIONS FOR EVERY CASE OF HEPATITIS. These questions may help determine where the patient acquired his/her infection. Please refer to the work sheet on the back of the last page for additional questions.**

**During the 2-6 weeks prior to illness**

1. was the patient a child or employee in a nursery, day care center, or preschool? (73) 1 2 9
2. was the patient a household contact of a child or employee in a nursery, day care center, or preschool? (74) 1 2 9
3. was the patient a contact of a confirmed or suspected hepatitis A case? (75) 1 2 9
   If yes, type of contact: 1 Sexual 2 Household (non-sexual) 3 Other
4. was the patient employed as a food handler? (76) 1 2 9
5. did the patient eat raw shellfish? (78) 1 2 9
6. was the patient suspected as being part of a common-source foodborne or waterborne outbreak? (79) 1 2 9
7. did the patient travel outside of the U.S. or Canada? (80) 1 2 9
   If yes, where: 1 So./Central America (including Mexico) 2 Africa 3 Caribbean 4 Middle East 5 Asia/So. Pacific 6 Australia/New Zealand 7 Other
8. was the patient employed in a medical, dental or other field involving contact with human blood? (81) 1 2 9
   If yes, degree of blood contact: 1 Frequent (several times weekly) 2 Infrequent
9. did the patient receive blood or blood products (transfusion)? (82) 1 2 9
   If yes, specify date(s) received: (88-93) From ___/___/___ to ___/___/___
10. was the patient associated with a dialysis or kidney transplant unit? (83) 1 2 9
    If yes, (101) 1 Patient 2 Employee 3 Contact of patient or employee
11. did the patient use needles for injection of street drugs? (84) 1 2 9
12. did the patient use needles for injection of street drugs? (85) 1 2 9
13. was the patient's sexual preference? (90) 1 Heterosexual 2 Homosexual 3 Bisexual 9 Unk
14. how many different sexual partners did the patient have? (91) 1 None 2 One 3 2-5 4 More than 5 9 Unk
15. did the patient have
   - dental work or oral surgery? (105) 1 Yes 2 No 9 Unk tattooing? (106) 1 Yes 2 No 9 Unk
   - other surgery? (107) 1 Yes 2 No 9 Unk
   - acupuncture? (108) 1 Yes 2 No 9 Unk
   - has this patient ever received the three dose series of Hepatitis B vaccine? (109) 1 2 9

**During the 6-8 weeks prior to illness**

8. was the patient a contact of a confirmed or suspected acute or chronic hepatitis B or non-A, non-B case? (85) 1 2 9
   If yes, type of contact: (88) 1 Sexual 2 Household (non-sexual) 3 Other
9. was the patient employed in a medical, dental or other field involving contact with human blood? (89) 1 2 9
   If yes, degree of blood contact: (85) 1 Frequent (several times weekly) 2 Infrequent
10. did the patient receive blood or blood products (transfusion)? (90) 1 2 9
    If yes, specify date(s) received: (91-96) From ___/___/___ to ___/___/___
11. was the patient associated with a dialysis or kidney transplant unit? (92) 1 2 9
    If yes, (103) 1 Patient 2 Employee 3 Contact of patient or employee
12. did the patient use needles for injection of street drugs? (93) 1 2 9
13. was the patient's sexual preference? (101) 1 Heterosexual 2 Homosexual 3 Bisexual 9 Unk
14. how many different sexual partners did the patient have? (102) 1 None 2 One 3 2-5 4 More than 5 9 Unk
15. did the patient have
   - dental work or oral surgery? (105) 1 Yes 2 No 9 Unk tattooing? (106) 1 Yes 2 No 9 Unk
   - other surgery? (107) 1 Yes 2 No 9 Unk
   - acupuncture? (108) 1 Yes 2 No 9 Unk
   - has this patient ever received the three dose series of Hepatitis B vaccine? (109) 1 2 9

**Has this patient ever received the three dose series of Hepatitis B vaccine?**

If yes, was the antibody test: (110) 1 Pos 2 Neg 3 Unknown

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<thead>
<tr>
<th>CDC 53.1 Rev. 6-93</th>
<th>Investigator's Name</th>
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WORK SHEET
CASE DEFINITION FOR REPORTING OF ACUTE VIRAL HEPATITIS

Illness with: 1) discrete onset of symptoms and 2) jaundice or elevated serum aminotransferase levels.

Hepatitis A: IgM anti-HAV positive.

Hepatitis B: IgM anti-HBc positive if done or HBsAg positive and IgM anti-HAV negative if done.

Non-A, Non-B Hepatitis: 1) IgM anti-HAV negative, and 2) IgM anti-HBc negative if done or HBsAg negative, and 3) serum aminotransferase levels greater than 2 1/2 times the upper limit of normal.

Delta Hepatitis: 1) HBsAg or IgM anti-HBc positive and 2) Anti-HDV positive.

FOR USE BY LOCAL HEALTH DEPARTMENTS TO DETERMINE THE PATIENT’S MOST PROBABLE SOURCE OF INFECTION

Patient’s name_________________________ Home phone_________________________ Employed by_________________________ Work phone_________________________

Reporting physician’s name, address, and phone #___________________________________________________________

If patient was hospitalized for hepatitis, give name of hospital___________________________________________________________________________________________________________________________

Results of liver function tests: SGOT (AST)___________ SGPT (ALT)_____________ Bilirubin___________

IF APPLICABLE:

___________________________ Investigator’s Name and Title___________________________________________Date of Interview_______________

___________________________________________________________

FURTHER INFORMATION FOR ADMITTED RISK FACTORS AND SOURCES LISTED ON FRONT PAGE

IF APPLICABLE:

1. Name, address, and phone # of child care center__________________________________________________________

2. Name and address of school, grade, classroom attended________________________________________________

3. Name, address, and phone # of restaurant where food handler worked (HEPATITIS A ONLY)____________________

4. Food history of patient for the 2-6 wks prior to onset: (HEPATITIS A ONLY)
   a. name and location of restaurants_____________________________________________________________
   b. name and location of food stores_____________________________________________________________
   c. name and location of bakery______________________________________________________________
   d. group meals attended (e.g., reception, church, meeting, etc.)_________________________________
   e. location raw shellfish purchased__________________________________________________________

5. Name, address, and phone # of known hepatitis A or hepatitis B contact____________________________________

   __________________________________________________________ Relationship_________________________

6. CONTACTS REQUIRING PROPHYLAXIS FOR HEPATITIS A OR HEPATITIS B

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship to case</th>
<th>IG</th>
<th>HBIG</th>
<th>Vaccine</th>
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7. If transfused, NOTIFY BLOOD CENTER! Name of blood center_____________________________________________________
   a. number of units of whole blood, packed RBC or frozen RBC received______________________________
   b. specify type of blood product (e.g., albumin, fibrinogen, factor VIII, etc.)____________________

8. IF DONOR, name, address, and phone # of donor or plasmapheresis center______________________________

   __________________________________________________________ Date_________________________

9. Name, address, and phone # of dialysis center________________________________________________________

10. Name, address, and phone # of dentist or oral surgeon_______________________________________________

11. If other surgery performed, name, address, and phone # of location___________________________________

12. Name, address, and phone # of acupuncturist or tattoo parlor___________________________________________

13. Is patient currently pregnant?___________ If yes, give obstetrician’s name, address and phone #________
   a. estimated date and location of delivery________________________________________________________

Comments:__________________________________________________________________________________________

__________________________________________________________ ____________________________
Investigator’s Name and Title Date of Interview