

Patient History- Acute Hepatitis A

NETSS ID NO.

STATE CASE NO. _____

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 _____								
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.								
In the 2- 6 weeks before symptom onset how many				0	1	2-5	>5	Unk
• male sex partners did the patient have?				<input type="checkbox"/>				
• female sex partners did the patient have?				<input type="checkbox"/>				
In the 2- 6 weeks before symptom onset				Yes	No	Unk		
Did the patient inject street drugs?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Did the patient use street drugs but did not inject?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Did the patient 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) _____								
In the 3 months 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 - NOT 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 TWO WEEKS prior to onset of symptoms or while ill?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

VACCINATION HISTORY						
				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?				1	≥ 2	
				<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"/>
				<input type="text" value="Y"/>	<input type="text" value="Y"/>	<input type="text" value="Y"/>
				Yes	No	Unk
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	

STATE CASE NO. _____

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Patient History- Acute Hepatitis B

<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? Yes No Unk</p> <p>If yes, type of contact</p> <ul style="list-style-type: none"> • 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"/> 	<p>Ask both of the following questions regardless of the patient's gender.</p> <p>In the 6 months before symptom onset how many 0 1 2-5 >5 Unk</p> <ul style="list-style-type: none"> • 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"/> <p>Was the patient EVER treated for a sexually-transmitted disease? Yes No Unk</p> <p>• If yes, in what year was the most recent treatment? <u> YY YY </u></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? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • use street drugs but not inject? <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- Yes No Unk</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] <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 20px;">• if yes, when? <u> MM/DD/YY YY </u> • have other exposure to someone else's blood <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 20px;">specify: _____ <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? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 20px;">If yes, frequency of direct blood contact? <li style="padding-left: 40px;">Frequent (several times weekly) <input type="checkbox"/> Infrequent <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"/> <li style="padding-left: 20px;">If yes, frequency of direct blood contact? <li style="padding-left: 40px;">Frequent (several times weekly) <input type="checkbox"/> Infrequent <input type="checkbox"/> • Did the patient receive a tattoo? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 20px;">where was the tattooing performed? (select all that apply) <li style="padding-left: 40px;"><input type="checkbox"/> commercial <input type="checkbox"/> correctional <input type="checkbox"/> other _____ <li style="padding-left: 40px;">parlor / shop facility 	<p>During the 6 weeks- 6 months prior to onset of symptoms</p> <ul style="list-style-type: none"> • Did the patient have any part of their body pierced (other than ear)? <li style="padding-left: 20px;">where was the piercing performed? (select all that apply) <li style="padding-left: 40px;"><input type="checkbox"/> commercial <input type="checkbox"/> correctional <input type="checkbox"/> other _____ <li style="padding-left: 40px;">parlor / shop facility <li style="padding-left: 40px;">Yes No Unk • Did the patient have dental work or oral surgery? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Did the patient have surgery? (other than oral surgery) .. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • Was the patient- Check all that apply <li style="padding-left: 20px;">• hospitalized? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 20px;">• a resident of a long term care facility? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 20px;">• incarcerated for longer than 24 hours? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 40px;">if yes, what type of facility (check all that apply) <li style="padding-left: 60px;">prison <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 60px;">jail <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 60px;">juvenile facility <input type="checkbox"/> <input type="checkbox"/> <hr style="border-top: 1px dashed black;"/> <p>During his/her lifetime, was the patient EVER</p> <ul style="list-style-type: none"> • incarcerated for longer than 6 months? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> • If yes, <li style="padding-left: 20px;">what year was the most recent incarceration? <u> YYYY </u> <li style="padding-left: 20px;">for how long? <u> </u> <u> </u> <u> </u> <u> </u> mos
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<p>Did the patient ever receive hepatitis B vaccine? Yes No Unk</p> <p>If yes, how many shots?..... 1 2 3+ Unk</p> <p>• In what year was the last shot received? <u> YY </u> <u> YY </u> <u> YY </u> <u> YY </u></p>	<p>Was the patient tested for antibody to HBsAg (anti-HBs) within 1-2 months after the last dose? Yes No Unk</p> <p>• If yes, was the serum anti-HBs \geq 10mIU/ml? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>(answer 'yes' if the laboratory result was reported as 'positive' or 'reactive')</p>
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Patient History- Chronic Hepatitis B Virus Infection

The following questions are provided as a guide for the investigation of lifetime risk factors for HBV infection. Routine collection of risk factor information from persons with chronic HBV infection 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 and to prevent further transmission.

<p>Yes No Unk</p> <ul style="list-style-type: none"> • 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"/> 	<p>Yes No Unk</p> <ul style="list-style-type: none"> • Was the patient ever a contact of a person who had hepatitis? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 20px;">If yes, type of contact <li style="padding-left: 40px;">• Sexual <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 40px;">• Household [Non-sexual] <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <li style="padding-left: 40px;">• Other: _____ <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"/>
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Perinatal Hepatitis B Virus Infection

NETSS ID NO.

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

