Hepatitis C, Acute Past or Present Report Form

INTERVIEW

EpiTrax #: ____________________________  Interviewer Name: ____________________________

Number of Call Attempts: ________________  Date of Interview (must enter MM/DD/YYYY): ________

Follow-up Status:  
☐ Interviewed  
☐ Refused Interview  
☐ Lost to Follow-Up*

Respondent was:  
☐ Self  
☐ Parent  
☐ Spouse  
☐ Other, Specify: ____________________________

*At least three attempts at different times of the day should be made before the considered lost to follow-up.

DEMOGRAPHICS

Birth Gender:  
☐ Male  
☐ Female

Date of Birth: ________

Age: ________

Hispanic/Latino Origin:  
☐ Yes  
☐ No  
☐ Unknown

How would you describe your race?  
☐ White  
☐ Black/African American  
☐ American Indian/Alaska Native  
☐ Asian  
☐ Native Hawaiian/Other Pacific Islander  
☐ Other ________  
☐ Unknown

CLINICAL

What date did you start to have symptoms of illness?  
Onset Date: ________  Onset Time: ________

Date Diagnosed: __________________________

Were you hospitalized?  
☐ Yes  ☐ No  ☐ Unknown

If yes, were you hospitalized for hepatitis?  
☐ Yes  ☐ No  ☐ Unknown

Hospital Name: __________________________

Admission Date: ________ Discharge Date: ________

Died?  
☐ Yes  ☐ No  ☐ Unknown

If yes, date of death: __________________________

Died of hepatitis?  
☐ Yes  ☐ No  ☐ Unknown
Are you pregnant?  

- Yes  - No  - Unknown  

If yes, expected delivery date:  

**EPIDEMIOLOGICAL**

Occupation:  

**Is the patient a:**

**Healthcare Worker?**

- Yes  
- No  
- Unknown  

Facility Name:  
Address:  
Telephone #:  

Does the position involve direct contact with human blood?  

- Yes  - No  - Unknown  

Frequency of direct blood contact?  

- Frequent  
- Infrequent  
- Unknown  

Specify Health field:  

**Public Safety Officer?**

- Yes  
- No  
- Unknown  

Facility Name:  
Address:  
Telephone #:  

Does the position involve direct contact with human blood?  

- Yes  - No  - Unknown  

Frequency of direct blood contact?  

- Frequent  
- Infrequent  
- Unknown  

Specify Public Safety field:  

**Correctional facility?**

- Yes  
- No  
- Unknown  

Facility Name:  
Address:  
Telephone #:  

Association?  

- Employee  - Incarcerated  

Does the position involve direct contact with human blood?  

- Yes  - No  - Unknown  

Frequency of direct blood contact?  

- Frequent  
- Infrequent  
- Unknown
Group Living? □ Yes □ No □ Unknown

Facility Name: _____________________________
Address: ________________________________
Telephone #: _____________________________

If Yes to any above, did you work or attend while ill? □ Yes □ No □ Unknown

If Yes, Dates Worked or Attended/Notes: ____________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Imported from: □ Indigenous □ Outside U.S. □ Outside of County □ Out of State □ Unknown

INVESTIGATION

A. Symptoms & Signs

Reason for testing:

□ Symptoms of acute hepatitis
□ Screening of asymptomatic patient with reported risk factors
□ Screening of asymptomatic patient with no risk factors (e.g. patient requested)
□ Prenatal screening
□ Evaluation of elevated liver enzymes
□ Age appropriate screening (e.g., baby boomers)
□ Blood/organ donor screening
□ Follow-up testing for previous marker of viral hepatitis
□ Other, _________________________________
□ Unknown

Are you symptomatic? □ Yes □ No □ Unknown
Jaundiced? □ Yes □ No □ Unknown Onset date of jaundice: ________________
Dark Urine? □ Yes □ No □ Unknown
Diarrhea? □ Yes □ No □ Unknown
Anorexia? □ Yes □ No □ Unknown
Abdominal Pain? □ Yes □ No □ Unknown
Clay Stools? □ Yes □ No □ Unknown
Fatigue? □ Yes □ No □ Unknown
Other Symptoms? □ Yes □ No □ Unknown If yes, specify: ______________________

B. Liver Enzymes Level at Diagnosis

ALT [SGPT] Result: ______ ALT Upper Limit Normal: ______ Date of ALT Result: ______
AST [SGOT] Result: ______ AST Upper Limit Normal: ______ Date of AST Result: ______

C. Exposure – Risk Factors

● What year were you first diagnosed with hepatitis C? Year: ______________
● Have you ever been a contact of a person with a confirmed or suspected hepatitis C virus infection?
  □ Yes □ No □ Unknown
  ○ If yes, type of contact?
  □ Household Contact (non-sexual) □ Sexual Contact □ Other, specify:____________________
● In the past 6 months, how many male sex partners have you had? □None □1 □ 2-5 □ > 5
● In the past 6 months, how many female sex partners have you had? □None □1 □ 2-5 □ > 5
● How many sexual partners (both male and female) have you had in your lifetime? Approximate #: ______
● Have you ever used any type of substances illegally? □ Yes □ No
  ○ If yes, have you ever injected any of these substances?
    □ Yes □ No
      ▪ If yes, have you ever shared needles or other injection equipment? □ Yes □ No
      ▪ If yes, when was the last time you injected any of these substances? □ In the past 6 months □ More than 6 months ago
• Have you ever had a tattoo?
  
  o If yes, where was the tattoo performed (check all that apply)?
  
  o If yes, have you had a tattoo in the last 6 months?
    
    ▪ If yes, please specify

• Have you ever had a body piercing (other than ear)?
  
  o If yes, where was the piercing performed (check all that apply)?
  
  o If yes, have you had a body piercing in the last 6 months?
    
    ▪ If yes, please specify
- Did you receive a blood transfusion prior to 1992?
  - Yes
  - No
  - Unknown

- Did you receive clotting factor concentrates prior to 1987?
  - Yes
  - No
  - Unknown

- Have you ever received an organ transplant?
  - Yes
  - No
  - If yes, please specify

  Location #1:
  Year: __________________________
  Organ: __________________________
  Facility Name: __________________
  Provider Name: __________________
  City: __________________________

  Location #2:
  Year: __________________________
  Organ: __________________________
  Facility Name: __________________
  Provider Name: __________________
  City: __________________________

  Location #3:
  Year: __________________________
  Organ: __________________________
  Facility Name: __________________
  Provider Name: __________________
  City: __________________________

- Have you ever received long-term hemodialysis?
  - Yes
  - No
  - If yes, have you had hemodialysis within the last 6 months?
    - Yes
    - No
• If yes, where did you receive hemodialysis?
  
  Location #1:
  Facility Name: ________________
  City: ________________

  Location #2:
  Facility Name: ________________
  City: ________________

  Location #3:
  Facility Name: ________________
  City: ________________

• Have you ever received acupuncture?
  
  o If yes, have you had acupuncture within the last 6 months?
    
    □ Yes
    □ No

  • If yes, where did you receive acupuncture?
    
    Location #1:
    Facility Name: ________________
    City: ________________

    Location #2:
    Facility Name: ________________
    City: ________________

    Location #3:
    Facility Name: ________________
    City: ________________

• Have you ever donated blood?
  
  o If yes, when was the last time you donated blood (approximate month/year)?
    
    □ Yes
    □ No

    Month (1-12): ________________
    Year: ________________
    Name of Organization: ________________

• Do you currently have your blood monitored using a fingerstick/lancet device (e.g., glucose, cholesterol, PT/PTT, etc.)?
  
  □ Yes
  □ No

  o If yes, have you shared any testing equipment with another person?
    
    □ Yes
    □ No
• In the past 6 months have you had dental work/oral surgery?
  - Yes
  - No
  - If yes, please specify
    - Location #1:
      - Facility Name: ____________
      - Provider Name: ____________
      - City: ____________
      - Procedure type: ____________
    - Location #2:
      - Facility Name: ____________
      - Provider Name: ____________
      - City: ____________
      - Procedure type: ____________
    - Location #3:
      - Facility Name: ____________
      - Provider Name: ____________
      - City: ____________
      - Procedure type: ____________

• In the past 6 months have you had surgery (other than oral surgery)?
  - Yes
  - No
  - If yes, please specify
    - Location #1:
      - Facility Name: ____________
      - Provider Name: ____________
      - City: ____________
      - Procedure type: ____________
    - Location #2:
      - Facility Name: ____________
      - Provider Name: ____________
      - City: ____________
      - Procedure type: ____________
    - Location #3:
      - Facility Name: ____________
      - Provider Name: ____________
      - City: ____________
      - Procedure type: ____________
- In the past 6 months have you received any IV infusions and/or injections in an outpatient setting?
  - Yes
  - No
  - If yes, please specify

- In the past 6 months have you received blood or blood products (transfusion)?
  - Yes
  - No
  - If yes, please specify

- In the past 6 months have you been exposed to someone else’s blood?
If yes, what type of exposure was it?  
- □ Accidental puncture/stick with a needle  
- □ Other, specify: _______________

Please provide the circumstances of the exposure: _______________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Public Health Interventions (Check all that apply)

- □ Hygiene Education Provided  
- □ Daycare Inspection  
- □ Follow-up of other household member(s)  
- □ Work or Daycare restriction for case  
- □ Other

If other, specify: __________________________________________________________

That completes the interview, thank you for taking the time to answer all these questions. Your responses may be helpful in preventing others from becoming sick.

Additional notes: __________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________