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 Facility Name: ______________________________
☐ No Address: __________________________________
☐ Unknown 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 Facility Name: ______________________________
☐ No Address: __________________________________
☐ Unknown 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 Facility Name: ______________________________
☐ No Address: __________________________________
☐ Unknown 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?
  ☐Yes
  ☐No

  - If yes, where was the tattoo performed (check all that apply)?
    ☐ Commercial Shop
    ☐ Correctional Facility
    ☐ Private Residence
    ☐ Other, specify: ________________

  - If yes, have you had a tattoo in the last 6 months?
    ☐Yes
    ☐No

    - If yes, please specify

      Location #1:
      Facility Name:___________________
      City: _____________________________

      Location #2:
      Facility Name:___________________
      City: _____________________________

      Location #3:
      Facility Name:___________________
      City: _____________________________

- Have you ever had a body piercing (other than ear)?
  ☐Yes
  ☐No

  - If yes, where was the piercing performed (check all that apply)?
    ☐Commercial Shop
    ☐ Correctional Facility
    ☐ Private Residence
    ☐ Other, specify: ________________

  - If yes, have you had a body piercing in the last 6 months?
    ☐Yes
    ☐No

    - If yes, please specify

      Location #1:
      Facility Name:___________________
      City: _____________________________

      Location #2:
      Facility Name:___________________
      City: _____________________________

Location #3:

Facility Name:___________________

City: _____________________________

- 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?

☐Yes
☐No

  - 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?

☐ Yes
☐ No

  - If yes, when was the last time you donated blood (approximate month/year)?

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

  - 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

    Location #1:

    Facility Name:____________________

    Provider Name: _____________________

    City: _______________________________

    Location #2:

    Facility Name:____________________

    Provider Name: _____________________

    City: _______________________________

    Location #3:

    Facility Name:____________________

    Provider Name: _____________________

    City: _______________________________

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

    Location #1:

    Facility Name:____________________

    Provider Name: _____________________

    City: _______________________________

    Location #2:

    Facility Name:____________________

    Provider Name: _____________________

    City: _______________________________

    Location #3:

    Facility Name:____________________

    Provider Name: _____________________

    City: _______________________________

- In the past 6 months have you been exposed to someone else's blood?
  - ☐ Yes
  - ☐ No

- 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: ____

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