Hepatitis B virus infection, acute 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*

*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

Hispanic/Latino Origin: ☐ Yes ☐ No ☐ Unknown

How would you describe your race?

☐ White ☐ Black/African American ☐ Asian

☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander

☐ Other ________ ☐ Unknown

Date of Birth: ________

Age: ________

CLINICAL

Did you have any symptoms? ☐ Yes ☐ No ☐ Unknown

If yes, turn to page 3 and record specific symptoms under Investigation.

What date did you start to have symptoms of illness? Onset Date:__________ Date Diagnosed: __________

Did you recover? ☐ Yes ☐ No ☐ Unknown

Were you hospitalized? ☐ Yes ☐ No ☐ Unknown

If Yes, Recovery Date: __________

If Yes, Hospital Name:________________________________________

Time Recovered: __________

Admit date: __________ Discharge Date: __________
Died of Hepatitis?
☐ Yes  ☐ No  ☐ Unknown  
If Yes, Date of Death: ____________

Are you pregnant?
☐ Yes  ☐ No  ☐ Unknown  
If Yes, Expected Delivery Date: ____________

Has “Pregnancy Event” been created?  ☐ Yes  ☐ No

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**LABORATORY**

<table>
<thead>
<tr>
<th>Hepatitis B surface antigen:</th>
<th>☐ Positive  ☐ Negative  ☐ Not Tested</th>
</tr>
</thead>
<tbody>
<tr>
<td>IgM Hepatitis B core antigens:</td>
<td>☐ Positive  ☐ Negative  ☐ Not Tested</td>
</tr>
</tbody>
</table>

**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
□ Yes □ No □ Unknown

Does the position involve direct contact with human blood?

Frequency of direct blood contact? □ Frequent
□ Infrequent □ Unknown

Group Living? □ Yes Facility Name: _____________________________
□ No Address: _____________________________
□ Unknown 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
□ Blood/organ donor screening
□ Follow-up testing for previous marker of viral hepatitis
□ Other, specify: _____________________________
□ Unknown
Are you symptomatic? □ Yes □ No □ Unknown
Jaundiced? □ Yes □ No □ Unknown
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. Vaccination History

Did you ever receive the hepatitis B vaccine? □ Yes □ No □ Unknown

If No, is the patient 18 or younger? □ Yes □ No □ Unknown (If yes, skip to page 5)

If Yes, how many doses? □ 1 □ 2+ □ Unknown

If Yes, please provide dates:

Year of last vaccine: __________

Vaccination Date #1: ____________________ □ Unknown
Vaccination Date #2: ____________________ □ Unknown
Vaccination Date #3: ____________________ □ Unknown
Vaccination Date #4: ____________________ □ Unknown

Were you tested for antibody to HBsAG (anti-HBs) within 1-2 months after the last dose? □ Yes □ No □ Unknown

If yes, what was the result of the antibody test? □ Positive □ Negative □ Unknown
If patient was **18 or younger**, why were they not vaccinated?

- [ ] Born outside the United States
- [ ] Provider diagnosis of previous disease
- [ ] Never offered vaccine
- [ ] Parent/patient refusal
- [ ] Philosophical objection
- [ ] Other
- [ ] Lab evidence of previous disease
- [ ] Medical contraindication
- [ ] Parent/patient forgot to vaccinate
- [ ] Parent/patient report of previous disease
- [ ] Religious exemption
- [ ] Unknown

### C. Exposure – Risk Factors

- In the 6 weeks to 6 months prior to the onset of symptoms, have you been a contact of a person with suspected or confirmed hepatitis B?
  - [ ] Yes
  - [ ] No
  - [ ] Unknown
  - If yes, what type of contact was it?
    - [ ] Household contact (non-sexual)
    - [ ] Sexual contact
    - [ ] Other, __________________________

- In the 6 weeks to 6 months prior to the onset of symptoms, how many **male** sex partners have you had?
  - [ ] None
  - [ ] 1
  - [ ] 2-5
  - [ ] > 5

- In the 6 weeks to 6 months prior to the onset of symptoms, how many **female** sex partners have you had?
  - [ ] None
  - [ ] 1
  - [ ] 2-5
  - [ ] > 5

- In the 6 weeks to 6 months prior to the onset of symptoms, have you used any type of substances illegally?
  - [ ] Yes
  - [ ] No
  - If yes, have you injected any of these substances?
    - [ ] Yes
    - [ ] No
    - If yes, have you shared needles or other equipment?
      - [ ] Yes
      - [ ] No

- In the 6 weeks to 6 months prior to the onset of symptoms, have you received a tattoo?
  - [ ] Yes
  - [ ] No
  - If yes, where was the tattoo performed (check all that apply)?
    - [ ] Commercial Shop
    - [ ] Correctional Facility
    - [ ] Private Residence
    - [ ] Other, specify: __________________________
- In the 6 weeks to 6 months prior to the onset of symptoms, have you had any part of your body pierced (other than ear)?
  - If yes, where was the piercing performed (check all that apply)?
    - Commercial Shop
    - Correctional Facility
    - Private Residence
    - Other, specify: ________________
  - If yes, please specify

- In the 6 weeks to 6 months prior to the onset of symptoms, have you undergone hemodialysis?
  - If yes, please specify

<table>
<thead>
<tr>
<th>Location #1:</th>
<th>Facility Name: ________________</th>
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<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Location #2:</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
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<tr>
<th>Location #3:</th>
<th>Facility Name: ________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>City: _________________________</td>
</tr>
</tbody>
</table>

- Yes
- No
• In the 6 weeks to 6 months prior to the onset of symptoms, did you receive an organ transplant?
  
  o If yes, please specify

• In the 6 weeks to 6 months prior to the onset of symptoms, have you received acupuncture?
  
  o If yes, please specify

Location #1:
Facility Name:___________________
City:__________________________

Organ: _________________________
Facility Name:___________________
Provider Name:________________
City:__________________________

Location #2:
Facility Name:___________________
City:__________________________

Organ: _________________________
Facility Name:___________________
Provider Name:________________
City:__________________________

Location #3:
Facility Name:___________________
City:__________________________

Organ: _________________________
Facility Name:___________________
Provider Name:________________
City:__________________________

□ Yes
□ No

Location #1:
Facility Name:___________________
City:__________________________

Location #2:
Facility Name:___________________
City:__________________________

Location #3:
Facility Name:___________________
City:__________________________
- Have you ever donated blood?
  - If yes, when was the last time you donated blood (approximate month/year)?

- In the 6 weeks to 6 months prior to the onset of symptoms, did you have your blood monitored using a fingerstick/lancet device (e.g., glucose, cholesterol, PT/PTT, etc.)?
  - If yes, did you share any testing equipment with another person?

- In the 6 weeks to 6 months prior to the onset of symptoms, did you have dental work/oral surgery?
  - 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: ____________________

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: ____________

In the 6 weeks to 6 months prior to the onset of symptoms, did you have your blood monitored using a fingerstick/lancet device (e.g., glucose, cholesterol, PT/PTT, etc.)?

- Yes
- No

If yes, did you share any testing equipment with another person?

- Yes
- No

In the 6 weeks to 6 months prior to the onset of symptoms, did you have dental work/oral surgery?

- Yes
- No

If yes, please specify

Location #3:
Facility Name: ____________________
Provider Name: ____________________
City: ____________________________
Procedure type: ____________________
• In the 6 weeks to 6 months prior to the onset of symptoms, did you have any surgery (other than oral surgery)?

  ⮚ Yes
  ⮚ No

  o  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 6 weeks to 6 months prior to the onset of symptoms, have you received any IV infusions and/or injections in the outpatient setting?

  ⮚ Yes
  ⮚ No

  o  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 6 weeks to 6 months prior to the onset of symptoms, have you received blood or blood products (transfusion)?

  o If yes, please specify

☐ Yes
☐ No

Location #1:
Facility Name:___________________
Provider Name: ____________________
City: _____________________________

Location #2:
Facility Name:___________________
Provider Name: ____________________
City: _____________________________

Location #3:
Facility Name:___________________
Provider Name: ____________________
City: _____________________________

• In the 6 weeks to 6 months prior to the onset of symptoms, were you exposed to someone else’s blood?

  o If yes, what type of exposure was it?

☐ Yes
☐ No

☐ Accidental puncture/stick with a needle
☐ Other, specify: _______________

  o 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: ____________________________________________________________

__________________________________________________________________________

__________________________________________________________________________