Kansas Department of Health and Environment
Epidemiology and Public Health Informatics

Hepatitis B virus infection, chronic 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.

Respondent was:
- ☐ Self
- ☐ Parent
- ☐ Spouse
- ☐ Other, *Specify:*_____

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

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:_____ Onset Time:_____

Date Diagnosed: _____

Did you recover?
- ☐ Yes
- ☐ No
- ☐ Unknown

If Yes, Recovery Date: _____

Time Recovered: _____

Were you hospitalized?
- ☐ Yes
- ☐ No
- ☐ Unknown

If Yes, Hospital Name:_____

Admit date: _____ Discharge Date: _____

Patient Died?

☐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

LABORATORY

Hepatitis B surface antigen:	☐ Positive	☐ Negative	☐ Not Tested
IgM Hepatitis B core antigens:	☐ Positive	☐ Negative	☐ Not Tested

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 #: _____

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, _____
☐ 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

- What year were you first diagnosed with hepatitis B? Year: _____

- Have you ever been a contact of a person with a confirmed or suspected hepatitis B virus infection?
  - ☐ Yes
  - ☐ No
  - ☐ Unknown
  - If yes, type of contact?
    - ☐ Household Contact (non-sexual)
    - ☐ Sexual Contact
    - ☐ Other, specify:_____
- How many male sex partners have you had?
  - ☐ None
  - ☐ 1
  - ☐ 2-5
  - ☐ > 5
- How many female sex partners have you had?
  - ☐ None
  - ☐ 1
  - ☐ 2-5
  - ☐ > 5
- 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

      <u>Location #1:</u>

      Facility Name:_____

      City: _____

      <u>Location #2:</u>

      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 the 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: _____

_____

_____