



Public Health
Prevent. Promote. Protect.

Muskegon County

209 E. Apple Avenue, Muskegon, Michigan 49442

Confidential Fax: 231-724-1325

Person Requesting Information:		Doctor:	
Phone:		Address:	
Date of Request:		City/Zip Code:	
PLEASE RETURN BY FAX AS SOON AS POSSIBLE		Phone:	Fax:

Hepatitis Questionnaire

Client Information:	Name:	DOB: / /	Race:	Address:	Old db: <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:	Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No	City/Zip:	Date: / /

Total Antibody, Hepatitis A Virus (total anti-HAV):	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	Antibody to Hepatitis C Virus (Anti-HCV):	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
IgM Antibody to Hepatitis A Virus (total anti-HAV):	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	Supplemental Anti-HCV Assay (e.g. RIBA):	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
Hepatitis B Surface Antigen (HbsAg):	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	HCV RNA (e.g. PCR):	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
Total Antibody, Hepatitis B Core Antigen (total anti-HBc):	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	Antibody to Hepatitis D Virus (Anti-HDV):	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
IgM Antibody, Hepatitis B Core Antigen (IgM anti-HBc):	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	Antibody to Hepatitis E Virus (Anti-HEV):	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown

Results/Liver Enzyme Levels at Time of Diagnosis – Date of Result: / /

ALT(SGPT): / *Range of Normal:* AST/SGOT: *Range of Normal:*

Diagnosis: (check all that apply)

- Acute Hepatitis A
- Acute Hepatitis B
- Acute Hepatitis C
- Acute Hepatitis E
- Chronic Hepatitis B
- Chronic Hepatitis C or Resolved
- Acute non-ABCD Hepatitis
- Prenatal HBV Infection
- Hepatitis Delta (Co – or Super Infection)

Reason for Testing: (check all that apply)

- Symptoms of Acute Hepatitis
- Screening of Asymptomatic Patient with Reported Risk Factors
- Screening of Asymptomatic Patient with No Risk Factors
- Prenatal Screening
- Evaluation of Elevated Liver Enzymes
- Blood/Organ Donor Screening
- Follow-up Testing for Previous Marker of Viral Hepatitis
- Unknown

Patient Information:

- Is the Patient Symptomatic? Yes No Unknown
- Is/Was the Patient Jaundiced? Yes No Unknown
- Is/Was the Patient Pregnant? Yes No Unknown
- If yes, Date of Delivery: / /
- Is/Was the Patient Hospitalized? Yes No Unknown
- If yes – Admission Date: / / ; Discharge Date: / /
- Place of Birth: USA Other Unknown
- Did the Patient Die from Hepatitis? Yes No Unknown – If yes – date: / /

Risk Factors Leading to Infection

- | | |
|--|--|
| <ul style="list-style-type: none"> Did the Patient Receive a Blood Transfusion Prior to 1992? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the Patient Receive an Organ Transplant Prior to 1992? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Was the Patient Ever on Long-Term Hemodialysis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Was the Patient Ever Incarcerated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the Patient Receive Clotting Factor Concentrates Produced Prior to 1992? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Has the Patient Ever Injected Drugs Not Prescribed by a Doctor Even if Only Once? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | <ul style="list-style-type: none"> How Many Sex Partners has the Patient Had in a Lifetime? _____ Was the Patient Ever Treated for Sexually Transmitted Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the Patient Ever Work in the Medical Field and Have a Blood Exposure? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Was the Patient Ever a Contact to a Person who had Hepatitis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes – contact type: <input type="checkbox"/> Sexual <input type="checkbox"/> Household <input type="checkbox"/> Other _____ |
|--|--|

Follow-up Plans or Referrals:	Date: / /
Person Completing This Form: _____	