Hepatitis D Questionnaire

Division of Viral Hepatitis, Centers for Disease Control and Prevention

For CDC Use only:	
HDMI ID# _____	**Date Specimen Received: ____ / ____ / _____**

Type of specimen: serum/plasma/other (specify):_____
Date specimen collected: _____ /_____ /_____

Requesting Physician/Healthcare Provider/Public Health Department Contact

Name of requesting physician/healthcare provider:_____
Phone: (_____) ____-_____ Fax: (_____) ____-_____ E-mail: _____@_____
Facility or practice name: _____
Phone: (_____) ____-_____ Fax: (_____) ____-_____ E-mail:_____@_____

Patient Information

Medical Record #:_____ Last name:_____ First name: _____

City: _____ State: ____ Postal Code: _____-_____
DOB: _____ /_____ /_____ or Age: _____ (years) Sex: ☐Male ☐Female

If born outside of US, state country of birth: _____ What year did patient move to US: _____

Ethnicity/race:
☐White ☐Black ☐Hispanic ☐East Asian ☐Alaskan Native ☐American Indian ☐Native Hawaiian ☐Mongolian
☐South Asian ☐Middle Eastern ☐South American ☐ Pacific Islander ☐Other *(specify)* _____

Hepatitis B vaccination: ☐Yes ☐No ☐Not known If vaccinated, approximate year: _____

Results from viral hepatitis serologic and NAT testing

	HBsAg (pos/neg)	HBeAg (pos/neg)	Anti-HBe (pos/neg)	Total anti-HBc (pos/neg)	Anti-HBc IgM (pos/neg)	Anti-HBs (pos/neg)	Anti-HBs (IU/ml)	HBV DNA (IU/mL)	Anti-HCV IgG (pos/neg)	HCV RNA (IU/mL)
Result										
Sample date										

	Total anti-HDV (pos/neg)	Anti-HDV IgM (pos/neg)	HDAg (pos/neg)	HDV RNA (pos/neg)	Anti-HAV IgM (pos/neg)	Total anti-HAV (pos/neg)	Anti-HEV IgM (pos/neg)	Anti-HEV IgG (pos/neg)
Result								
Sample date								

Liver Function Tests
Most recent values known of: ALT (SGPT) _____U/L AST (SGOT) _____U/L Bilirubin _____mg/dL
Sample date: _____ /_____ /_____ _____ _____ /_____ /_____ _____ _____ /_____ /_____ _____

Details of current illness

Date of onset of illness: _____ /_____ /_____

Signs and Symptoms (check all that apply):

☐Scleral icterus ☐Dark urine ☐Hepatomegaly ☐Abdominal pain ☐Diarrhea ☐Fever ☐Arthralgia ☐Rash ☐Other *(specify)*_____

Has patient been previously diagnosed with hepatitis B: ☐Yes ☐No ☐Not known

If yes: date of diagnosis? _____ /_____ /_____

Has patient a liver biopsy: ☐Yes ☐No ☐Not known

If Yes: stage:_____ grade: _____ when: _____ /_____ /_____

Did patient have cirrhosis by imaging or laboratory testing? ☐Yes ☐No ☐Not known

Did patient have liver cancer by imaging tests or biopsy? ☐Yes ☐No ☐Not known

Was patient hospitalized? ☐Yes ☐No

*If Yes: what was duration of hospitalization (in days?)*_____

Did patient develop liver failure? ☐Yes ☐No

Did patient die? ☐Yes ☐No

If Yes: what was date of death? _____ /_____ /_____

did patient die from liver failure? ☐*Yes* ☐*No*

*If No: what was the cause of death?*_____

Has patient ever received an organ/tissue transplant? ☐Yes ☐No ☐Not known

If Yes: what organ/tissue? _____ *Date of transplant:* _____ /_____ /_____ ☐*Not known*

Is patient on immunosuppressive therapy? ☐Yes ☐No ☐Not known

If Yes: specify medications _____

Has patient ever received blood transfusion? ☐Yes ☐No ☐Not known

If Yes: date of last transfusion: _____ /_____ /_____

Has patient ever received blood product(s)? ☐Yes ☐No ☐Not known

*If Yes: what product(s)?*_____ *Date received:* _____ /_____ /_____ ☐*Not known*

Additional Patient History

What is patient's primary occupation? _____

Have any family members been diagnosed with chronic hepatitis B and/or hepatitis D? ☐Yes ☐No ☐Not known

During the **3 months** prior to illness, did patient receive any:

prescribed Injection	☐Yes	☐No	☐Not known	surgery	☐Yes	☐No	☐Not known
hemodialysis	☐Yes	☐No	☐Not known	dental procedure	☐Yes	☐No	☐Not known

During the **3 months** prior to illness, did patient inject drugs not prescribed by a doctor? ☐Yes ☐No ☐Not known

If Yes: was needle sharing involved? ☐Yes ☐No ☐Not known

During the **patient's lifetime,** did patient inject drugs not prescribed by a doctor? ☐Yes ☐No ☐Not known