DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-02241 (03/2018)

STATE OF WISCONSIN
Bureau of Communicable Diseases

HEPATITIS A WORKSHEET
CONFIRMED AND SUSPECTED CASES

INSTRUCTIONS: Enter responses in WEDSS or fax completed worksheet to the Bureau of Communicable Diseases at (608) 261-4976 or submit with the Acute & Communicable Disease Case Report, F-44151.

PATIENT INFORMATION

Patient Name *(last, first, middle initial)*

Current Age	Date of Birth	Sex ☐ Male ☐ Female

Street Address

City	Zip Code	County

Telephone: Home	Work	Cell

Race	☐ White ☐ Black ☐ Native American/Native Alaskan ☐ Asian (specify): ☐ Native Hawaiian/Other Pacific Islander ☐ Other:
Ethnicity	☐ Hispanic ☐ Non-Hispanic

*Occupation (Specify if multiple jobs)	Last day worked or attended school or day care

* Note: If patient is a food-handler, childcare provider, health care worker, or works with the developmentally disabled, fill out the high-risk occupation questionnaire in addition to this one.

Employer/School/Daycare - Name — If School specify grade

Address

Patient's Physician Name	Address

Hep A Vaccination History ☐ None Vx 1 date: Vx2 date:

SYMPTOM AND SIGNS HISTORY

Onset date of first symptoms: _____ or Date of onset of jaundice _____

Symptoms or signs (check all that apply)

☐ Fever ☐ Nausea ☐ Diarrhea
☐ Fatigue ☐ Dark urine ☐ Jaundice
☐ Other _____

LABORATORY RESULTS

Date blood drawn for hepatitis testing

Liver enzyme values:
SGPT(ALT) _____
SGOT (AST) _____
Other test(s) _____

HAV serology results (check one)

☐ Total HAV positive, IgM positive ☐ Total HAV positive, IgM negative
☐ Total HAV antibody negative ☐ Pending
☐ Not done / unknown

EXPOSURE HISTORY

Use a calendar to establish the dates 50 days and 15 days prior to onset of first symptoms. This establishes the time-period during which the patient became infected.

Date 50 days prior to onset: _____ **Date 15 days prior to onset:** _____

Use this **time interval above** to answer the following questions. It may be helpful for the patient to consult his/her personal or business calendar to assist recall.

If the patient cannot recall specific meals/drinks or items purchased at restaurants/bars, grocery stores, or bakery visits, ask which establishments they would have been most likely to frequent. Attach additional pages if necessary.

Restaurants and bars (where foods were eaten or beverages consumed during this time-period)

Name	City	Date(s)	Food(s) Eaten / Drink(s) Consumed

Grocery store or bakeries (where food was purchased during this time-period)

Name	City	Date(s)	Items purchased

Group Meals (Potlucks, dinner parties, meals on wheels, etc. attended during this time-period)

Type of function	City	Date(s)	Describe what was consumed

During this time, did patient consume raw shellfish? ☐ Yes ☐ No

During this time, did patient travel outside of U.S.A.
☐ Yes ☐ No If Yes, specify place and date(s)

Did anyone in patient's household travel outside of U.S.A. before patient's onset?
☐ Yes ☐ No If Yes, specify place and date(s)

If patient traveled, did they receive IG or hepatitis A vaccine prior to travel? ☐ Yes ☐ No Date received:

During this time, did patient travel outside of Wisconsin?
☐ Yes ☐ No If Yes, specify place and date(s)

EXPOSURE HISTORY (continued)

During this period, did patient have contact with other confirmed/suspected cases of hepatitis A, or with other persons who were sick with similar symptoms? ☐ Yes ☐ No

If yes, list names, date(s) of contact, and nature of contact (e.g. family member, dinner party, social gathering, sexual partner, etc.)

Name	Date(s)	Nature of contact

During this period, was the patient an attendee or employee of a day care center or preschool? ☐ Yes ☐ No

If yes, name and location of the day care/preschool(s)

Name	Location	Date last attended/worked	Day care or Preschool

During this period, did the patient have contact with young children (< 6 years of age)? ☐ Yes ☐ No

If yes, list name and address of child(ren), and day care attended below.

Name(s) of Child(ren)	Address	Date of contact	Name of day care attended

What is the source of patient's drinking water? ☐ Private well ☐ Municipal water supply

During this period, did the patient receive blood or blood products? ☐ Yes ☐ No

During this period, did the patient use illegal drugs including marijuana? ☐ Yes ☐ No If yes, describe and specify injecting or non-injecting drug use.

For males only

During this period, have you had sexual contact with another man? ☐ Yes ☐ No

TRANSMISSION

Use a calendar to establish the dates 14 days prior to onset of symptoms and 10 days after onset. This establishes the time-period during which the patient been infectious to others.

Date 14 days prior to onset: _____ **Date 10 days after onset:** _____

During this infectious period, did patient prepare or handle food, consumed at any gatherings by people outside of the patient's household (e.g. school parties, potlucks; bringing food to worksite, dinner parties etc.)?
☐ Yes ☐ No If yes, please list below.

Occasion	Location	Food(s) handled	Date(s)

List all of the patient's household contacts, work contacts, and other close or intimate contacts, that the patient was with during the infectious period. Indicate whether these contacts work in food service, work/attend day care or pre-school, or work in health care.

In the last column, provide the date that contact received immune globulin or hepatitis A vaccine. Indicate if none given

Name of Contact	Age	Food Service	Day care/ Pre-school	Health care	IG/Vx Date given	
		☐	☐	☐		☐ None
		☐	☐	☐		☐ None
		☐	☐	☐		☐ None
		☐	☐	☐		☐ None
		☐	☐	☐		☐ None
		☐	☐	☐		☐ None

For these close contacts above who attend or work in these high-risk environments listed above, list the name and location of the food service, day care/preschool, or health care.

Name of Food Service/Day care/Pre-school or Health Care	Location

Name/Agency of Interviewer	Date of Interview

Clear Entire Form