

E. RISK FACTORS

<p>26. Did the patient have a contact history of jaundice during the last 6 months? <input type="checkbox"/> 1. yes <input type="checkbox"/> 2. no <input type="checkbox"/> 3. not known</p> <p>27. If yes, where? <input type="checkbox"/> 1. home <input type="checkbox"/> 2. neighbourhood <input type="checkbox"/> 3. school <input type="checkbox"/> 4. working place <input type="checkbox"/> 5. not known <input type="checkbox"/> 6. other (specify) </p> <p>28. Has the patient shared razors or syringes with other people? <input type="checkbox"/> 1. yes <input type="checkbox"/> 2. no <input type="checkbox"/> 3. not known</p>	<p>29. Does the patient have any tattoos? <input type="checkbox"/> 1. yes <input type="checkbox"/> 2. no <input type="checkbox"/> 3. not known</p> <p>30. Had the patient been administered any injections (including immunization or other parenteral interventions) during the last 6 months? <input type="checkbox"/> 1. yes <input type="checkbox"/> 2. no <input type="checkbox"/> 3. not known</p> <p>31. If 'yes', where? <input type="checkbox"/> 1. hospital <input type="checkbox"/> 2. private sector <input type="checkbox"/> 3. other (specify): </p>	<p>32. Has the patient had any surgical or dental intervention during the last 6 months? <input type="checkbox"/> 1. yes <input type="checkbox"/> 2. no <input type="checkbox"/> 3. not known</p> <p>33. If "yes", where? <input type="checkbox"/> 1. hospital <input type="checkbox"/> 2. private sector <input type="checkbox"/> 3. not known <input type="checkbox"/> 4. other (specify)</p> <p>34. Specify the intervention:</p>
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F. PERSONAL AND DOMESTIC HYGIENE

<p>35. Water supply <input type="checkbox"/> 1. pipe <input type="checkbox"/> 2. own well <input type="checkbox"/> 3. common well <input type="checkbox"/> 4. stream/ river <input type="checkbox"/> 5. other (specify)</p>	<p>36. Type of drinking water <input type="checkbox"/> 1. boiled <input type="checkbox"/> 2. unboiled <input type="checkbox"/> 3. other (specify)</p>	<p>37. Type of latrine <input type="checkbox"/> 1. flush <input type="checkbox"/> 2. water seal <input type="checkbox"/> 3. pit <input type="checkbox"/> 4. no latrine <input type="checkbox"/> 5. other (specify)</p>
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G. VACCINATION STATUS

38. Has the patient received vaccination against hepatitis in the past? 1. yes 2. no 3. not known

39. If yes, type of vaccine:	Date of immunization (dd/mm/yy)	Place of immunization*
<input type="checkbox"/> Hepatitis A		
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> 1 st dose	
	<input type="checkbox"/> 2 nd dose	
	<input type="checkbox"/> 3 rd dose	

* MOH office / government hospital / PHM Field clinic / private hospital / clinic / GP / not known / other

H. FURTHER INFORMATION

40. Presence of risk factors (eg. alcohol and drug use, unsafe sex, family history of hepatitis, recent gathering/attending festivals, etc.)

41. The most likely route(s) of transmission in this case as judged by the officer (more than one response is allowed):

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> 1. water | <input type="checkbox"/> 2. food | <input type="checkbox"/> 3. person to person |
| <input type="checkbox"/> 4. parenteral | <input type="checkbox"/> 5. sexual | <input type="checkbox"/> 6. perinatal |

42. Remarks:

Signature: Name:

Date: Designation:

Please return to:

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