

HEPATITIS B TESTING REGISTRATION



A) CLIENT INFORMATION

Last (family) Name	M.I.	First (given) Name	Date of Birth (MM/DD/YY) / /	Other ID
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	Ethnicity <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Thai <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Other API : _____			
Primary Language(s)	How many people live in your household in addition to yourself?			
Country of Birth	Year Arrived in US	Mother's Country of Birth	Father's Country of Birth	

B) CONTACT INFORMATION

Home Phone Number (<i>with area code</i>) ()		Work Phone ()	Cell Phone ()	
Street Address	Apt #	City	State	Zip Code
E-mail address		Preferred Primary Contact <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> E-mail		

C) QUESTIONS

Have you ever been vaccinated for Hepatitis A?	Yes	No	Not Sure	If yes, how many?
Have you ever had a blood test for Hepatitis B?	Yes	No	Not Sure	If yes, do you know your test result?
Have you ever been vaccinated for Hepatitis B?	Yes	No	Not Sure	If yes, how many?
Has a doctor ever told you that you have Hepatitis B?	Yes	No	Not Sure	
Does anyone in your family have or had Hepatitis B?	Yes	No	Not Sure	If yes, who?
Have you ever had a blood test for Hepatitis C?	Yes	No	Not Sure	If yes, do you know your test result?
Has a doctor ever told you that you have Hepatitis C?	Yes	No	Not Sure	
Have you ever been tested for liver disease?	Yes	No	Not Sure	If yes, do you know your test result?
Do you have a family history of Liver Cancer?	Yes	No	Not Sure	If yes, who?
Do you have health insurance?	Yes	No	Not Sure	If yes, name of insurance company
Do you currently have a primary care doctor?	Yes	No	Not Sure	If yes, name & city of provider

DO NOT COMPLETE NEXT SECTION (CLINIC USE ONLY)

Date of Screening	HepBsAg Status	HepBsAb Status	Lab Requisition #	Date client contacted or results mailed