Baseline Evaluation (Adult)

Patient ID __ __ - __ **ID** __ - __ __ __

Date of Evaluation: **DOEDATE**

Screening Log Reference: Page **PNUM** Line **LNUM**

SECTION I: DEMOGRAPHICS

1. Patient's country of birth: _ **CBORN** _ (Code) ___ **CBORNS** ____ (Country) *(enter code or country)* ☐ Unknown

   If not born in the United States or Canada, year patient came to U.S. or Canada *(yyyy)*: **CAMEUSY** ☐ Unknown

2. Patient's parents countries of birth:
   a. Birth Mother _ **CBORNM** _ ___ **CBORNMS** _ *(enter code or country)* ☐ Unknown
   b. Birth Father _ **CBORNF** _ (Code) ____ **CBORNFS** (Country) _ *(enter code or country)* ☐ Unknown

3. Highest level of school completed *(check only one)*: **EDUC**

   1 ☐ None or some grade school
   2 ☐ Grade school
   3 ☐ Some high school
   4 ☐ High school diploma or equivalent (GED)
   5 ☐ Some college, no degree
   6 ☐ Vocational or Technical School
   7 ☐ Associate (2 year) degree
   8 ☐ Bachelor's degree
   9 ☐ Master's degree
   10 ☐ Doctoral degree
   11 ☐ Other degree: ____ **EDUCOS** ___
   ☐ Prefer not to answer

4. Current employment status *(check only one)*: **WORK**

   1 ☐ Employed at a job for pay, full-time
   2 ☐ Employed at a job for pay, part-time
   3 ☐ Homemaker, not currently working for pay
   4 ☐ Not currently employed, retired
   5 ☐ Not currently employed, not retired
   6 ☐ Other: _____ **WORKOS** _____

   If 1 or 2, go to question 4.1
   If 3, 4, or 5, go to question 4.3

   ☐ Prefer not to answer

   4.1 Are you employed outside of the home? **HEMP** ☐ Yes ☐ No

   4.2 Have you had to reduce the number of hours that you work in an average week because of your hepatitis B? **REDHR** ☐ Yes ☐ No

   4.3 Did you stop working because of your hepatitis B? **ENDWORK** ☐ Yes ☐ No

5. Method of insurance *(check all that apply)*:

   ☐ Medicaid **INSMEDCD**
   ☐ Medicare **INSMEDCR**
   ☐ Tricare **INSTRIC**
   ☐ Government (not Medicaid/Medicare/Tricare) **INSGOV**
   ☐ Private **INSPRIV**
   ☐ Other **INSOTH**, specify ____**INSOTHS**_____
   ☐ None / self pay **INSNONE**
   ☐ Prefer not to answer **INSPNTA**

SECTION II: FAMILY HISTORY

1. Presence of chronic hepatitis B (HBsAg positivity) in family members: ☐ Yes ☐ No ☐ Unknown **HXHBV**
   If Yes, *(check all that apply)*

   ☐ mother **HXHBVM** ☐ father **HXHBVF** ☐ siblings **HXHBVS** ☐ children **HXHBVC** ☐ spouse/partner **HXHBVP** ☐ aunts/uncles **HXHBVA** ☐ grandparents **HXHBVG**

2. Liver cancer in family members: ☐ Yes ☐ No ☐ Unknown **HXHCC**
   If Yes, *(check all that apply)*

   ☐ mother **HXHCCM** ☐ father **HXHCCF** ☐ siblings **HXHCCS** ☐ children **HXHCCC** ☐ aunts/uncles **HXHCCA** ☐ grandparents **HXHCCG**

3. Diabetes in family members: ☐ Yes ☐ No ☐ Unknown **HXDIAB**
   If Yes, *(check all that apply)*

   ☐ mother **HXDIABM** ☐ father **HXDIABF** ☐ siblings **HXDIABS** ☐ children **HXDIABC** ☐ aunts/uncles **HXDIABA** ☐ grandparents **HXDIABG**

SECTION III: MEDICAL HISTORY

1. Do you have or are you being treated for:

	Yes	No	Unknown	
a. Diabetes	☐	☐	☐	**MXDIAB**
b. Hypertension	☐	☐	☐	**MXHYPT**
c. Hyperlipidemia	☐	☐	☐	**MXCHOL**
d. Infections				
i. HCV	☐	☐	☐	**MXHCV**
ii. HDV	☐	☐	☐	**MXHDV**
e. Other liver disease				
i. Alcoholic	☐	☐	☐	**MXALC**
ii. Non-alcoholic fatty liver disease	☐	☐	☐	**MXNASH**
iii. Autoimmune	☐	☐	☐	**MXAUTO**
iv. Genetic/metabolic	☐	☐	☐	**MXMETAB**
v. Cirrhosis (if Yes, complete FE form)	☐	☐	☐	**MXCIRR**
f. Glomerulonephritis	☐	☐	☐	**MXGN**
g. Vasculitis / Polyarteritis Nodosa	☐	☐	☐	**MXVASC**
h. Malignancy (other than HCC)	☐	☐	☐	**MXMAL**

specify _____ **MXMALS** _____

SECTION IV: MEDICATION HISTORY

1. Is the patient currently taking medication for any of the following reasons? ☐ Yes ☐ No **MEDHX**
   If Yes, *(check all that apply)*

☐ Immunosuppressants **MEDIMM** ☐ Lipid-lowering agents **MEDLIP** ☐ Anticoagulants **MEDCOAG**
☐ Anti-hypertensive agents **MEDHYP** ☐ Anti-diabetic agents **MEDDIAB** ☐ Estrogen/birth control pills **MEDEST**
☐ Other antivirals (e.g. famciclovir) **MEDOTH**

2. Is the patient currently taking any herbs, "natural" or herbal medications? ☐ Yes ☐ No ☐ Unknown **MEDHERB**
3. Is the patient currently taking vitamins or minerals? ☐ Yes ☐ No ☐ Unknown **MEDVIT**
   If Yes, *(check all that apply)*

☐ Multi-vitamin **VITMULT** ☐ Vitamin D **VITD** ☐ Vitamin E **VITE** ☐ Folate **VITFOL** ☐ Iron **VITFE** ☐ Calcium **VITCA** ☐ Other **VITOTH**

SECTION V: PHYSICAL EXAM

1. Height: **HGT** 1 ☐ inches 2 ☐ cm **HINCM** ☐ Not done
2. Weight: **WGT** 1 ☐ lbs. 2 ☐ kg **WLBKG** ☐ Not done
3. Waist: **WAIST** 1 ☐ inches 2 ☐ cm **WINCM** ☐ Not done
4. Blood pressure **BPS** / **BPD** mmHg ☐ Not done
5. Does the patient currently have any of the following conditions:
   a. Jaundice ☐ Yes ☐ No ☐ Not done **PEJAU**
   b. Tender liver ☐ Yes ☐ No ☐ Not done **PETL**
   c. Enlarged liver ☐ Yes ☐ No ☐ Not done **PEEN**
   d. Enlarged spleen ☐ Yes ☐ No ☐ Not done **PESP**
   e. Peripheral edema ☐ Yes ☐ No ☐ Not done **PEEDMA**
   f. Muscle wasting ☐ Yes ☐ No ☐ Not done **PEMW**
   g. Spider angiomata ☐ Yes ☐ No ☐ Not done **PESA**
   h. Palmar erythema ☐ Yes ☐ No ☐ Not done **PEPALM**
6. Has patient ever been pregnant? ☐ Yes ☐ No ☐ N/A **PREGE** **(If Yes, complete Pregnancy Questionnaire)**
7. Is the patient pregnant now? ☐ Yes ☐ No ☐ N/A **PREGN**
   If Yes, date of last menstrual period *(mm/dd/yy)*: **LMENM** / **LMEND** / **LMENY**

SECTION VI: DIAGNOSTIC TESTS

1. Imaging (within 2 years) performed? ☐ Yes ☐ No ☐ Unknown **IMG**
   If Yes,
   a. Date of most recent test *(mm/yy)*: **IMGM** / **IMGY**
   b. Tests performed *(check all that apply)*:

   ☐ CT **IMCT** ☐ MRI **IMMRI** ☐ Liver ultrasound **IMULT** ☐ PET **IMPET** ☐ PET/CT **IMPETCT** ☐ Other _ **IMOS** _____ **IMO**

   c. Report(s) available? ☐ Yes ☐ No **IMREP**
   If Yes, results:

   i. Nodular liver ☐ Yes ☐ No ☐ Unknown **IMNOD**
   ii. Abnormal liver texture ☐ Yes ☐ No ☐ Unknown **IMABT**
   iii. Enlarged spleen ☐ Yes ☐ No ☐ Unknown **IMSPN**
   iv. Ascites ☐ Yes ☐ No ☐ Unknown **IMASC**
   v. Venous collaterals ☐ Yes ☐ No ☐ Unknown **IMVEN**
   vi. Changes indicative of steatosis ☐ Yes ☐ No ☐ Unknown **IMSTEAT**
   vii. Other _____ **IMOTHS** _____ ☐ Yes ☐ No ☐ Unknown **IMOTH**

2. Liver biopsy within the last 2 years? ☐ Yes ☐ No ☐ Unknown **LBX**
   If Yes,
   a. Date of most recent biopsy *(mm/yy)*: **LBXM** / **LBXY**
   b. Slides requested? ☐ Yes ☐ No **LBXSL**

SECTION VII: TREATMENT

1. Has patient ever received treatment for HBV (interferon, oral agent)?
   ☐ Yes ☐ No ☐ N/A, participating in HBV/HIV Co-infected Ancillary Study **(All HBV and HIV therapy should be captured on the AH Log for HBV/HIV co-infected participants.)**
   TXHBV

   If Yes, record all treatment ever received:

Antiviral Therapy (see codes)	Data Started* *(mm/dd/yy)*	Date Stopped* *(mm/dd/yy)*	**or** Currently on Therapy
TXB1	**TXB1BM/D/Y**	**TXB1EM/D/Y**	**TXB1CUR**
TXB2	**TXB2BM/D/Y**	**TXB2EM/D/Y**	**TXB2CUR**
TXB3	**TXB3BM/D/Y**	**TXB3EM/D/Y**	**TXB3CUR**
TXB4	**TXB4BM/D/Y**	**TXB4EM/D/Y**	**TXB4CUR**
TXB5	**TXB5BM/D/Y**	**TXB5EM/D/Y**	**TXB5CUR**
TXB6	**TXB6BM/D/Y**	**TXB6EM/D/Y**	**TXB6CUR**

1 = IFN
2 = Entecavir
3 = Telbivudine
4 = Lamivudine
5 = Adefovir
6 = Peg-IFN
7 = Tenofovir/TDF
8 = Emtricitabine
9 = Truvada
12 = Tenofovir/TAF
-3 = Unknown

* record UNK for any piece of the date that is not known

SECTION VIII: RISK ASSESSMENT

1. When was the patient diagnosed with HBV *(mm/yyyy)*? **DXHBVM** / **DXHBVY** ☐ Unknown
2. Has the patient ever had a blood transfusion? ☐ Yes ☐ No ☐ Unknown **BLDTX**
   If Yes, date of first transfusion *(mm/yyyy)*: **BLDTXM** / **BLDTXY** ☐ Unknown
3. Has the patient ever had renal dialysis? ☐ Yes ☐ No ☐ Unknown **RENDY**
4. Did the patient ever work in a hospital or other health care setting? ☐ Yes ☐ No ☐ Unknown **HOSP**
   If Yes, did a needle stick occur? ☐ Yes ☐ No ☐ Unknown **HOSPNS**
   If needle stick occurred, was the source patient hepatitis B positive? ☐ Yes ☐ No **HOSPNSRC**
5. Has the patient ever used injection drugs except as prescribed by a physician? ☐ Yes ☐ No ☐ Unk **DRUGINJ**
6. Has the patient ever used intra-nasal illicit drugs? ☐ Yes ☐ No ☐ Unknown **DRUGINI**
7. Has the patient ever lived with someone who had hepatitis B when they were living together or shared household items (i.e. razors, toothbrushes, nail clippers) with someone who had hepatitis B? **BCOHAB**
   ☐ Yes ☐ No ☐ Unknown
8. Has the patient ever had a body piercing other than the ears? ☐ Yes ☐ No ☐ Unknown **PIERC**
   If Yes, was the piercing done by a professional? ☐ Yes ☐ No ☐ Unknown **PIERCPRO**
9. Has the patient ever had a tattoo? ☐ Yes ☐ No ☐ Unknown **TAT**
   If Yes, was the tattoo done by a professional? ☐ Yes ☐ No ☐ Unknown **TATPRO**
10. Was the patient's birth mother ever diagnosed with hepatitis B? ☐ Yes ☐ No ☐ Unknown **VERTRM**

SECTION IX: SEROLOGIES AND AUTOANTIBODIES

Instructions: *Record the most recent result for each. If a test was never performed or a result is not available, check "Not done".*

		Positive	Negative	Equivocal	Titer	Date of sample *(mm/yyyy)*	Not done	
1. HBsAg	**HBSAG**	☐	☐	☐		**HBSAGM/HBSAGY**	☐	
2. HbeAg	**HBEAG**	☐	☐	☐		**HBEAGM/HBEAGY**	☐	
3. Anti-HBs	**HBS**	☐	☐	☐		**HBSM/HBSY**	☐	
4. Anti-Hbe	**HBE**	☐	☐	☐		**HBEM/HBEY**	☐	
5. Anti-HDV	**HDV**	☐	☐	☐		**HDVM/HDVY**	☐	
6. Anti-HCV	**HCV**	☐	☐	☐		**HCVM/HCVY**	☐	
7. Anti-HIV	**HIV**	☐	☐	☐		**HIVM/HIVY**	☐	
8. Anti-HBc IgM	**HBC**	☐	☐	☐		**HBCM/HBCY**	☐	➔ At eval if acute h is suspected
9. ANA	**ANA**	☐	☐	☐	1: **ANAT**__	**ANAM/ANAY**	☐	
10. ASMA	**ASMA**	☐	☐	☐	1: **ASMAT**_	**ASMAM/ASMAY**	☐	
11. ALKM	**ALKM**	☐	☐	☐	1: **ALKMT**_	**ALKMM/ALKMY**	☐	

SECTION X: VIROLOGY TESTS

1. HBV genotype: **BGEN** ☐ Unknown
2. Most recent HBV DNA level: **BDNA** ☐ Unknown Date *(mm/yy)*: **BDNAM** / **BDNAY**
   Method/Unit: **BUNIT** 1 ☐ IU/mL 2 ☐ copies/mL Lower limit of detection: **BDNALL**

SECTION XI: LABS

Instructions: *Record the most recent result for each. If a lab was not completed as part of the baseline evaluation or within 3 months prior to the initial baseline visit, check "Not done".*

Date of sample *(mm/dd/yy)*: **LSAMPM**/**LSAMPD**/**LSAMPY**

			Date of sample (If different from above) *mm/dd/yy*	Not Done	
1. White blood cells	**WBC**	$x10^3/mm^3$	**WBCM**/**D**/**Y**	☐	
2. Platelets	**PLAT**	$x10^3/mm^3$	**PLATM**/**D**/**Y**	☐	
3. Hemoglobin	**HGB**	g/dL	**HGBM**/**D**/**Y**	☐	
4. Hematocrit	**HTC**	%	**HTCM**/**D**/**Y**	☐	
5. ALT	**ALT**	IU/L	**ALTM**/**D**/**Y**	☐	ALT normal range: **ALTL** - **ALTU**
6. AST	**AST**	IU/L	**ASTM**/**D**/**Y**	☐	AST normal range: **ASTL** - **ASTU**
8. Alkaline phosphatase	**ALKP**	IU/L	**ALKPM**/**D**/**Y**	☐	Alk P normal range: **ALKPL** - **ALKPU**
8. Total bilirubin	**TBILI**	mg/dL	**TBILIM**/**D**/**Y**	☐	
9. Direct bilirubin	**DBILI**	mg/dL	**DBILIM**/**D**/**Y**	☐	
10. Indirect bilirubin	**IBILI**	mg/dL	**IBILIM**/**D**/**Y**	☐	
11. Albumin	**ALB**	g/dL	**ALBM**/**D**/**Y**	☐	
12. Total protein	**TP**	g/dL	**TPM**/**D**/**Y**	☐	
13. Creatinine	**CREAT**	mg/dL	**CREATM**/**D**/**Y**	☐	
14. Alpha-fetoprotein	**AFP**	ng/mL	**AFPM**/**D**/**Y**	☐	
15. INR	**INR**		**INRM**/**D**/**Y**	☐	

NOTE: If serum ALT result is ≥ 300 U/L (male) or ≥ 200 U/L (female) then complete Follow-Up Event form

SECTION XII: LABS *(These should be fasting labs - optimal is 12 hours, minimum of 8 hours fasting)*

Instructions: *The following labs should be performed as part of the baseline evaluation. Record the result for each. If a lab was not completed as part of the baseline evaluation, check "Not done".*

1. Was the patient fasting for this visit *(optimal is 12 hours, minimum is 8 hours)?* ☐ Yes ☐ No **FASTYN**
   If Yes, number of hours fasting *(round to nearest hour)*: **FASTHR**

Date of sample *(mm/dd/yy)*: **FLSAMPM**/**FLSAMPD**/**FLSAMPY**

			Date of sample (If different from above) *mm/dd/yy*	Not Done
a. Cholesterol (total)	**TCHOL**	mg/dL	**TCHOLM**/**D**/**Y**	☐
b. Triglycerides	**TGY**	mg/dL	**TGYM**/**D**/**Y**	☐
c. HDL	**HDL**	mg/dL	**HDLM**/**D**/**Y**	☐
d. LDL	**LDL**	mg/dL	**LDLM**/**D**/**Y**	☐
e. Glucose	**GLU**	mg/dL	**GLUM**/**D**/**Y**	☐
f. Insulin	**INS**	mcU/mL	**INSM**/**D**/**Y**	☐

SECTION XIII: FIBROSCAN and BREATH TEST

1. Did patient consent to fibroscan testing? ☐ Yes ☐ No ☐ Not participating **FBSCON**
2. Was a fibroscan performed as part of the baseline evaluation? ☐ Yes ☐ No **FBS**
   If Yes, date of fibroscan *(mm/dd/yy)*: **FBSM**/**FBSD**/**FBSY** *(Complete the Fibroscan form)*
3. Did patient consent to the breath testing? ☐ Yes ☐ No ☐ Not participating **BTCON**
4. Was a breath test performed as part of the baseline evaluation? ☐ Yes ☐ No **BT**
   If Yes, date of breath test *(mm/dd/yy)*: **BTM**/**BTD**/**BTY** *(Complete the Breath Test form)*

SECTION XIV: BIOSPECIMENS

1. Indicate the status of consent for each:
   a. Serum/plasma for research/storage 1 ☐ Obtained 2 ☐ Refused 3 ☐ Not attempted at this visit **CSERP**
   b. Liver tissue for research/storage 1 ☐ Obtained 2 ☐ Refused 3 ☐ Not attempted at this visit **CLIV**
   c. Genetic sample 1 ☐ Obtained 2 ☐ Refused 3 ☐ Not attempted at this visit **CGEN**
   d. Immunology study 1 ☐ Obtained 2 ☐ Refused 3 ☐ Not attempted at this visit **CIMM**
2. Samples obtained at this visit (*check all that apply*):
   ☐ NIDDK repository (serum/plasma) ☐ Genetics ☐ Immunology study ☐ Central testing lab ☐ None
   NIDDKR **GEN** **IMM** **CLAB** **NONE**

Note: if participating in immunology study and a patient presents with acute hepatitis B or ALT flare at the initial baseline visit, collect the sample for the immunology study (50mL) and 10mL whole blood for serum at the visit.

SECTION XV: ADMINISTRATIVE

1. Was the baseline evaluation completed in one visit? ☐ Yes ☐ No **BASE**
   If No, date all components of baseline evaluation were complete (last visit date) *(mm/dd/yy)*: **BASEM**/**D**/**Y**

2. Does the patient speak English? ☐ Yes ☐ No **LANG**
   If No, indicate language used to obtain information for HBRN network: **LANGO**
   1 ☐ Spanish 2 ☐ Chinese 3 ☐ Korean 4 ☐ Vietnamese 5 ☐ Other, specify _____**LANGOS**_____

Data collector initials: **DCID**

Date data collection completed *(mm/dd/yy)*: **DCM**/**DCD**/**DCY**