

Dear Sir/Madame,

We would like to invite you to participate in the Project concerning improvement of HCV diagnosis in the primary health care. This questionnaire aims at collecting your experience, which will be analysed together with the test results in order to develop recommendations for provider-initiated testing offered by the primary health care doctors. The questionnaire is fully anonymous. Any identifying information collected will not be released and all the data will be used only for scientific purpose.

We ask you to provide accurate answers. This is the only way to assess the risks of hepatitis C.

Important: In case you have difficulties understanding some of the questions in the questionnaire please consult your doctor.

General health

1. Have you ever suffered from any of the diseases below:

- haemophilia Yes No
- diabetes Yes No
- heart insufficiency / coronary heart disease Yes No
- astma/ COPD Yes No
- cancer Yes No
- kidney diseases Yes No
- complicated injuries Yes No
- other chronic disease, due to which you were hospitalised 2 or more times:
 Yes, please list: No

2. Have you ever been tested for hepatitis C (HCV)?

- Yes
- No
- I don't know / I don't remember

2a. If YES, what were the circumstances?

- during hospitalisation (e.g. before surgical procedure)
- donating blood (after 1992)
- abnormal liver function tests, liver disease, abdominal pain
- partner/close contact diagnosed with the infection
- screening of risk group (e.g. people on dialysis, drug users, occupational exposure)
- own initiative (self-paid)
- other circumstances, please list:

3. Have you ever received a positive test result of an HCV test?

- Yes
- No
- I don't know / I don't remember

4. Have you ever been infected or ill with the following diseases?

- Hepatitis A Yes Year No I don't know
 Hepatitis B Yes Year No I don't know
 Hepatitis C Yes Year No I don't know
 HIV Yes Year No I don't know

Medical exposures

5. Have you ever received blood transfusion (including platelets, plasma, clotting factors, albumines, immunoglobulines)?

- No
 Yes, before 1992 how many times: which blood element:
 Yes, after 1992 how many times: which blood element:
 Yes, not remember date how many times: which blood element:

6. How many times have you been in the hospital (lifetime, excluding at birth)?

(please include all admissions to hospital, including one-day stays and diagnostic stays)

- never 1 -2 times 3-4 times 5 times and more

7. Have you ever had the following procedures performed on you:

- Dental surgery Yes No
 Endoscopy (e.g. gastroscopy, colonoscopy, bronchoscopy) Yes No
 Small surgical procedures Yes No
 (e.g. wound sutures, abscess incision, nevus removal)
 Biopsy Yes No
 Caesarean section Yes:how many times:... No
 Other procedures at delivery (e.g. episiotomy) Yes:how many times:... No
 Major surgery (also otolaryngologic, cardiologic, Yes:how many times:... No
 orthopedic, gynecologic other that CC)
 Other medical procedures, please list: Yes No
 Dialysis Yes No

8. During the last year did you have any injections (do not include blood collection)?

- Yes No

8a. If YES please estimate the total number of injections during the last year in each category:

	hospital	In patient clinic	At home	Other places
Medication by injection (e.g. antibiotics, analgesics, steroids, vitamins)				
Vaccination				
Anesthesia (also at dentist)				
Contrast, diagnostic tests				
i.v. line				

Non-medical exposures

9. Have you ever had any of the following body modifications /non-medical procedures performed?

- | | | | |
|---|---|--|-----------------------------|
| tattoo | <input type="checkbox"/> Yes, professional studio | <input type="checkbox"/> Yes, other places | <input type="checkbox"/> No |
| piercing | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| acupuncture | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| botox/mesotherapy | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| manicure/pedicure in beauty parlour | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| other cosmetic or non-conventional medicine procedures, | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| please list:..... | | | |

10. Have you ever been treated for alcohol addiction? (in detox/ rehabilitation ward, AA groups) ?

- Yes No

11. Have you ever used illegal drugs by injection or snorting?

- Yes, by injection Yes, snorting Yes, snorting and injection
 No

12. Have you ever been detained for more than 3 months (prison, correctional facility, detention centre)?

- Yes No

13. According to your best knowledge, is one of your current of past householders:

a.) Infected with HCV?

- Yes – what is your relationship with this person:
 No

b.) Injecting drug user?

- Yes – what is your relationship with this person:
 No

c.) Snorting drug user?

- Yes – what is your relationship with this person:
 No

14. According to your best knowledge, is one of your current of past sexual partners:

- | | |
|--------------------------|--|
| a.) Infected with HCV | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b.) Injecting drugs user | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c.) Snorting drug user | <input type="checkbox"/> Yes <input type="checkbox"/> No |

General information

15. Sex: Female Male

16. Year of birth: |_|_|_|_|_|_|_|_|

17. Education:

- Elementary
 Occupational
 High school
 Post high-school
 Higher

18. Residence:

- city \geq 100,000 inhabitants
 city 50,000-99,999
 city 20,000 – 49,999
 city <20,000
 rural

19. Number of people living in your household:

20. Average monthly net income per household member during the past 12 months:

- <500 PLN
 500 – 1000 PLN
 1001 – 2500 PLN
 2501 – 4000 PLN
 > 4000 PLN

21. Have you ever worked in one of the following professions?:

- | | | |
|--|--|-----------------------------|
| Medical profession (direct contact with the patient) | <input type="checkbox"/> Yes, what profession: | <input type="checkbox"/> No |
| Cleaning/ removal of medical waste | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Work at diagnostic laboratory | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Fireman | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Prison officer | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Police, civil guard etc. | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Work with people addicted to drugs or homeless | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

We would like to thank you for your time.