Foodborne Illness Questionnaire

Date: ___________ Time: ___________ Taken By: ________________

Name of Establishment: ____________________ Address: ____________________

Date Complainant Ate at Establishment: ___________ Time Consumed: ___________

Name of Complainant: ____________________

Name (if different) of sick individuals: ____________________

# in party who ate at establishment: ______ # who became ill after eating: ______

Anyone else sick in household?: Yes No

Information on sick individuals (use additional sheet for each individual):

Sex: M F DOB: / / Phone #: ( )
Address:
City: County:

Student at a local college? Yes No

If yes, obtain second mailing address:

(If under 18) Mother’s Name: Father’s Name:

Symptom Onset Date and Time: / / Duration of symptoms: ___________

Morning Afternoon Evening

Symptoms: Check all that apply.

☐ Fever (Highest temp ) ☐ Explosive Diarrhea (couldn’t get to bathroom)

☐ Vomiting ☐ Chills

☐ Bloody diarrhea ☐ Abdominal cramps

☐ Non-bloody diarrhea ☐ Nausea

☐ Watery diarrhea

If person had diarrhea, how many loose stools per day?
1-3 per day 4-6 per day 7-10 per day 10+ per day

Was the person ill enough to require a doctor visit? Yes No

Was the person hospitalized? Yes No

If yes, which hospital:

Physician visit date:

Hospital admission date:

Name of physician seen:

Was the person treated with antibiotics? Yes No

MD phone:

Did you provide a stool sample for testing? Yes No

If yes, which prescription:

Prescription start date:

Revised 1/4/2017
Two days prior to eating at establishment

Breakfast:

Lunch:

Dinner:

Day before they ate at establishment

Breakfast:

Lunch:

Dinner:

Day they ate at establishment

Breakfast:

Lunch:

Dinner:

Day after they ate at establishment

Breakfast:

Lunch:

Dinner: