

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.

- | | |
|--|--|
| <input type="checkbox"/> Fever (Highest temp) | <input type="checkbox"/> Explosive Diarrhea (couldn't get to bathroom) |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Bloody diarrhea | <input type="checkbox"/> Abdominal cramps |
| <input type="checkbox"/> Non-bloody diarrhea | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> 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

Physician visit date:

If yes, which hospital:

Name of physician seen:

Hospital admission date:

MD phone:

Was the person treated with antibiotics? Yes
 No

Did you provide a stool sample for testing? Yes
 No

If yes, which prescription:
Prescription start date:

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: