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)
- ❑ Vomiting
- ❑ Bloody diarrhea
- ❑ Non-bloody diarrhea
- ❑ Watery diarrhea
- ❑ Explosive Diarrhea (couldn't get to bathroom)
- ❑ Chills
- ❑ Abdominal cramps
- ❑ Nausea

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

Physician visit date:

Name of physician seen:

MD phone:

Did you provide a stool sample for testing? Yes No

Was the person hospitalized? Yes No

If yes, which hospital:

Hospital admission date:

Was the person treated with antibiotics? 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: