

Foodborne Illness Complaint Form

The Environmental Health Specialists Network (EHS-Net) designed this form for state and local environmental health specialists working in food safety programs to use to capture information from consumers about their foodborne illness complaints. The information collected with this form can be used to help determine whether a consumer foodborne illness complaint should be investigated as potentially linked to a foodborne illness outbreak.

Incident No. _____ Contact No. _____

Origin of Complaint

Date Received: _____ Receiving Agency: _____ Call Received By: _____

Complainant Data

Name: _____ DOB: _____ Gender: M F

Phone: (Work) _____ (Home) _____ (Cell) _____ (Email) _____

Occupation(s): _____ Previous Illness or Chronic Condition: Y N Existing Medications: Y N

Comments: _____

Illness Data

Illness Onset: Date: _____ Time: _____ AM / PM Illness Stopped: Date: _____ Time: _____ AM / PM

Illness Ongoing

Signs and Symptoms:

<input type="checkbox"/> Diarrhea <u>Watery</u> <u>Bloody</u>	<input type="checkbox"/> Headache	<input type="checkbox"/> Itching (location) _____
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Myalgia (muscle ache)	<input type="checkbox"/> Numbness (location) _____
<input type="checkbox"/> Nausea	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Tingling (location) _____
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Edema (location) _____
<input type="checkbox"/> Fever _____ °F	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Rash
<input type="checkbox"/> Chills	<input type="checkbox"/> Weakness	<input type="checkbox"/> Other: _____

Diarrhea Onset: Date: _____ Time: _____ AM / PM Diarrhea Stopped: Date: _____ Time: _____ AM / PM

Illness Ongoing

Vomiting Onset: Date: _____ Time: _____ AM / PM Vomiting Stopped: Date: _____ Time: _____ AM / PM

Illness Ongoing

Clinical Data

Was a doctor or other healthcare provider visited? Y N

Date Visited: _____ Time: _____ AM / PM Admitted: Y N Length of Stay: _____ (hrs)

Healthcare Facility: _____ Physician Name: _____ Phone: _____

Were clinical specimens taken? Y N Blood Stool Diagnosis: _____

Would you be willing to provide a stool sample? Y N N/A – Samples no longer available

Foodborne Illness Complaint Form

Suspect Meal Data

Date: _____ **Location:** _____ **Suspect Meal:** _____

Time: _____ AM / PM _____

Number of people in party: _____ **Number of people reportedly ill:** _____ **Group Contact:** _____

(Use following page for additional contacts) **(Phone):** _____

List anything unusual about the meal (temperature, taste, color, etc.): _____

Other Contacts

<u>Name</u>	<u>Phone</u>	<u>Associated Meal and/or Location</u>
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____

Other Exposures

Other Possible Non-food Exposures within Past 2 Weeks: (swimming pool, river, lake, etc.)

Travel outside the US: Y N **Location(s):** _____

Water consumed outside residence: Y N **Location(s):** _____

Well water consumed: Y N **Location(s):** _____

Exposure to recreational water: Y N **Location(s):** _____

Exposure to the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Petting zoo | <input type="checkbox"/> Ill person at home or outside of home | <input type="checkbox"/> Ill animal | <input type="checkbox"/> Diapered kids or adults |
| <input type="checkbox"/> Mass gatherings | <input type="checkbox"/> Domestic animals or livestock | <input type="checkbox"/> Birds or reptiles | <input type="checkbox"/> Visit nursing home |
| <input type="checkbox"/> Daycare facility | <input type="checkbox"/> Other _____ | | |

Foodborne Illness Complaint Form

72-hr Food History (Continued)	Date: _____		
<u>One Day Prior to Illness Onset:</u>			
Breakfast: _____ _____	Location: _____ _____	Time: _____ AM / PM	Suspect Meal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Contacts: _____			
Lunch: _____ _____	Location: _____ _____	Time: _____ AM / PM	Suspect Meal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Contacts: _____			
Dinner: _____ _____	Location: _____ _____	Time: _____ AM / PM	Suspect Meal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Contacts: _____			
Other Foods/Water*: _____ _____	Location: _____ _____	Time: _____ AM / PM	Suspect Meal? <input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Two Days Prior to Illness Onset:</u>			
Breakfast: _____ _____	Location: _____ _____	Time: _____ AM / PM	Suspect Meal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Contacts: _____			
Lunch: _____ _____	Location: _____ _____	Time: _____ AM / PM	Suspect Meal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Contacts: _____			
Dinner: _____ _____	Location: _____ _____	Time: _____ AM / PM	Suspect Meal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Contacts: _____			
Other Foods/Water*: _____ _____	Location: _____ _____	Time: _____ AM / PM	Suspect Meal? <input type="checkbox"/> Yes <input type="checkbox"/> No

* This section is to be used to collect information on any food the complainant ate or drank at times other than breakfast, lunch, and dinner, and to ensure that the complainant is asked about the water he or she drank.