

FOOD AND WATERBORNE ILLNESS INVESTIGATION FORM

Case #: _____

Surname	First Name	DOB(y/m/d)	Male <input type="checkbox"/> Female <input type="checkbox"/>	Phone #: (H) _____ (W) _____
Home Address/Community		Daycare/School/Institution/Workplace:		Occupation:
Guardian (if child):	Patient's Physician/ phone number:	Person Reporting:		Diagnosis date (y/m/d)
		Onset date (y/m/d):		____ / ____ / ____ Clinical _____ Lab _____
Health Care #	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>	Name of Hospital	Admission date (y/m/d)	Discharge date (y/m/d)

DISEASE INFORMATION

SALMONELLA <input type="checkbox"/> SHIGELLA <input type="checkbox"/> CAMPYLOBACTER <input type="checkbox"/> E.COLI (verotoxigenic) <input type="checkbox"/> GIARDIA <input type="checkbox"/> CRYPTOSPORIDIUM <input type="checkbox"/> BOTULISM <input type="checkbox"/> TRICHINOSIS <input type="checkbox"/> FOOD POISONING <input type="checkbox"/> TAPE WORM <input type="checkbox"/> AMOEBIASIS <input type="checkbox"/> OTHER: <input type="checkbox"/>	Symptoms: VOMITING <input type="checkbox"/> DIARRHOEA <input type="checkbox"/> BLOOD IN STOOL <input type="checkbox"/> MALAISE <input type="checkbox"/> CRAMPS <input type="checkbox"/> FEVER <input type="checkbox"/> CHILLS <input type="checkbox"/> HEADACHE <input type="checkbox"/> BLURRED VISION <input type="checkbox"/> DIZZINESS <input type="checkbox"/> DIFFICULTY SWALLOWING <input type="checkbox"/> CONVULSIONS <input type="checkbox"/> WEIGHT LOSS <input type="checkbox"/> OTHER: <input type="checkbox"/>	Duration: <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	Specimens (stool/vomitus/blood) Collected (y/m/d & time): Treatment Prescribed:
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GENERAL ASSESSMENT INFORMATION:

1. Contact of a <u>previously</u> diagnosed case?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Name: _____ Address: _____
2. Travel (including foreign travel & farm visits)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Location: _____ Departed (y/m/d): _____ Returned (y/m/d): _____
3. Common Events/Feasts/Gatherings?	Yes <input type="checkbox"/> No <input type="checkbox"/>	List: _____
4. Contact with untreated water/milk? (Specify source)	Yes <input type="checkbox"/> No <input type="checkbox"/>	List: _____
5. Animals at home? (Note health of animals)	Yes <input type="checkbox"/> No <input type="checkbox"/>	List: _____
6. Hobbies and recreation (list): (eg. hunting, fishing, camping)		
7. Other medical conditions (list):		