Foodborne Illness Complaint Form

Incident/Outbreak ID#:________ Complainant ID #:_______

Origin of Complaint

Date Received: _____________ **Receiving Agency**: ___________________ **Call Received By**: ________________________

Complainant Data

Name: _____________________ **DOB**: ___________ **Gender**: M F **Race**: W B H A Other: ________________

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:

❑ Diarrhea ___ Watery ____ Bloody	❑ Headache	❑ Itching (location) ____________________
❑ Vomiting	❑ Myalgia (muscle ache)	❑ Numbness (location) _________________
❑ Nausea	❑ Dizziness	❑ Tingling (location) ___________________
❑ Abdominal Pain	❑ Double Vision	❑ Edema (location) ___________________
❑ Fever ______ ^{o}F	❑ Jaundice	❑ Rash
❑ Chills	❑ Weakness	❑ 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

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.)? ____

Foodborne Illness Complaint Form

Other Contacts

Name		Phone	Associated Meal and/or Location
______	❑ Ill ❑ Well	______	______
______	❑ Ill ❑ Well	______	______
______	❑ Ill ❑ Well	______	______
______	❑ Ill ❑ Well	______	______
______	❑ Ill ❑ Well	______	______
______	❑ Ill ❑ Well	______	______
______	❑ Ill ❑ Well	______	______
______	❑ Ill ❑ Well	______	______
______	❑ Ill ❑ Well	______	______

Other Exposures

Other Possible Non-food Exposures <u>within Past 2 Weeks</u>: (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:

- ❑ Petting zoo
- ❑ Ill person at home or outside of home
- ❑ Ill animal
- ❑ Diapered kids or adults
- ❑ Mass gatherings
- ❑ Domestic animals or livestock
- ❑ Birds or reptiles
- ❑ Visit nursing home
- ❑ Daycare facility
- ❑ Other ______

Notes:

______

Foodborne Illness Complaint Form

72-hr Food History

Day of Illness Onset: **Date:**

Breakfast: ______ **Location**: ______ **Time**: ______ AM / PM
______ ______ **Suspect Meal?** ❑ Yes ❑ No
______ **Contacts**: ______

Lunch: ______ **Location**: ______ **Time**: ______ AM / PM
______ ______ **Suspect Meal?** ❑ Yes ❑ No
______ **Contacts**: ______

Dinner: ______ **Location**: ______ **Time**: ______ AM / PM
______ ______ **Suspect Meal?** ❑ Yes ❑ No
______ **Contacts**: ______

Other Foods/Water: ______ **Location**: ______ **Time**: ______ AM / PM
______ ______ **Suspect Meal?** ❑ Yes ❑ No

One Day Prior to Illness Onset: **Date:**

Breakfast: ______ **Location**: ______ **Time**: ______ AM / PM
______ ______ **Suspect Meal?** ❑ Yes ❑ No
______ **Contacts**: ______

Lunch: ______ **Location**: ______ **Time**: ______ AM / PM
______ ______ **Suspect Meal?** ❑ Yes ❑ No
______ **Contacts**: ______

Dinner: ______ **Location**: ______ **Time**: ______ AM / PM
______ ______ **Suspect Meal?** ❑ Yes ❑ No
______ **Contacts**: ______

Other Foods/Water: ______ **Location**: ______ **Time**: ______ AM / PM
______ ______ **Suspect Meal?** ❑ Yes ❑ No

Two Days Prior to Illness Onset: **Date:**

Breakfast: ______ **Location**: ______ **Time**: ______ AM / PM
______ ______ **Suspect Meal?** ❑ Yes ❑ No
______ **Contacts**: ______

Lunch: ______ **Location**: ______ **Time**: ______ AM / PM
______ ______ **Suspect Meal?** ❑ Yes ❑ No
______ **Contacts**: ______

Dinner: ______ **Location**: ______ **Time**: ______ AM / PM
______ ______ **Suspect Meal?** ❑ Yes ❑ No
______ **Contacts**: ______

Other Foods/Water: ______ **Location**: ______ **Time**: ______ AM / PM
______ ______ **Suspect Meal?** ❑ Yes ❑ No