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| **Foodborne Illness Complaint Form**  *Items in italics are interviewer instructions; Items in* ***bold*** *indicate script prompts.* | | | | | | | | | | | | | | | |
| **Date Complaint Received: (MM/DD/YYYY)** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Time Received: \_\_\_\_\_\_\_\_\_\_\_\_\_ AM / PM**  **Receiving Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency Representative Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| ***Reporting Individual’s Information* (***If the individual is ill, be sure to complete all information, including food history on page 2.*) | | | | | | | | | | | | | | | |
| **Name:**  **Sex:** Male Female | | **Date of Birth:**  \_\_\_\_/\_\_\_/\_\_\_\_ | | | | **Phone:**  **( ) \_\_\_\_\_ -\_\_\_\_\_\_** | | | | | **City:** | | | | **County:** |
| ***Suspected Site Information* – I’d like to ask you for some details regarding the location about which you have concerns.** | | | | | | | | | | | | | | | |
| **Is the suspected site a…**  **Restaurant Residence Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | **Name of Site:** | | | | | | | | |
| **Date and Time Visited?**  \_\_\_\_/\_\_\_\_/\_\_\_\_ **\_\_\_\_\_\_**AM /PM | | | | | | | **Address/Location:** | | | | | | | | |
| **Phone:** | | | | | | | **County:** | | | | | | | | |
| **Did you eat in a group/party?** Y / N/ / Unk *If Yes,* **how many individuals were in group?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |
| **What food items do you suspect made you/others ill?**  **Are there any leftovers of the food/beverage?** Y / N / Unk *If Yes,* **Where are the leftovers currently?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| ***Product Complaint Information*  (*Complete only for commercially manufactured products*)** | | | | | | | | | | | | | | | |
| **Brand Name/Product Identity**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Product Size/Description:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Date of Purchase:** \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **Place of Purchase**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Is the product in your possession**? Y / N / Unk *If No*, **Is it still available and where?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *If Yes, Instruct person to keep packaging and await further instruction.* **Are you willing/able to send a picture of the product?** Y / N / Unk | | | | | | | | | | | | | | | |
| ***Illness Information* – Now I’d like to ask you some questions about the illness you experienced.** *Complainant not ill (only reporting)* | | | | | | | | | | | | | | | |
| **Date of Illness Onset:**  \_\_\_\_/\_\_\_\_/\_\_\_\_ **Time of Onset: \_\_\_\_\_\_\_AM / PM** **Duration of Symptoms? \_\_\_\_\_\_\_\_\_\_Hrs / Days** | | | | | | | | | | | | | | | |
| ***Symptoms* – Did you have any:**  **Diarrhea Bloody Diarrhea** **How many stools did you have in a 24 hr period**? \_\_\_\_\_\_\_\_  (*If clarification needed, explain*: **By diarrhea, I mean ≥3 loose stools in a 24 hr period.**)  **Nausea Vomiting Fever** (\_\_\_\_\_\_\_°F) **Muscle Aches Headache Cramps Chills Other**:\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| **Do you know of any others ill with similar symptoms?**  Y / N /Unk *If Yes*, **How many?** \_\_\_\_\_\_\_  **Would you provide contact information for the others ill?** Y / N *If Yes, complete Other Ill Contact Information section.*  *If No, Ask reporting individual to provide your phone number to other ill people to call and stress the importance of doing so.*  **Do you have any underlying illness or chronic condition?** Y / N / Unk **Are you** **currently taking any medications?** Y / N /Unk  *If Yes, Please list conditions and medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | | | | | | | |
| ***Medical Care* – Next I’d like to ask you for specifics regarding any medical care you may have received for your illness.** | | | | | | | | | | | | | | | |
| **Did you seek medical care**? Y / N /Unk *If Yes*, **Facility Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Care**: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_  **Were you hospitalized?** Y / N / Unk *If Yes*, **Length of Stay**: **\_\_\_\_\_\_\_\_\_\_**Hrs / Days **Facility Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Were clinical specimens collected?** Y / N / Unk *If Yes, Check all that apply*: **Blood** **Stool**  **Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *If Yes*, **What was the Diagnosis/Lab Result?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result Unknown  *If No*, **Would you be willing to submit a stool sample?** Y / N *If Yes, provide instructions for process*. | | | | | | | | | | | | | | | |
| ***Other Possible Exposures*– Now I’d like to ask about other types of exposures you might have had during the 2 weeks prior to symptoms.** | | | | | | | | | | | | | | | |
| **Animal/Pet Exposures?** Y / N / Unk  *If Yes, Location, Date, and Type of Animal*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | **Diaper Changing Exposures?** Y / N /Unk  *If Yes, Location and Dates*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | | |
| **Recent Travel?** Y / N /Unk **Mode of Travel**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *If Yes, Location and Dates*: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | | | **Drinking Water Exposures?** Y / N / Unk  *If Yes,* **Tap Well Bottled** (Brand:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | | | | | | | |
| **Recreational Water Exposure?** Y / N / Unk  *If Yes, Location and Dates*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_/\_\_\_\_/\_\_\_\_ | | | | | | | | **Do you work in any of the following occupations?**  Childcare Healthcare Food Handler | | | | | | | |
| **Did you have contact with other ill persons during the 2 weeks prior to symptom onset?** Y / N/ Unk *If Yes*, **How many?** \_\_\_\_\_\_\_\_\_\_\_  **What is your primary relationship to the other ill persons? Household Work Social Other**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
| ***Other Ill Contact Information* – Please provide the names and phone numbers of other persons who have had a recent similar illness.** | | | | | | | | | | | | | | | |
| Name:  Phone: **( ) \_\_\_\_\_\_\_ -\_\_\_\_\_\_\_\_** | | | Name:  Phone: **( ) \_\_\_\_\_\_\_ -\_\_\_\_\_\_\_\_** | | | | | | | | | Name:  Phone: **( ) \_\_\_\_\_\_\_ -\_\_\_\_\_\_\_\_** | | | |
| ***General Comments*:** | | | | | | | | | | | | | | | |
| ***Food/Beverage History* – Please list all foods/beverages consumed during the 3 days prior to onset of symptoms.**  **Be as specific as possible for all foods consumed and include the location where any food was consumed, including the restaurant name.**  **It may be helpful to refer to a calendar or datebook as you recall meals and events. Let’s begin with the day you became ill and work our way backwards.**  *If the reporting individual indicates ill are from multiple households only collect information on common meals here.* | | | | | | | | | | | | | | | |
| **Day of Symptom Onset**  **Date:**  **\_\_\_\_/\_\_\_\_/\_\_\_\_** | **Breakfast \_\_\_\_AM / PM** | | | | **Lunch \_\_\_\_AM / PM** | | | | **Dinner \_\_\_\_AM / PM** | | | | **Snack Foods** | | |
|  | | | |  | | | |  | | | |  | | |
| No Recall  None Eaten | | | | No Recall  None Eaten | | | | No Recall  None Eaten | | | | No Recall  None Eaten | | |
| **1 Day**  **Before Symptoms**  **Date:**  **\_\_\_\_/\_\_\_\_/\_\_\_\_** | **Breakfast \_\_\_\_AM / PM** | | | **Lunch \_\_\_\_AM / PM** | | | | | | **Dinner \_\_\_\_AM / PM** | | | | **Snack Foods** | |
|  | | |  | | | | | |  | | | |  | |
| No Recall  None Eaten | | | No Recall  None Eaten | | | | | | No Recall  None Eaten | | | | No Recall  None Eaten | |
| **2 Days**  **Before Symptoms**  **Date:**  **\_\_\_\_/\_\_\_\_/\_\_\_\_** | **Breakfast \_\_\_\_AM / PM** | | | **Lunch \_\_\_\_AM / PM** | | | | | | **Dinner \_\_\_\_AM / PM** | | | | **Snack Foods** | |
|  | | |  | | | | | |  | | | |  | |
| No Recall  None Eaten | | | No Recall  None Eaten | | | | | | No Recall  None Eaten | | | | No Recall  None Eaten | |
| **3 days**  **Before Symptoms**  **Date:**  **\_\_\_\_/\_\_\_\_/\_\_\_\_** | **Breakfast \_\_\_\_AM / PM** | | | **Lunch \_\_\_\_AM / PM** | | | | | | **Dinner \_\_\_\_AM / PM** | | | | **Snack Foods** | |
|  | | |  | | | | | |  | | | |  | |
| No Recall  None Eaten | | | No Recall  None Eaten | | | | | | No Recall  None Eaten | | | | No Recall  None Eaten | |
| **During the week prior to symptom onset, did you attend any Group/Catered Events?** Y / N / Unk  *If Yes*, **Where and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_** | | | | | | | | | | | | | | | |

**Thank you for calling to report your concerns. If additional information is necessary to complete this investigation, public health staff may need to contact you again. Complete information is crucial to protecting the public’s health. If you have any other concerns please don’t hesitate to contact the public health department again. Thank you for your time.**