

FOODBORNE DISEASE REPORT INDIVIDUAL CASE HISTORY

INTERVIEWER INITIALS: _____ DATE OF INTERVIEW: _____ I.D. NO: _____
 NAME: _____ AGE: _____ SEX: _____
 ADDRESS: _____ TELEPHONE: _____

SYMPTOMS:

	YES	NO	DON'T KNOW
Cramps			
Diarrhea			
Bloody diarrhea			
Nausea			
Vomiting			
Headache			
Body aches			
Chills			
Fever			

Other (specify) _____

When did you eat the suspect meal? Date: _____ Time: _____ am/pm (circle one)

When did the first symptom begin? Date: _____ Time: _____ am/pm (circle one)

Incubation period: _____ hours

When did you start to feel better? Date: _____ Time: _____ am/pm (circle one)

Duration: _____ hours

Place of eating suspect meal: _____

Was a physician consulted? Yes _____ No _____

If yes, name: _____ Telephone _____

Were you hospitalized? Yes _____ No _____

Number of persons in household who did NOT eat suspect meal: _____

Of these, number who became ill with similar symptoms after the case: _____

Date(s) and hour(s) of onset: _____

Determine if case is willing to submit a specimen for culture.

Does the case have any leftover food for culture?

Remarks: