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.*

	Breakfast ____AM / PM	**Lunch ____AM / PM**	**Dinner ____AM / PM**	**Snack Foods**
Day of Symptom Onset **Date:** ____/____/___ –				
	☐ 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.