

## Foodborne Illness Complaint Form

The Environmental Health Specialists Network (EHS-Net) designed this form for state and local environmental health specialists working in food safety programs to use to capture information from consumers about their foodborne illness complaints. The information collected with this form can be used to help determine whether a consumer foodborne illness complaint should be investigated as potentially linked to a foodborne illness outbreak.

Incident No. \_\_\_\_\_ Contact No. \_\_\_\_\_

### Origin of Complaint

Date Received: \_\_\_\_\_ Receiving Agency: \_\_\_\_\_ Call Received By: \_\_\_\_\_

### Complainant Data

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M F  
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:**

<input type="checkbox"/> Diarrhea    ___ Watery    ___ Bloody	<input type="checkbox"/> Headache	<input type="checkbox"/> Itching (location) _____
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Myalgia (muscle ache)	<input type="checkbox"/> Numbness (location) _____
<input type="checkbox"/> Nausea	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Tingling (location) _____
<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Edema (location) _____
<input type="checkbox"/> Fever _____ °F	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Rash
<input type="checkbox"/> Chills	<input type="checkbox"/> Weakness	<input type="checkbox"/> 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

## Foodborne Illness Complaint Form

### 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.)?** \_\_\_\_\_

### Other Contacts

<u>Name</u>	<u>Phone</u>	<u>Associated Meal and/or Location</u>
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____
_____ <input type="checkbox"/> Ill <input type="checkbox"/> Well	_____	_____

### Other Exposures

**Other Possible Non-food Exposures within Past 2 Weeks:** (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:**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Petting zoo      | <input type="checkbox"/> Ill person at home or outside of home | <input type="checkbox"/> Ill animal        | <input type="checkbox"/> Diapered kids or adults |
| <input type="checkbox"/> Mass gatherings  | <input type="checkbox"/> Domestic animals or livestock         | <input type="checkbox"/> Birds or reptiles | <input type="checkbox"/> Visit nursing home      |
| <input type="checkbox"/> Daycare facility | <input type="checkbox"/> Other _____                           |  |  |

# Foodborne Illness Complaint Form

Notes:

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**72-hr Food History**

**Date:** \_\_\_\_\_

This section is to be used to collect information about what the consumer ate and drank in the 72-hour period prior to the complaint.

**Day of Illness Onset:**

**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

## Foodborne Illness Complaint Form

<b>72-hr Food History (Continued)</b>	<b>Date:</b> _____
<b><u>One Day Prior to Illness Onset:</u></b>	
Breakfast: _____	Location: _____
_____	Time: _____ AM / PM
_____	Suspect Meal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Contacts: _____	
Lunch: _____	Location: _____
_____	Time: _____ AM / PM
_____	Suspect Meal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Contacts: _____	
Dinner: _____	Location: _____
_____	Time: _____ AM / PM
_____	Suspect Meal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Contacts: _____	
Other Foods/Water*: _____	Location: _____
_____	Time: _____ AM / PM
_____	Suspect Meal? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b><u>Two Days Prior to Illness Onset:</u></b>	
<b>Date:</b> _____	
Breakfast: _____	Location: _____
_____	Time: _____ AM / PM
_____	Suspect Meal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Contacts: _____	
Lunch: _____	Location: _____
_____	Time: _____ AM / PM
_____	Suspect Meal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Contacts: _____	
Dinner: _____	Location: _____
_____	Time: _____ AM / PM
_____	Suspect Meal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Contacts: _____	
Other Foods/Water*: _____	Location: _____
_____	Time: _____ AM / PM
_____	Suspect Meal? <input type="checkbox"/> Yes <input type="checkbox"/> No

\* This section is to be used to collect information on any food the complainant ate or drank at times other than breakfast, lunch, and dinner, and to ensure that the complainant is asked about the water he or she drank.