Initial Foodborne Illness Complaint Report
Confidential Document – Interview Form

SOURCE OF INITIAL INFORMATION

☐ Voice or email message
☐ In-person interview
☐ Phone interview

Form completed by:
☐ Self
☐ Staff ______________________________

Name: [ ]   Birth Date: [ ] (MM/DD/YYY)

Local Address: [ ]

Phone Number: [ ]   Pronoun: [ ]

Email: [ ]

Have you seen a Healthcare provider for your symptoms? ☐ Yes ☐ No

If yes, please provide date(s) seen, their name and contact information:

[ ]

Do you have any food allergies or sensitivities to any food or specific ingredients?
☐ Yes
List allergies: [ ]
☐ No

SYMPTOMS

Date symptom(s) started: _______________________

What time of day did your symptom(s) start? ______________________________

Name: ________________________________ Date of Birth: ______________

Symptoms experienced. Check all that apply:

☐ Nausea ☐ Cough ☐ Unusual taste in mouth ☐ Muscle Aches ☐ Stiff neck ☐ Fever Highest temperature recorded ______ ☐ Very Tired / Lethargic ☐ Vomiting Dry Heaves ☐ Decreased or no appetite ☐ Joint aches ☐ Other ______________________	☐ Visual Changes ☐ Abdominal Pain ☐ Chills ☐ Headache ☐ Swollen lymph nodes ☐ Diarrhea Number of bowel movements per day ______ ☐ Blood in stool ☐ Shortness of breath ☐ Sore Throat ☐ Rash

Which symptom did you experience first?

Which symptom was the worst?

Are you currently in pain?

☐ Yes

- Is the pain localized (in one location) or does it radiate:
- On a scale of 1-10 rate your pain ____ (A score of 0 means no pain, and 10 means the worst pain you have ever felt).

☐ No

Are you currently experiencing any symptom(s)?

FOOD EXPOSURE

Where (including name and address, if applicable) do you think you may have become ill?

Name: ______________________________ Date of Birth: _____________

Date and Time [ ]

What time of day did you eat the specific food that you suspect made you ill?

How many other people in your household (family members or roommates) were sick with the same symptoms around the same time as you? Please provide details.

How many other people, excluding household members, were sick with the same symptoms around the same time as you? Please provide details.

Name: ______________________________ Date of Birth: _____________

List any places where you ate food during the __ days before the START of symptoms. Please provide approximate time food/drink was eaten. Please do not leave any field blank. Write in "*Cannot recall*" or "*No food consumed*" if applicable. Please indicate the location number where food was eaten under Breakfast, Snack, Lunch and Dinner.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Date	Date	Date	Date	Date	Date	Date
Location 1 Location 2 Location 3	Location 1 Location 2 Location 3	Location 1 Location 2 Location 3	Location 1 Location 2 Location 3	Location 1 Location 2 Location 3	Location 1 Location 2 Location 3	Location 1 Location 2 Location 3
Breakfast Location __	Breakfast Location __	Breakfast Location __	Breakfast Location __	Breakfast Location __	Breakfast Location __	Breakfast Location __
Snack Location __	Snack Location __	Snack Location __	Snack Location __	Snack Location __	Snack Location __	Snack Location __
Lunch Location __	Lunch Location __	Lunch Location __	Lunch Location __	Lunch Location __	Lunch Location __	Lunch Location __
Dinner Location __	Dinner Location __	Dinner Location __	Dinner Location __	Dinner Location __	Dinner Location __	Dinner Location __

Note: To identify how many days of dietary recall are needed for specific suspected pathogens, see individual incubation periods on the **Centers for Disease Control (CDC) website**. If no specific pathogen suspected, enter 4 days.

CDC.gov - Diagnosis and Management of Foodborne Illnesses: A Primer for Physicians and Other Health Care Professionals

Name: ______________________________ Date of Birth: _____________

OTHER SECONDARY EXPOSURES

During the 4 days before the START of the symptoms, did you:

Attend a group event (wedding, reunion, picnics, campus social etc.)?

☐ Yes

☐ No

Have contact with animals?

☐ Yes

☐ No

Have contact with children under the age of 5?

☐ Yes

☐ No

Recent travel?

☐ Yes

Within the U.S.? __________

Outside the U.S.? _________

☐ No

Have contact with a sick person?

☐ Yes

☐ No

Prepare food for other people?

☐ Yes

☐ No

OTHER NOTES OR COMMENTS: