Foodborne Illness Questionnaire

La Crosse County Health Department (608)785-9872
300 4th St. N. La Crosse WI 54601

INVESTIGATOR INITIALS: _____

DATE: _____

Name:	Address:	City:
		Phone:

Occupation: (food handler circle & state where)	Sex: (circle) M F	Age:

Are you ill or have you recently been ill?	When did you first become ill?
O Yes O No	DATE: _____ HOUR: _____

WHAT ARE YOUR SYMPTOMS?

	Duration:		
O Diarrhea	_____	O Nausea	O Chills
Bloody Diarrhea		O Vomiting	O Sweats
O Yes O No		O Abdominal Cramps	O Fatigue
O Fever	_____	O Body ache	
Take Temperature?		O Muscle Aches	O Other (specify)
O Yes O No		O Headache	
_____°F			

STILL SICK? O Yes O No
WHEN DID YOU RETURN TO YOUR USUAL STATE OF HEALTH?

Recovered by: _____ *(date)* _____ AM PM *(time)*

O Physician Consulted
O Clinical specimens collected — Doctor's name and phone number: Type:

O Hospitalized — Hospital name, location: Date:

O Name others who are ill **or** ate the same food — Names and phone numbers:

WHERE/WHAT DID YOU EAT AND DRINK FOR THE FOLLOWING MEALS?

	DATE: _____	DATE: _____	DATE: _____
Breakfast			
Lunch			
Dinner			

Comments: