

# **Appendix I: Foodborne/ Waterborne Illness Investigation Form**

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# Foodborne/Waterborne Illness Investigation Form

**SECTION 1.**

**PATIENT INFORMATION:**

*Section 1 may be completed prior to contacting the patient, if the information is known. If information is not known, the patient may be asked.*

**NEDSS ID #** \_\_\_\_\_ **Patient Initials:** \_\_\_\_\_ **Date of First Attempt to Interview:** \_\_\_/\_\_\_/\_\_\_ **No. of Attempts:** \_\_\_\_\_  
**Date of Interview:** \_\_\_/\_\_\_/\_\_\_ **Refused Interview:**  Yes  No  Unknown **Interview Partially Completed:**  Yes  No  Unknown  
**Letter Mailed?**  Yes  No  Unknown **Lost to Follow-up:**  Yes  No  Unknown  
**Delayed report to County/State resulting in limited exposure recall:**  Yes  No  Unknown **Earliest Date Reported to County:** \_\_\_/\_\_\_/\_\_\_

**Circle one:**

*Campylobacter, Cryptosporidium, GI Illness/Outbreak of Unknown Etiology, Hemolytic Uremic Syndrome (HUS), Norovirus Outbreak, Salmonella, Shiga toxin-producing E. coli (STEC), Shigella*

**1. Sex:**  Male  Female    **2. DOB** \_\_\_/\_\_\_/\_\_\_    **3. Age (years/months)** \_\_\_\_\_

**4. County of Residence** \_\_\_\_\_

**5. Ethnicity:**     Hispanic or Latino                      **6. Race:**                       White  
                           Not Hispanic or Latino     Black or African American  
                           Unknown     Asian  
     Native American/Pacific Islander/Alaskan Native  
     Unknown

**7. Was patient specimen sent for laboratory testing:**     Yes  No  Unknown

Type of Test: \_\_\_\_\_ Specimen Source: \_\_\_\_\_  
 Collection Date: \_\_\_/\_\_\_/\_\_\_ Result:  Positive  Negative  
 Name of organism isolated: \_\_\_\_\_ Serotype: \_\_\_\_\_  
 Isolate sent to the Division of Laboratory Services (State Lab):  Yes  No

**8. Admitted to hospital for illness:**  Yes  No Where: \_\_\_\_\_  
 Admission Date: \_\_\_/\_\_\_/\_\_\_ Discharge Date: \_\_\_/\_\_\_/\_\_\_

**9. Antibiotic Therapy:**  Yes  No

If yes, name of antibiotic: \_\_\_\_\_ Date initiated: \_\_\_/\_\_\_/\_\_\_  
 Duration of prescription: \_\_\_\_\_  
 Antibiotic resistance/susceptibility report available:  Yes  No  Unknown  
 If yes, please send a copy to the Reportable Diseases Section with this form and the lab report.

**SECTION 2.**

**INTRODUCTION**

*Hello, my name is \_\_\_\_\_ and I am calling from the \_\_\_\_\_ Health Department in regard to \_\_\_\_\_. I have some questions that I would like to ask you about the events and exposures prior to your illness. The answers you provide to the following questions may be used to help identify what made you ill. We may use the information you provide to prevent others from becoming ill in the future. All of the information you share will be kept confidential.*

**1. Are you a:**  Daycare/school worker  Healthcare worker  Food service worker  Other

If other, what is your current occupation? \_\_\_\_\_  
 If ill individual is a child, is the child:  Daycare attendee/worker  School attendee/worker  Healthcare Worker  Food service worker  Other  
 If other, what is the child's current occupation? \_\_\_\_\_

**2. Who is your employer (name and address)?** \_\_\_\_\_  
 If a child, who is the child's employer (name and address)? \_\_\_\_\_

3. Please give a brief description of your job: \_\_\_\_\_

4. Did you (or your child) work or attend daycare/school while sick?  Yes  No

If a daycare or school, list name of daycare/school and address: \_\_\_\_\_

6. If individual's occupation is in farming, working in a poultry factory, or other high-risk transmission setting, did they wear clothing into the house that they wore on the job? e.g. shoes worn in cattle lots or on the farm, shoes/clothes worn in a chicken processing factory, etc.?  Yes  No

**Clinical Information:**

7. Date and time of illness onset: \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_ AM / PM (circle one)

8. Still ill at time of interview:  Yes  No If no, duration of illness: \_\_\_\_\_ hours / days (circle one)

9. Did you have any of the following symptoms? If they are unsure if they had a symptom, please leave it blank.

Unknown:  Yes  No

Headache:  Yes  No

Other: \_\_\_\_\_

Fever:  Yes  No

Diarrhea:  Yes  No

\*Highest Recorded Temp \_\_\_\_\_

Bloody Stool:  Yes  No

Nausea:  Yes  No

Abdominal Cramps:  Yes  No

Vomiting:  Yes  No

10. Do you have a weakened Immune System? (e.g. Have you had cancer or are you currently under a doctor's care for cancer? Are you taking steroids? Have you had any transplants? Are you pregnant?):  Yes  No

If so, why? (list reason for weakened immune system). \_\_\_\_\_

**General Exposures**

1. Do you have any family, friends, or co-workers with similar illness:  Yes  No  Unknown

If so, please specify:

Name	Age	Relationship to Patient	Symptoms	Occupation	Employer / Facility	Recommendations/Exclusion

2. Usual source(s) of drinking water?  Tap water  Bottled water  Water from refrigerator (filtered by your refrigerator)

3. Usual source(s) of ice?  Tap water  Bottled water  Store-bought  Ice from refrigerator (ice made from water filtered by your refrigerator)

4. Type of water supply in your home?  Public (e.g. city)  Private (e.g. well)  Unknown

5. What type of sewage system does your home have?  Public (e.g. city sewer)  Private (e.g. septic)  Unknown

End of Page Notes \_\_\_\_\_

**6. In the month prior to illness onset, have you had any problems with your water supply or sewage system at home or work?** (e.g. boil water advisories, septic system back-up, water shut off, etc.)  Yes  No  Unknown  
 If yes, please describe: \_\_\_\_\_

**7. In month prior to illness onset, have you participated in any recreational water activities?** (e.g. swimming, hot tub use, water-skiing, boating, attending a water park, or a therapy pool)  Yes  No  Unknown  
 If yes, What/Where (location): \_\_\_\_\_ When: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Number of people in the pool (estimated)? \_\_\_\_\_ Any children or infants?  Yes  No  Unknown

**8. Have you been around any recent construction or soil disturbances?** (e.g. gardening, farming, excavation for a house, home remodeling, potting soil, mulch or fertilizer, etc.)  
 Yes  No  Unknown

**9. Have you had any indoor animal exposure?**  Yes  No  Unknown

**10. Have you had any outdoor animal exposure?**  Yes  No  Unknown

If answered "no" to questions 9 and 10, skip to question 13.

**11. Have you been exposed to any of the following animals in the month preceding your illness?**

<b>Dog</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If yes (circle appropriate choice): adult/puppy indoor/outdoor
<b>Cat</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If yes, (circle appropriate choice): adult/kitten indoor/outdoor
<b>Cattle</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If yes, (circle appropriate choice): adult/calf
<b>Swine</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If yes, (circle appropriate choice): adult/piglet
<b>Poultry</b> (chicken/turkey)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If yes (circle appropriate choice): chicken/turkey adult/chick type _____
<b>Bird</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If yes, (circle appropriate choice): adult/chick indoor/outdoor
<b>Goat</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If yes, (circle appropriate choice): adult/kid
<b>Sheep</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If yes, (circle appropriate choice): adult/lamb
<b>Equine</b> (donkey, horse)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If yes, (circle appropriate choice): adult/colt
<b>Reptile</b> (bearded dragon, lizard, snake, turtle)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If yes, type _____ Circle One: indoor/outdoor
<b>Amphibian</b> (frog, salamander, toad)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If yes, type _____ Circle One: indoor/outdoor
<b>Rodent</b> (gerbil, guinea pig, hamster, mouse, prairie dog, rat, squirrel, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If yes, type _____ Circle One: indoor/outdoor
<b>Other animal(s)</b> (hedgehog, rabbit, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	If yes, type _____ Circle One: indoor/outdoor

**12. What type of pet food do you use?**  Wet  Dry  Unknown Brand: \_\_\_\_\_  
 Treats?  Yes  No  Unknown Brand: \_\_\_\_\_

**13. Who is responsible for feeding the animals you own?** \_\_\_\_\_

**14. Who is responsible for cleaning the animal's area (cage, aquarium, kennel, etc.)?** \_\_\_\_\_

**15. Have you been exposed to any ill pets or other sick animals?**  Yes  No  Unknown

End of Page Notes \_\_\_\_\_

If yes: Description of sick animal (type of animal, illness symptoms): \_\_\_\_\_

**16. Did you visit a farm/petting zoo/fair/animal exhibit in the month preceding your illness?**  Yes  No  Unknown

Where: \_\_\_\_\_ When: \_\_\_/\_\_\_/\_\_\_ Type of animal(s): \_\_\_\_\_

**17. Did you travel in the month preceding illness?** (e.g. visited friends/family, day trips to other counties/states, vacation):  Yes  No  Unknown

If yes: Travel in the U.S: Where: \_\_\_\_\_ When: \_\_\_/\_\_\_/\_\_\_

Travel outside of the U.S: Where: \_\_\_\_\_ When: \_\_\_/\_\_\_/\_\_\_

Mode of Travel:  Airplane  Bus  Car  Cruise  Train  Other

Identifier, such as flight no. airline, etc. \_\_\_\_\_

Did you travel alone, with family, or with a tour group?  Alone  Family  Group

If with a group, what is the name of the organization/group you traveled with? \_\_\_\_\_

**18. Did you attend any social events seven days preceding illness?** (e.g. parties, church functions, picnics, weddings, etc.):  Yes  No  Unknown When: \_\_\_/\_\_\_/\_\_\_

If yes: What: \_\_\_\_\_ Where: \_\_\_\_\_

Were others ill?  Yes  No If yes, please list: \_\_\_\_\_

Was food prepared onsite or catered?  Onsite  Catered

If catered, name and address of Caterer: \_\_\_\_\_

Foods consumed: \_\_\_\_\_

Activities (e.g. canoeing, petting zoo, etc.): \_\_\_\_\_

### PART 3

*The next group of questions that I am going to ask you will address the different food(s) that you (or your child) may have eaten during the 5 days before your illness onset. If you have a calendar nearby it may help to look at it while answering these questions, as it may prompt your recollection of activities/events you may have attended. Also, you may want to review receipts, your check book register, and credit/debit card statements for that time period to give you clues to restaurant or grocery store purchases. For children, you may want to review their school/daycare menu for that time period if it is available.*

**1. What grocery store(s) did you purchase the food(s) you may have eaten in the 5 days before your illness?**

Grocery Store (Name and Address/Cross Street/Landmark): \_\_\_\_\_

When: \_\_\_/\_\_\_/\_\_\_ Do you have a shoppers card/reward card?  Yes  No  Unknown

If yes, number/alternate ID: \_\_\_\_\_

Grocery Store (Name and Address/Cross Street/Landmark): \_\_\_\_\_

When: \_\_\_/\_\_\_/\_\_\_ Do you have a shoppers card/reward card?  Yes  No  Unknown

If yes, number/alternate ID: \_\_\_\_\_

Grocery Store (Name and Address/Cross Street/Landmark): \_\_\_\_\_

When: \_\_\_/\_\_\_/\_\_\_ Do you have a shoppers card/reward card?  Yes  No  Unknown

If yes, number/alternate ID: \_\_\_\_\_

**2. Did you eat at any restaurants or have take-out food in the 5 days before your illness?**  Yes  No  Unknown

If yes, were they (choose all that apply):  Fast Food  Sit-down  Other \_\_\_\_\_

Where (Name and Address/Cross Street/Landmark): \_\_\_\_\_

End of Page Notes \_\_\_\_\_

When: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_ Foods Eaten: \_\_\_\_\_

**Where** (Name and Address/Cross Street/Landmark): \_\_\_\_\_

When: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_ Foods Eaten: \_\_\_\_\_

**Where** (Name and Address/Cross Street/Landmark): \_\_\_\_\_

When: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_ Foods Eaten: \_\_\_\_\_

**Where** (Name and Address/Cross Street/Landmark): \_\_\_\_\_

When: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_ Foods Eaten: \_\_\_\_\_

**3. Now I am going to ask you about the specific foods and beverages you may have consumed at home or away from home in the 5 days before your illness.**

**We are specifically talking about meals consumed on the following days (date range):** \_\_\_\_\_

**Limited Food Recall**

**Meat, Poultry, Fish, Dairy, and Eggs,**

<b>Bacon</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Ham</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Pork (Not ham or bacon)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Beef (not ground)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Ground Beef</b> *If you ate ground beef in the 5 days prior to illness onset:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
	Date of Purchase: ___/___/___	Location of purchase:	Type and Brand of Beef (e.g. package size, percent lean)
<b>Chicken</b> *If you ate chicken in the 5 days prior to illness onset:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
	Date of Purchase: ___/___/___	Location of purchase:	Type and brand of chicken (e.g. breast, whole, ground, grilled)
<b>Turkey</b> *If you ate turkey in the 5 days prior to illness onset:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
	Date of Purchase: ___/___/___	Location of purchase:	Type and brand of turkey (e.g. breast, whole, ground, grilled)
<b>Deli Meats</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Hot dogs</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Seafood (besides oysters)</b> *If you ate seafood in the 5 days prior to illness onset:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
	Date of Purchase: ___/___/___	Location of purchase:	Type and brand of seafood (e.g. lobster, shrimp, calamari, etc.):
<b>Fish</b> *If you ate fish in the 5 days prior to illness onset:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
	Date of Fish Purchase: ___/___/___	Location of Purchase:	Type and preparation of fish (e.g. canned, smoked, grilled, etc.):
<b>Oysters</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Wild Game (deer, pheasant, rabbit, fish)</b> *If you ate any wild game in the 5 days prior to illness onset:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
	What type was it?	Where did you acquire it?	How was it prepared?
<b>Did you eat any other Meat Products?</b> *If you ate any other meat products in the 5 days prior to illness onset:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
	Date Eaten: ___/___/___	Location of purchase:	Type and brand of meat (e.g. lamb, goat, etc.):
<b>Block cheese</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

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<b>Mexican Style Cheese</b> (Queso Fresco, Queso Blanco)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Pre sliced Cheeses</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Ricotta</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Cheese made with raw or unpasteurized milk</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Other cheeses (e.g. soft cheeses)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Eggs</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Cottage Cheese</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Ice Cream</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Milk</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
*If you drank any milk in the 5 days prior to illness onset:	Date of Purchase: ___/___/___	Location of purchase	Type and brand of milk (e.g. whole milk, 2% milk, skim milk):
<b>Soy Milk</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Unpasteurized (Raw) Milk</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
*If you drank any unpasteurized milk in the 5 days prior to illness onset:	Date of Purchase: ___/___/___	Location of purchase:	Type and brand of milk
<b>Yogurt</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
<b>Raw Foods from Animal Origin</b> (raw eggs, raw meat, raw shellfish)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
*If you ate any raw food from animal origin in the 5 days prior to illness onset:	Date of Purchase: ___/___/___	Location of purchase:	Type and brand of raw food

### Juice/Fruit

### Vegetables

<b>Apple</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Basil, Parsley or Cilantro</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Apple Juice</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Broccoli</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Bananas</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Cabbage</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Blackberries</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Carrot</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Blueberries</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Cucumber/zucchini/squash</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Cantaloupe</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Frozen Vegetables</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Frozen fruit</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Lettuce on sandwich</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Grapes</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Mushrooms</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Honeydew</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Onion/Garlic</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Orange Juice</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Potatoes</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Pomegranate Seeds</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Pepper (sweet, green, hot)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Pomegranate Juice</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Type of Pepper: _____				
<b>Frozen Berries</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Tomatoes</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Frozen Berry Blends/Mixtures</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Salad (leafy greens)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Papaya</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Bagged/Pre-packaged Salad</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Pineapple</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Brand: _____ Type: _____ Location of purchase: _____				
<b>Raspberries</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Spinach</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Strawberries</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Sprouts</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Unpasteurized Juice/Cider</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Other Fresh Vegetable</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Watermelon</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Type of Vegetable: _____				
<b>Other Fresh Fruit</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<b>Other Leafy Greens (kale, collards, swiss chard)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Type of Fresh Fruit _____					Type: _____			

End of Page Notes \_\_\_\_\_

Other Juice	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Any Prepackaged fresh foods? (precut apples, salad kits)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
	Type of Juice _____				Type: _____		

**Premade/Processed Foods**

<b>Baby food</b> (including taste testing for child)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Beans</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Cereal</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Cole slaw within 24 hours of illness?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
*If you ate cole slaw in the past 24 hours before illness onset:	Date and time of Consumption: _/_/___	Where was it eaten?	Was it catered and by whom?	Type and brand of cole slaw:
<b>Dried fruit</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Frozen Dinners</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Lentils</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Nuts</b> (e.g. walnuts, almonds, peanuts)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Peanut butter</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Tofu</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Potato Salad within 24 hours of illness? (store bought or homemade)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
*If you ate Potato Salad in the past 24 hours before illness onset:	Date and time of Consumption: _/_/___	Where was it eaten?	Was it catered and by whom?	Type and brand of potato salad:
<b>Pre-made dinner requiring reheat</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Rice within 24 hours of illness?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
*If you ate Rice in the past 24 hours before illness onset:	Date and time of Consumption: _/_/___	Where was it eaten?	Was it catered and by whom?	Type and brand of rice:
<b>Salsa</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Store-bought egg salad</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Store-bought pasta salad</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Other store-bought premade salads (e.g. ham salad, chicken salad, seafood salad)</b> Specify type: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Spices purchased at an ethnic food store or imported spices (e.g. Chinese spices, Indian spices, Mexican spices, etc.)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
<b>Home canned foods</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
	Date and time of Consumption: _/_/___	Type of food:	Is there any unused canned food available for testing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

Interview Comments/Notes: \_\_\_\_\_

End of Page Notes \_\_\_\_\_

**Counseling (initial once completed):**

- \_\_\_\_\_ Educate on pathogen and source (e.g. animal, human)
- \_\_\_\_\_ Mode of transmission/prevention/control
- \_\_\_\_\_ Proper hand washing and personal hygiene
- \_\_\_\_\_ Avoid sharing personal hygiene products
- \_\_\_\_\_ Washing all fruits and vegetables; proper food storage and thorough cooking of meats
- \_\_\_\_\_ Avoiding cross contamination (surfaces, cutting boards, utensils, stored food in refrigerator)
- \_\_\_\_\_ Avoid direct contact with reptiles (lizards, snakes, iguanas, turtles)
- \_\_\_\_\_ Risks associated with unpasteurized dairy products, milk/juice
- \_\_\_\_\_ Avoid preparation of food for others
- \_\_\_\_\_ Disinfecting surfaces
- \_\_\_\_\_ Unrecognized foods (raw eggs in homemade ice cream, homemade salad dressings/sauces, raw cookie dough)
- \_\_\_\_\_ High risk circumstances for transmission identified.
- \_\_\_\_\_ Counseled to avoid activities that put others at risk of catching disease.
- \_\_\_\_\_ Directed individual to website for education: \_\_\_\_\_ or Mailed educational information to (address) \_\_\_\_\_

*That is the end of our questionnaire. If I need any other information in the future, may I call you back? Please keep all receipts or other documents that you may have referred to during our interview today, we may have more questions related to those items.*

*If you think of anything else that you would like to report, please feel free to call me back. My contact information is \_\_\_\_\_. Again, thank you so much for your time and have a wonderful day.*

**Childcare Health Consultant Notified (if appropriate):** Yes No N/A

If yes, whom? Name: \_\_\_\_\_

**Environmentalist Notified:** Yes No N/A

If yes, whom? Name: \_\_\_\_\_

Interviewer Name and Agency: \_\_\_\_\_

**Enter completed questionnaire into NEDSS and retain a copy at the Local Health Department along with pertinent case information.**

**Fax laboratory reports to the Reportable Disease Section secure fax 502-696-3803.**

End of Page Notes \_\_\_\_\_