



Kentucky Public Health
Prevent. Promote. Protect.

Foodborne and Waterborne Illness Investigation Form

Cryptosporidiosis and Giardiasis FBWB Questionnaire



Cryptosporidiosis

Giardiasis

NEDSS ID: _____

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Interviewer Name: _____ Interviewer Agency: _____

Patient Initials: _____ Date of First Attempt to Interview: _____ Date of Interview: _____ No. of Attempts: _____

Refused: Yes No Unk Partially Completed: Yes No Unk Letter Mailed? Yes No Unk

Lost to Follow-up: Yes No Unk Delayed report to LHD/KDPH causing limited exposure recall: Yes No Unk

Earliest Date Reported to County: _____

Person Being Interviewed: Patient Surrogate (name and describe):

Section 1: Patient Info

- DOB: _____
- Age (years/months): _____
- Is the patient deceased? Yes No Unk
- Marital Status? Married Single Widowed

Occupation Information

5. Are you: Employed Unemployed Retired Student A Volunteer Unk

If employed:

Occupation: _____

Employer (Name and Address): _____

Job Title and Description: _____

Please mark if the patient works in one of the following high-risk transmission occupations:

Daycare/school Healthcare Food service Other (describe)

Did you work or attend school while sick? Yes No Unk

Dates worked: _____

Describe job duties while sick: _____

Describe hand hygiene practices while sick: _____

Does the patient attend/reside in a congregate living facility? Yes No Facility Name _____

If yes, please select the type of facility: Assisted Living/Long-Term Care/Nursing Home

Correctional Shelter Other, Please specify: _____

6. Is there anyone in the home that lives or works on a farm, works in a poultry factory, or other high-risk transmission setting? Yes No Unk

If yes: Did they wear clothing into the house that they wore on the job? (Shoes worn in cattle lots or on the farm, shoes/clothes worn in a chicken processing factory, etc.) Yes No Unk

Daycare/School Information (obtain is patient is a child)

7. Does the child attend: Daycare School Other No/Unk

(describe): _____

Daycare/School Name and Address: _____

Grade or room: _____

Did your child attend daycare/school while sick? Yes No N/A Unk

Dates Attended: _____

Have any others at the daycare/school been ill? Yes No N/A Unk

8. Address

County of Residence: _____

**Clinical Info**

9. Admitted to hospital for illness? Yes No Unk

Name of Hospital: _____

Admission Date: _____ Discharge Date: _____

Did patient die? Yes No Unk Was death a result of illness? Yes No Unk

10. Date and time of illness onset: _____ (Onset Time)

11. Still ill at time of interview? Yes No Unk

If no, date illness ended: _____ (Illness End Time)

12. Did your doctor prescribe antibiotics to treat your illness? Yes No Unk

If yes,

<u>Name of Antibiotic</u>	<u>Date Initiated</u>	<u>Duration of Prescription</u>	<u>Complete Prescription</u>
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

13. Did you have any of the following symptoms?

Fever: Yes No Unk

Diarrhea: Yes No Unk

Highest Recorded Temp: _____

Days of Diarrhea: _____

Nausea: Yes No Unk

Bloody Stool: Yes No Unk

Vomiting: Yes No Unk

Abdominal Cramping: Yes No Unk

Headache: Yes No Unk

Other Symptoms: _____

14. Do you have a weakened immune system? (Have you had cancer/currently under a doctor's care for cancer? Are you taking steroids? Have you had any transplants? Are you pregnant?): Yes No Unk

Reason for weakened immune system: _____



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15. Do you have any family, friends, or co-workers with similar illness? Yes No Unk

If yes, please specify:

Name	Age	Phone Number	Relationship to Patient	Symptoms	Onset Date	Occupation	Employer / Facility

16. Were you exposed to adults or children using diapers? Yes No Unk

If yes, did the person have diarrhea? Yes No Unk

Describe nature of the exposure (date, type of contact, etc.): _____

17. Did you take any new medication/supplements in the 30 days before you became sick? (e.g., prescribed medication, over the counter medication, vitamins, antacids, probiotics, supplements): Yes No Unk

List medications/supplements: _____

SECTION 2: Exposure Assessment

A. WATER

1. **What source do you typically drink water from?** (Bottled, tap, filter, etc.)
 Describe: _____

2. **What source do you typically use ice from?** (Bagged, tap, etc.)
 Describe: _____

3. **What type of water supply does your home have?**
 Public (e.g., city) Private (e.g., well) Unk

4. **What type of sewage system does your home have?**
 Public (e.g., city sewer) Private (e.g., septic) Unk

5. **In the 7 days before you became sick, did you had any problems with your water supply or sewage system at home or work?** (e.g., boil water advisories, water main break, septic system back-up, etc.)
 Yes No Unknown
 If yes, please describe: _____

6. **In the 7 days before you became sick, did you participate in any activities in treated recreational water?** (swimming pool, hot tub, water park, splash pad, fountain, or a therapy pool)
 Yes No Unk
 If yes, What/Where (location): _____ When: _____
 Number of people in the water (estimated)? _____
 Any children/infants? Yes No Unk

- In the 7 days before you became sick, did you participate in any activities in untreated recreational water?** (creek, pond, lake, ocean, etc.)
 Yes No Unk
 If yes, What/Where (location): _____ When: _____
 Number of people in the water (estimated)? _____
 Any children/infants? Yes No Unk

B. MANURE EXPOSURE

- In the 7 days before you became sick, did you apply manure, compost or soil?** Yes No Unk
- If yes, type/brand: _____
 Describe exposure: _____

C. ANIMAL CONTACT

In the 7 days before you became sick, did you have any contact with animals?
Contact would be defined as touching animals, anything the animal came in contact with, and being around animals and their environments even if you do not touch them .

<u>Indoor?</u>	<u>Outdoor?</u>
Yes No Unk	Yes No Unk

If answered "No" to both questions, skip to Section D. Travel



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If yes, which animals?

Type of Animal	Y/N/U?	Please Select	Specify Type (Circle One or Describe)	Where is animal kept?	Who feeds animal?	Who cleans up after animal?
Dog	Yes No Unk	Adult Puppy		Indoor Outdoor	Pt Family Other	Pt Family Other
Cat	Yes No Unk	Adult Kitten		Indoor Outdoor	Pt Family Other	Pt Family Other
Cattle	Yes No Unk	Adult Calf			Pt Family Other	Pt Family Other
Swine	Yes No Unk	Adult Piglet			Pt Family Other	Pt Family Other
Poultry (chicken, turkey, duck, etc.)	Yes No Unk	Adult Chick	Chicken Turkey Duck	Indoor Outdoor	Pt Family Other	Pt Family Other
Bird	Yes No Unk	Adult Chick		Indoor Outdoor	Pt Family Other	Pt Family Other
Goat	Yes No Unk	Adult Kid			Pt Family Other	Pt Family Other
Sheep	Yes No Unk	Adult Lamb			Pt Family Other	Pt Family Other
Equine (donkey, mule, horse)	Yes No Unk	Adult Colt	Donkey Mule Horse		Pt Family Other	Pt Family Other
Reptile (snake, lizard, turtle, etc.)	Yes No Unk			Indoor Outdoor	Pt Family Other	Pt Family Other
Amphibian (frog, salamander, newt, etc.)	Yes No Unk			Indoor Outdoor	Pt Family Other	Pt Family Other
Rodent (rat, gerbil, hamster, mouse, etc.)	Yes No Unk			Indoor Outdoor	Pt Family Other	Pt Family Other
Other animal(s) (hedgehog, rabbit, etc.,)	Yes No Unk			Indoor Outdoor	Pt Family Other	Pt Family Other

Please list the foods and/or treats you give to your pets.

Type of Animal	Type of Food	Food Brand/Flavor	Give pet treats?	Type of Treats	Treat Brand/Flavor
	Dry Wet Raw Unk		Yes No Unk	Dry Wet Raw Unk	
	Dry Wet Raw Unk		Yes No Unk	Dry Wet Raw Unk	
	Dry Wet Raw Unk		Yes No Unk	Dry Wet Raw Unk	
	Dry Wet Raw Unk		Yes No Unk	Dry Wet Raw Unk	



NEDSS ID: _____

1. **Do you purchase animals that you use to feed other animals?** (mice to feed snakes, crickets to feed lizards) Yes No Unk N/A

Type of Feeding Animal	Alive or Dead at Purchase	Purchase Location
	<input type="checkbox"/> Alive <input type="checkbox"/> Dead	

2. **Were any of the animals you were exposed to sick?**

Yes No Unk

If yes, description of sick animal (type of animal, illness symptoms):

3. **Did you live on or visit a farm/fair/animal exhibit/petting zoo in the 7 days before you became sick?**

Yes No Unknown

If yes, where: _____ *When:* _____

Type of animal(s): _____

D. TRAVEL

1. **Did you travel in the 7 days before you became sick?** (Visited friends/family, day trips to other counties, vacation): Yes No Unk

Within KY Outside of KY Where: _____ When: _____

Within KY Outside of KY Where: _____ When: _____

Mode of travel: Airplane Bus Car Cruise Train Other

Travel identifier (flight number, airline, cruise line): _____

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

If travelled with a group, what is the name of the organization/group you travelled with?

2. **Did you travel internationally in the 30 days before you became sick?** Yes No Unk

If yes, Where: _____ *When:* _____

Mode of travel: Airplane Cruise Train Other

Travel identifier: _____

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

If travelled with a group, what is the name of the organization/group you travelled with?

E. SOCIAL GATHERINGS

Did you attend any social events in the 7 days before you became sick? (Parades, festivals, church, work events):

Yes No Unk

Event Description	Location and Date	Were Others Ill?	Food Prepared By? (catered, bought and brought, potluck)	Foods Pt Consumed
		Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
		Yes No <input type="checkbox"/> Unk		

F. SPECIALTY/RESTRICTIVE DIETS

Do you eat a specialty/restricted diet? (Food allergy, vegan, diabetic, gluten free, formula, breast-fed infant)

Y Yes No Unk

If yes, please specify: _____

G. FOOD SOURCE

1. Which grocery store(s) would you have eaten food from in the **7 days** before you became sick?

<u>Location (name, address/landmark)</u>	<u>Date Visited</u>	<u>Shoppers/Reward Card</u>	<u>Alternate ID/Card Number</u>
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	
		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	

2. Do we have consent to utilize shopper card information (including sharing with federal partners) for possible outbreak investigation, if necessary? Yes No Unk

3. **Did you eat at any restaurants or take-out food in the 7 days before you became sick?** (Fast-food or sit-down restaurants, gas stations, food trucks, cafeterias, etc.) Yes No Unk

<u>Location (name, address/landmark)</u>	<u>Date</u>	<u>Time</u>	<u>Foods Eaten</u>

4. **Alternative Food Source Information**

Did you eat any food from any of the following sources in the 7 days before you became sick?

Source:	Confirmation:	Date Eaten:	Received Date:	Location Eaten:	Details: Meat type, fruit/veggie type, order date etc.
Hunting/Fishing/Trapping	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	_____	_____		
Private Garden (private, community, friend)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	_____	_____		
Food Delivery Service or Meal Kit Delivery Service? (Meals on Wheels, Hello Fresh, Doordash, Uber Eats)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	_____	_____		
Butcher Shop	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	_____	_____		
Farmer's Market/ Community-Supported Agriculture (CSA)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	_____	_____		
Friend/Relative	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	_____	_____		



H. Race, Ethnicity, and Sex: This section asks about race, ethnicity, and sex. This information is collected from all sick people. By knowing more about your race, ethnicity, and sex, we can get a better understanding of specific health risks that can help us identify what caused you to become ill. These questions are completely optional, and you may choose to not answer any and/or all of them. **All of this information will remain confidential.**

- 1. **Ethnicity**
 - Hispanic or Latino Not
 - Hispanic or Latino
 - Unk

- 2. **Race**
 - American Indian or Alaska Native Asian
 - Black or African American
 - Native Hawaiian or Other Pacific Islander
 - White
 - Unk
 - Other _____

- 3. **Sex**
 - Male
 - Female
 - Unk

Interview Comments / Additional Notes:

Counseling (initial once completed)

- _____ Education 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, raw cookie dough)
- _____ High risk circumstances for transmission identified.
- _____ Counseled to avoid activities that put other at risk of contracting disease.

Childcare Health Consultant Notified (if appropriate)

- Yes No N/A
If yes, whom? Name: _____

Environmentalist Notified?

- Yes No N/A
If yes, whom? Name: _____

Referred back to Local Health Department?

- Yes No N/A
If yes, whom? Name: _____

Interviewer Name and Agency: _____