



Kentucky Public Health
Prevent. Promote. Protect.

Foodborne and Waterborne Illness Investigation Form

Shiga-Toxin Producing E. Coli (STEC) /
Hemolytic Uremic Syndrome (HUS) FBWB Questionnaire

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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

1. **DOB:** _____ 2. **Age (years/months):** _____
3. **Is the patient deceased?** Yes No Unk 4. **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 _____

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

Address

8. 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,

Name of Antibiotic	Date Initiated	Duration of Prescription	Complete Prescription
_____	_____	_____	<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. Were you diagnosed with either of the following conditions?

Hemolytic Uremic Syndrome (HUS)? Yes No Unk

Thrombocytopenic Purpura (TTP)? Yes No Unk

****Interviewer Note: HUS is a life-threatening complication resulting in kidney failure.**

TTP is a blood disease characterized by decreased platelet counts (thrombocytopenia) and hemolytic anemia.

15. 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: _____



16. 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

17. 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.): _____

18. 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 did not touch them)

<u>Indoor?</u>	<u>Outdoor?</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

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

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	



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, etc.):

Yes No Unk

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

Yes No Unk

If yes, please specify: _____

Note: If patient answers "yes" to formula consumption, complete section N.

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. Meal History	Meal	Food/Beverage Consumed	Location
Day 1 _____ (Day patient started to feel ill)	Breakfast		
	Lunch		
	Dinner		
Day 2 _____ (Day before patient started to feel ill)	Breakfast		
	Lunch		
	Dinner		
Day 3 _____ (Two days before patient got sick)	Breakfast		
	Lunch		
	Dinner		
Day 4 _____ (Three days before patient got sick)	Breakfast		
	Lunch		
	Dinner		
Day 5 _____ (Four days before patient got sick)	Breakfast		
	Lunch		
	Dinner		

I. ENTERIC - MEAT, POULTRY, FISH

Bacon	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> At home <input type="checkbox"/> Away <input type="checkbox"/> Both	Type/Brand:
Ham	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> At home <input type="checkbox"/> Away <input type="checkbox"/> Both	Type/Brand:
Pork (Not ham or bacon)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> At home <input type="checkbox"/> Away <input type="checkbox"/> Both	Type/Brand:
Beef (Steak, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> At home <input type="checkbox"/> Away <input type="checkbox"/> Both	Type/Brand:
Ground Beef	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> At home <input type="checkbox"/> Away <input type="checkbox"/> Both	Date and Location of Purchase: Type/Brand:
Chicken	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> At home <input type="checkbox"/> Away <input type="checkbox"/> Both	Date and Location of Purchase: Type/Brand:
Turkey	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> At home <input type="checkbox"/> Away <input type="checkbox"/> Both	Date and Location of Purchase: Type/Brand:
Deli Meats	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> At home <input type="checkbox"/> Away <input type="checkbox"/> Both	Type/Brand:
Seafood (Not fish or oysters)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> At home <input type="checkbox"/> Away <input type="checkbox"/> Both	Date and Location of Purchase: Type/Brand:
Fish	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> At home <input type="checkbox"/> Away <input type="checkbox"/> Both	Date and Location of Purchase: Type/Brand:
Wild Game (deer, pheasant, rabbit, fish)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> At home <input type="checkbox"/> Away <input type="checkbox"/> Both	Date and Location of Purchase: Type/Brand:
Did you eat any other meat products?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> At home <input type="checkbox"/> Away <input type="checkbox"/> Both	Date and Location of Purchase: Type/Brand:
Raw/undercooked liver	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> At home <input type="checkbox"/> Away <input type="checkbox"/> Both	Type/Brand:
Hot Dogs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> At home <input type="checkbox"/> Away <input type="checkbox"/> Both	Type/Brand:
Do you or any family members handle raw poultry?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Who

J. CHEESE, DAIRY, MILK, EGGS

Block Cheese	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Type/Brand:
Mexican Style Cheese (Queso, Fresco, Queso Blanco)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Type/Brand:
Pre Sliced Cheese	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Type/Brand:
Ricotta	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Type/Brand:
Cheese Made with Raw or Unpasteurized Milk Other unpasteurized or raw milk products	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Type/Brand:
Other Cheeses	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Type/Brand:
Eggs <input type="checkbox"/> Raw/undercooked	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	How were they prepared? <input type="checkbox"/> At Home <input type="checkbox"/> Away
Egg Whites <input type="checkbox"/> Raw/undercooked	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	How were they prepared? <input type="checkbox"/> At Home <input type="checkbox"/> Away
Cottage Cheese	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Type/Brand:
Ice Cream	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Type/Brand:
Milk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date and Location of Purchase: Type/Brand:
Non-dairy Milk (Soy, Almond, Coconut, Cashew)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Type/Brand:
Raw or Unpasteurized milk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date and Location of Purchase: _____ Type/Brand: _____
Yogurt	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Type/Brand:
Raw Foods From Animal Origin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Date and Location of Purchase: _____ Type/Brand: _____

K. FRUITS AND VEGETABLES

Fruits	
Apples	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Apple Juice	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Bananas	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Blackberries	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Blueberries	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cantaloupe	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Frozen Fruit	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Grapes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Honeydew	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Orange Juice	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Pomegranate Seeds	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Pomegranate Juice	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Frozen Berries	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Frozen Berry Blends/Mixtures	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Papaya	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Pineapple	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Raspberries	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Strawberries	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Unpasteurized Juice/Cider	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Watermelon	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Other Fresh Fruit (<i>peaches, oranges, etc.</i>):	_____
Other Juices:	_____
Smoothies/Blended Drinks Type/Brand:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Date of Purchase: _____
Location of purchase:	_____
Tea Type/Brand:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Date of Purchase: _____
Location of purchase:	_____

Fresh Vegetables	
Fresh Herbs Type of herb:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Broccoli	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cabbage	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Carrots	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cucumber	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Zucchini or Other Squash Type of Squash:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Frozen Vegetables	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Lettuce on Sandwich	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Mushrooms	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Onion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Garlic	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Potatoes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Pepper (<i>sweet, green, hot</i>) Type of Pepper:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Tomatoes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Salad (<i>iceberg, romaine, spinach, kale.</i>) Type of Salad:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Bagged/Pre-Packaged Salad Brand(s):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Type(s):	
Location of Purchase:	
Spinach	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Sprouts	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Other Fresh Vegetables	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Other Leafy Greens	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Prepackaged Fresh Foods	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

L. PREMADE / PROCESSED FOODS

Baby Food (<i>including taste testing for child</i>)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Beans		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Cereal (<i>hot/cold</i>)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Lentils		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Peanut Butter		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Tofu		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Potato Salad	Date/Time of Consumption: _____	
Where was it eaten?	Was it catered/by whom?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Type/Brand:		
Pre-made dinner requiring reheat (<i>frozen dinners</i>)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Fresh Salsa or Pico de Gallo		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Store bought egg salad	Date/Time of Consumption: _____	
Where was it eaten?	Was it catered/by whom?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Type/Brand:		
Pasta Salad	Date/Time of Consumption: _____	
Where was it eaten?	Was it catered/by whom?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Type/Brand:		
Other Deli Salads (<i>e.g., seafood salad, chicken salad</i>)	Date/Time of Consumption: _____	
Where was it eaten?	Was it catered/by whom?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Type/Brand:		
Spices purchased at an ethnic food store or imported spices (<i>Chinese spices, Indian spices, Mexican spices</i>)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Home-canned foods (<i>produced in the home, not purchased at a grocery store</i>)	Date/Time of Consumption: _____	
Where was it eaten?	Unused canned food available for testing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Uncooked Dough/Batter		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Dried Fruit		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Nuts (<i>e.g., walnuts, almonds, peanuts, etc.</i>)		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Nut Spread (excluding peanut)	Type of Nut Spread:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Hummus or Other Prepared Dip	Date/Time of Consumption: _____	
Where was it eaten?	Was it catered/by whom?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Type/Brand:		

Note: Make sure to record any detailed brand information collected for processed foods in the comment section below if there is not a space for a free text entry.

M. SEXUAL HISTORY

1. Did you have sexual contact with a male during the week prior to your illness? Yes No
2. Did you have sexual contact with a female during the week prior to your illness? Yes No

SKIP THIS PAGE IF THE PATIENT WAS NOT DIAGNOSED WITH HUS

ANSWER ALL QUESTIONS ON THIS PAGE IF THE PATIENT WAS DIAGNOSED WITH HUS

N. HUS INFORMATION

1. Name of Physician: _____
2. Diagnosis Date: _____
3. Is the Patient Pregnant? Yes No Unk
4. Does the Patient have pelvic inflammatory disease? Yes No Unk
5. Is the case part of an outbreak? Yes No Unk
 - a. Describe outbreak (source, location, cases, etc...):

6. Has the case been in close contact with someone who has been diagnosed with STEC or has had a recent diarrheal illness? Yes No Unk
 - a. Name of contact: _____
 - b. Nature of contact: _____

Clinical Information

1. Did the patient experience any of the following:

- | | | | |
|--------------------|-----|----|-----|
| Hematuria: | Yes | No | Unk |
| Proteinuria: | Yes | No | Unk |
| Hemodialysis: | Yes | No | Unk |
| Blood Transfusion: | Yes | No | Unk |

2. In the absence of diarrheal illness, did the patient have:

- | | | | |
|--|-----|----|-----|
| History of any other infection such as HIV, flu, or other pneumococcal bacteria? | Yes | No | Unk |
| History of use of immunosuppressant medication or medication to treat cancer? | Yes | No | Unk |
| Diagnosis of autoimmune disease or cancer? | Yes | No | Unk |

Lab Information

1. Did the patient have:

- | | | | | | | | |
|-----------------------------|-----|----|-----|---------------|-----|----|-----|
| Positive STEC Result: | Yes | No | Unk | Schistocytes: | Yes | No | Unk |
| Positive Salmonella Result: | Yes | No | Unk | Burr Cells: | Yes | No | Unk |
| Positive Shigella Result: | Yes | No | Unk | Helmet Cells: | Yes | No | Unk |

- Red Blood Cell Count: _____
 Hemoglobin: _____
 Hematocrit: _____
 Platelet Count: _____
 Creatinine: _____



O. 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: _____