Kentucky Public Health
Prevent. Promote. Protect.

Foodborne and Waterborne Illness Investigation Form

Shigellosis 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 ☐ 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,

Name of Antibiotic	Date Initiated	Duration of Prescription	Complete Prescription
	_____		☐ Yes ☐ No ☐ Unk
	_____		☐ Yes ☐ No ☐ Unk
	_____		☐ Yes ☐ No ☐ 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 4 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 4 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 4 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 4 days before you became sick, did you apply manure, compost or soil? ☐ Yes ☐ No ☐ Unk

If yes, type/brand: _____

Describe exposure: _____

C. TRAVEL

1. **Did you travel in the 4 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?
   _____

D. SOCIAL GATHERINGS

Did you attend any social events in the 4 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 ☐ No ☐ Unk		
		☐ Yes ☐ No ☐ Unk		

E. 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: _____

F. FOOD SOURCE

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

Location (name, address/landmark)	Date Visited	Shoppers/Reward Card	Alternate ID/Card Number
		☐ Yes ☐ No ☐ Unk	
		☐ Yes ☐ No ☐ Unk	
		☐ Yes ☐ No ☐ Unk	
		☐ Yes ☐ No ☐ Unk	
		☐ Yes ☐ No ☐ 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

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

G. 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

H. SEXUAL HISTORY

1. **What is your sexual orientation/preference?**

☐ Heterosexual ☐ Lesbian or Gay ☐ Bisexual ☐ Other ☐ Do not know ☐ Choose not to disclose

If other, please specify:

2. **Are you currently sexually active?** (if no, skip to end of questionnaire)

☐ Yes ☐ No ☐ Unk/Refused

3. In the 4 days before your illness started, did you have sexual contact with another person? Sexual contact would include genital sex, anal sex, oral sex, or any other sexual contact.

(if no, skip to end of questionnaire)

☐ Yes ☐ No ☐ Unk/Refused

***If yes*, were your sex partners?** (check all that apply)

☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male

☐ Unknown ☐ Prefer Not to Answer ☐ Another (specify): _____

***If yes*, in the 4 days before your illness started, did any of your sexual partners have diarrhea or symptoms similar to your own?**

☐ Yes ☐ No ☐ Unk/Refused

4. Since your illness started, have you had sexual contact with another person? Sexual contact would include genital sex, anal sex, oral sex, or any other sexual contact.

☐ Yes ☐ No ☐ Unk/Refused

***If yes*, would you be willing to share name(s) of sexual partners?** _____

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 daily 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: _____