General Foodborne Illness Questionnaire

Section I: Demographics

Patient Name: ____________________  State ID: ______  Date of Birth: ___/___/___
Address: __________________________________________________  Home Phone: (    )____-_______
City: ____________________  County: ____________________  Zip Code: ____________________
Person Interviewed: ____________________  Relationship to Patient: ____________________
Occupation: ____________________  (If high risk occupation, ask additional questions)
Place of Employment: ____________________  Work Phone: (    )____-_______

If now is not a good time to talk, when would a good time be for me to call you back?
Day: ___________  Time: ___________  Phone: (    )____-_______

Section II: Clinical Information

What were your symptoms?  Did you have:
- Diarrhea:  Y  N  Maximum number of stools passed in 24 hour period: ______
- Bloody Diarrhea:  Y  N  Diarrhea with mucus:  Y  N
- Date of onset of diarrhea: ___/___/___  Are you still experiencing diarrhea?  Y  N
  If no, how long did it last?  ______ days

- Nausea:  Y  N  Vomiting:  Y  N  Abdominal Cramps:  Y  N
- Fever:  Y  N  Headache:  Y  N  Chills:  Y  N
- Fatigue:  Y  N  Body aches:  Y  N

Did you see a healthcare provider for this illness?  Y  N  Date: ___/___/___
Were you admitted to a hospital overnight?  Y  N  Where: ____________________
Was a stool culture done?  Y  N  Date: ___/___/___
  If yes, what was the result of the culture: ____________________  Serotype: ____________________
  If no, and still having diarrhea, would you be willing to submit a specimen?  Y  N
    If yes, when would be a good time to drop off a specimen collection kit?
      Day: ______  Time: ______

Were you taking any medications prior to this illness (e.g., antacids, meds for other illness)?  Y  N
What medications? ________________________________________________________________

Did you, or are you, taking medications for this illness?  Y  N
What medications? ________________________________________________________________

Did anyone else in your household have diarrhea?  Y  N  Who? ____________________

Do you know of anyone else who experienced a similar illness during the same period?  Y  N
  If yes, who? ____________________  Phone (    )____-_______
    ____________________  Phone (    )____-_______
    ____________________  Phone (    )____-_______
    ____________________  Phone (    )____-_______
Section III: Exposures

a. Events within one week of symptoms (from ____/___/___).

Child Care Settings.

do you: Have children < 2 years old? □Y □N
   If yes, do they attend a child care facility? □Y □N Where? __________
Visit any households with children < 2 years old? □Y □N
Change any diapers? □Y □N
Attend, work, or volunteer in a child care setting? □Y □N Where? __________

Miscellaneous Settings.

did you: Travel? □Y □N
   If yes, where?
Visit or live on a farm? □Y □N
   If yes, were there any cattle, chickens, or pigs? □Y □N
Visit a petting zoo? □Y □N
   If yes, were there any cattle, chickens, pigs, or reptiles? □Y □N
Have a pet? □Y □N
   If yes, what kind of pet? □Dog □Cat □Reptile □Chicks
Go Swimming? □Y □N
   If yes, what type of facility: □Pool □Ocean □Lake/Pond □River □Other
Primary source of drinking water: □Municipal □Private well □Bottled □Other

Groceries.

Where did you shop for groceries consumed during the 5 days before your illness?

Store Name: __________________________ Location: __________________________
Foods purchased: ________________________________________________________
Store Name: __________________________ Location: __________________________
Foods purchased: ________________________________________________________
Store Name: __________________________ Location: __________________________
Foods purchased: ________________________________________________________

b. Restaurant exposures within one week of symptoms (from ____/___/___).

Did you eat out (away from home) during the 5 days prior to your illness? □Y □N
If yes: Restaurant (sit down)? □Y □N
Where/what? __________________________ Date: ___/___/___
Fast food restaurant? □Y □N
Where/what? __________________________ Date: ___/___/___
Cafeterias? □Y □N
Where/what? __________________________ Date: ___/___/___
Deli counter (e.g., at supermarkets)? □Y □N
Where/what? __________________________ Date: ___/___/___
Street vendor (Farmer’s market included)? □Y □N
Where/what? __________________________ Date: ___/___/___
Concession stand at sporting event? □Y □N
Where/what? __________________________ Date: ___/___/___
Snack bar (e.g., athletic club, pool)? □Y □N
Where/what? __________________________ Date: ___/___/___
Gas station (e.g., microwave foods)? □Y □N
Where/what? __________________________ Date: ___/___/___

Patient Name: ______________________________
c. Food History within one week of symptoms (from __/__/___). (Also, see appendix.)

Egg and Dairy Products.

Did you eat: Yogurt? ☐ Y ☐ N Brand: ______________________
Milk? ☐ Y ☐ N Brand: ______________________
  If yes, was it pasteurized? ☐ Y ☐ N
Cheese? ☐ Y ☐ N Brand: ______________________
Ice Cream? ☐ Y ☐ N Brand: ______________________
Eggs? ☐ Y ☐ N Brand: ______________________
  If yes, how were they prepared? ______________________
Egg containing dish (e.g., potato salad)? ☐ Y ☐ N

Vegetables.

Did you eat: Food from a salad bar? ☐ Y ☐ N From where? ________________
Lettuce? ☐ Y ☐ N
Raw or uncooked carrots? ☐ Y ☐ N
Bean or alfalfa sprouts? ☐ Y ☐ N
Raw or uncooked celery? ☐ Y ☐ N
Uncooked tomatoes? ☐ Y ☐ N
Raw onions? ☐ Y ☐ N
Raw or uncooked broccoli? ☐ Y ☐ N
Other raw or uncooked vegetables? ☐ Y ☐ N (Specify: ________________)

Fruits.

Did you eat: Cantaloupe? ☐ Y ☐ N
  If yes, sliced at home? ☐ Y ☐ N → If no, where? ________________
Honeydew melon? ☐ Y ☐ N
  If yes, sliced at home? ☐ Y ☐ N → If no, where? ________________
Watermelon? ☐ Y ☐ N
  If yes, sliced at home? ☐ Y ☐ N → If no, where? ________________
Strawberries? ☐ Y ☐ N
Drink any type of juice? ☐ Y ☐ N Pasteurized? ☐ Y ☐ N
  If yes, brand name: ______________________ Type: ________________

Animal Proteins.

Did you eat: Chicken? ☐ Y ☐ N
  Was chicken hot when eaten? ☐ Y ☐ N
  Was chicken cooked through? ☐ Y ☐ N
Turkey? ☐ Y ☐ N
Hamburgers eaten and cooked at home? ☐ Y ☐ N
  If yes, Pink inside? ☐ Y ☐ N
  Hamburger purchased in: ☐ Bulk ☐ Preformed patties
  Where purchased: ______________________ Date: __/__/___
Hamburgers eaten elsewhere? ☐ Y ☐ N → If yes, Where: ________________
  If yes, pink inside? ☐ Y ☐ N
Steak tartare or other raw ground beef? ☐ Y ☐ N
Beef jerky? ☐ Y ☐ N Steak? ☐ Y ☐ N?
Roast beef? ☐ Y ☐ N Veal? ☐ Y ☐ N
Pork chops or roast pork? ☐ Y ☐ N Lamb? ☐ Y ☐ N
Venison (deer meat)? ☐ Y ☐ N Sausage? ☐ Y ☐ N
Hot Dog? ☐ Y ☐ N Salami? ☐ Y ☐ N
Goat’s milk? ☐ Y ☐ N
Section IV: Hygiene Practices

Food Preparation.

Do you handle raw meat (i.e., beef and/or chicken)? ☐ Y ☐ N

If yes, please answer the following questions:

Do you use the same cutting board to cut meat and vegetables, fruit, etc.? ☐ Y ☐ N

If yes, do you wash the cutting board after cutting meat, or before cutting fruits, vegetables, etc.? ☐ Y ☐ N

Do you use the same knife to cut meat and vegetables, fruit, etc.? ☐ Y ☐ N

If yes, do you wash the knife after cutting meat, or before cutting fruits, vegetables, etc.? ☐ Y ☐ N

Hand Washing.

How often do you wash your hands after handling meat? ☐ Sometimes ☐ Often ☐ Always

Interviewer Notes:
### Appendix

Open-ended food history within one week of symptoms (from ___/___/___).

#### 1 day before onset of illness

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