Warren County Health District

FOODBORNE ILLNESS QUESTIONNAIRE

Today's Date:_____

CONTACT INFORMATION:

Name: _____ Age: _____

Phone Number: _____ Email: _____

Address: _____

FACILITY INFORMATION:

Name of facility:_____

Address: _____

Date visited: _____ Time of Visit: _____AM/PM

SYMPTOMS:

Nausea ☐	Cramps ☐	Chills ☐
Vomiting ☐	Fever ☐	Fatigue ☐
Diarrhea ☐	Headache ☐	Body Aches ☐

Onset time of symptoms: _____ AM/PM When did you start to feel better? _____ AM/PM

Did you visit a doctor? YES ☐ NO ☐ Doctor's Diagnosis (if known): _____

FOOD:

What did you eat? Be sure to include all sides/condiments/dressings, etc. _____

_____

What did you drink? _____ Dessert or appetizer? _____

What else have you eaten in the past 24 hours? _____

_____

Is anyone else from your party ill? YES ☐ NO ☐

If yes, what are their names? _____

What did the other members of your party have to eat? _____

Did your party share any meals? YES ☐ NO ☐ If yes, what meal? _____

Any other details that you believe are pertinent? _____

_____