

# FOOD POISONING HISTORY FORM



**Report Received and Information Recorded on:**

## 1. Personal Information

|  |  |         |
|--|--|---------|
| Surname:   |  |         |
| Given Name:  | Date of Birth:   | Age:    |
| Address:   |  |         |
| Telephone (cell):  | (home):  | (work): |
| Occupation:  |  |         |
| Work Name & Address:   |  |         |
| Do you handle food where your work / volunteer?<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  | Are you the person who is sick? Yes <input type="checkbox"/> No <input type="checkbox"/> |         |
| What was the last day you worked?  |  |         |
| How Many People, that you know, are sick with the same symptoms at the same time? What are their names & phone numbers? (Use additional paper if necessary). |  |         |

## 2. Clinical Details

|   |  |      |
|---|--|------|
| Date and Time of Onset of Symptoms:   |  |      |
| Date the illness was reported to the Public Health Department:  |  |      |
| <b>Symptoms:</b><br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Vomiting<br><input type="checkbox"/> Abdominal Pain<br><input type="checkbox"/> Fever | <input type="checkbox"/> Nausea<br><input type="checkbox"/> Headache<br><input type="checkbox"/> Blood Stained Feces (red or black)<br><input type="checkbox"/> Other: |      |
| Duration of Illness (hours, days):    Days  |  |      |
| Did you seek medical advice? Yes <input type="checkbox"/> No <input type="checkbox"/>   | When?  | Who? |
| Family Doctor (name & address):   |  |      |
| Where samples taken for laboratory analysis? Yes <input type="checkbox"/> No <input type="checkbox"/>   |  |      |
| Nature of test specimen and results:  |  |      |

### 3. Food Consumption History *(include the approximate time the food was eaten)*

#### Day of Illness:

|            |
|------------|
| Breakfast: |
| Lunch:     |
| Dinner:    |
| Snacks:    |
| Drinks:    |
| Other:     |

#### 24 hours Before Onset:

|            |
|------------|
| Breakfast: |
| Lunch:     |
| Dinner:    |
| Snacks:    |
| Drinks:    |
| Other:     |

#### 24-48 hours Before Onset:

|            |
|------------|
| Breakfast: |
| Lunch:     |
| Dinner:    |
| Snacks:    |
| Drinks:    |
| Other:     |

#### 48-72 hours Before Onset:

|            |
|------------|
| Breakfast: |
| Lunch:     |
| Dinner:    |
| Snacks:    |
| Drinks:    |
| Other:     |

|                 |                 |
|-----------------|-----------------|
| Suspected Food: | Purchased From: |
| Date Purchased: | Date Consumed:  |

|  |  |
|--|--|
| Do you have any of the suspected food left over for analysis? Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| Did anyone else consume this food? Yes <input type="checkbox"/> No <input type="checkbox"/>                            | Were they sick? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If so, please provide their contact information:   |  |
| <br><br><br><br>   |  |