

**Washington State Department of Health**  
**FOODBORNE ILLNESS CASE INVESTIGATION WORKSHEET**

**COMPLAINT INFORMATION**

Date of complaint ____/____/____	Complainant name	Address	(H) Phone (C) Phone
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**SUSPECTED MEAL OR ACTIVITY**

# persons ill: _____	If <u>&gt; 1</u> person ill: Do all ill persons live together? <input type="checkbox"/> Y <input type="checkbox"/> N Do all ill persons work together? <input type="checkbox"/> Y <input type="checkbox"/> N # meals in common: _____	If <u>only 1</u> person ill: Any recent travel: <input type="checkbox"/> Y <input type="checkbox"/> N Any animal exposures: <input type="checkbox"/> Y <input type="checkbox"/> N Type: _____
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Suspected place of exposure including address	Date of meal: ____/____/____ Time of meal: _____	# ill persons who ate suspect meal: _____ Total # persons who ate suspect meal: _____
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**CLINICAL DATA**

Name				
Phone				
Address				
Date interviewed				
Date of birth or Age				
Sex	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk <input type="checkbox"/> Other
Date and time ate	Date            Time	Date            Time	Date            Time	Date            Time
First symptom	<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Not Ill	<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Not Ill	<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Not Ill	<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Not Ill
Date & time of first episode of vomiting or diarrhea	Date            Time	Date            Time	Date            Time	Date            Time
Incubation (hours)				
Date & time of last episode of vomiting or diarrhea	Date            Time	Date            Time	Date            Time	Date            Time
Duration (hours or days)				

**SIGNS OR SYMPTOMS – (+) if person experienced symptom, (-) if person did not experience symptom**

Vomiting				
Diarrhea				
Avg # stools/24 hrs				
Bloody diarrhea				
Fever				
Abdominal cramps				
Body ache				
Other (list)				

**HEALTHCARE VISITS AND LABORATORY - (+) if Yes, (-) if No**

HCP visit (if yes, name)				
ER visit (if yes, name)				
Hospitalization (if yes, name)				
Stool submitted				
Lab results				

