



Wabash County Health Department

Environmental Food Division

89 W. Hill St. Wabash, IN 46992

260-563-0661 Fax: 260-563-6082

Individual Illness History of Foodborne Gastroenteritis

CONTACT INFO

PLEASE PRINT THE ENTIRE FORM LEGIBLY

Name _____ Age _____
 Address _____ Phone _____
 City _____ Occupation _____
 State _____ Gender: Male Female
 Zip Code _____ Email _____

Date of Illness: _____

Were you taking any medications prior to the date of illness? Yes No

If yes please specify: _____

What Symptoms Did You Experience?

	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Onset Date	Onset Time	Duration of Symptom
Cramps	<input type="checkbox"/>	<input type="checkbox"/>		AM PM	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>		AM PM	
Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>		AM PM	
Nausea	<input type="checkbox"/>	<input type="checkbox"/>		AM PM	
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>		AM PM	
Headache	<input type="checkbox"/>	<input type="checkbox"/>		AM PM	
Body Aches	<input type="checkbox"/>	<input type="checkbox"/>		AM PM	
Fever	<input type="checkbox"/>	<input type="checkbox"/>		AM PM	
Chills	<input type="checkbox"/>	<input type="checkbox"/>		AM PM	
Other:	<input type="checkbox"/>	<input type="checkbox"/>		AM PM	

Date that symptoms ceased: _____

Did you consult a doctor? Yes No

If yes, Doctors name: _____ Phone: _____

Was a stool specimen collected? Yes No

If yes, Lab Results: _____

Were you hospitalized overnight? Yes No

If yes, Where and how long: _____

Are you on a public water supply? Yes No Are you on a well water supply? Yes No

Have you had any exposure to animals? Yes No if yes, explain: _____

Have you had any exposure to children in diapers? Yes No

When was the last date you consumed alcohol? _____

Have you attended any pitch-ins, wedding receptions, etc. 72 hours prior to becoming ill? Yes No

Have you traveled inside or outside the state of Indiana recently? Yes No

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