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?

			Onset Date	Onset Time	Duration of Symptom
Cramps	Yes ☐	No ☐		AM PM	
Diarrhea	Yes ☐	No ☐		AM PM	
Blood in Stool	Yes ☐	No ☐		AM PM	
Nausea	Yes ☐	No ☐		AM PM	
Vomiting	Yes ☐	No ☐		AM PM	
Headache	Yes ☐	No ☐		AM PM	
Body Aches	Yes ☐	No ☐		AM PM	
Fever	Yes ☐	No ☐		AM PM	
Chills	Yes ☐	No ☐		AM PM	
Other:	Yes ☐	No ☐		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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Please use the space below to document all food and drink items consumed 72 hours prior to the date of illness. Take your time, and be specific. Include dates, times, and amounts you consumed i.e.:(half a sandwich or a whole one). Please print legibly

Date	Time	Items consumed and amount	Location
	AM PM		
	AM PM		
	AM PM		
	AM PM		
	AM PM		
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	AM PM		
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Did any of the food or drink items look, taste, or smell funny? Yes ☐ No ☐
If yes please specify: ______________________________

Did you share any of the food items with anyone? Yes ☐ No ☐
If yes please specify: ______________________________

Are there any leftover food items? Yes ☐ No ☐

Did you have contact with anyone else who was ill before the date of illness? Yes ☐ No ☐
If yes please specify: ______________________________

Please include any additional information. You may attach additional information to this form.
____

Signature: ______________________________ **Date:** ______________