

# Michigan Gastrointestinal Illness Complaint Interview Form

Ill  Well  Suspect case  Confirmed case Pathogen/Contaminant identified \_\_\_\_\_  
 If outbreak- #ill \_\_\_\_\_ Total # in party \_\_\_\_\_

## Patient Information

<b>Patient ID</b>	<b>RFP ID</b>	<b>First</b>	<b>Last</b>	<b>Middle</b>
<b>Street Address</b>				
<b>City</b>	<b>County</b>	<b>State</b>		<b>Zip</b>
<b>Home Phone #</b>		<b>Other phone</b>	<b>Ext</b>	<b>Cell phone</b>
<b>Medications taken for this illness</b>			<b>Allergies</b>	
<b>Parent/Guardian (required if pt under 18)</b>				
<b>First</b>		<b>Last</b>		<b>Middle</b>

## Investigation Information

<b>Investigation/complaint ID</b>	<b>Part of an outbreak?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Outbreak Name</b>	<b>Date/Time Receipt initial rpt rec'd by LHD (accreditation)</b> <small>mm/dd/yyyy</small> _____ <input type="checkbox"/> am <input type="checkbox"/> pm
<b>Investigation Status</b> <input type="checkbox"/> New <input type="checkbox"/> Active <input type="checkbox"/> Completed <input type="checkbox"/> Superseded <input type="checkbox"/> Cancelled		<b>Onset Date/Time</b> _____ <input type="checkbox"/> am <input type="checkbox"/> pm	<b>Incubation</b> _____ <input type="checkbox"/> hrs <input type="checkbox"/> days

## Demographics

<b>Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	<b>Date of Birth</b> mm/dd/yyyy	<b>Age</b>	<b>Age Units</b> <input type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Years
<b>Race</b> <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____			
<b>Ethnicity</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown		<b>Worksite/School/Daycare</b>	<b>Occupation/School grade</b>

## Physician/Hospital Referral Information

<b>Person providing referral</b>					
<b>First</b>	<b>Last</b>	<b>Phone</b> ###-###-####	<b>Ext</b>	<b>Email</b>	
<b>Primary Physician</b>					
<b>First</b>	<b>Last</b>	<b>Phone</b> ###-###-####	<b>Ext</b>	<b>Email</b>	
<b>Street Address</b>		<b>City</b>	<b>County</b>	<b>State</b>	<b>Zip</b>

<b>Name of LHD person receiving report</b>	<b>Title</b>	<b>Referred to whom in LHD for Investigation?</b>
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**Illness & Hospital Information**

<b>Patient Hospitalized</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Hospital Name</b>	<b>City</b>	<b>Hospital Record #</b>
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<b>Admission Date</b> <i>mm/dd/yyyy</i>	<b>Discharge Date</b> <i>mm/dd/yyyy</i>	<b>Days Hospitalized</b>	<b>Patient Deceased?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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<b>Date/Time Recovery</b> <input type="checkbox"/> am <input type="checkbox"/> pm	<b>Lab Diagnosis</b>	<b>Diagnosis Date</b>
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**Symptoms** (Check all that apply)  No Symptoms  Abdominal Cramps  Body Ache  Diarrhea  Diarrhea w/blood  Chills

Fatigue  Headache  Nausea  Vomiting  Blurred Vision  Tingling  Hives  Sore Throat

Burning in Mouth  Metallic taste  Difficulty Swallowing or Breathing  Difficulty Speaking  Numbness  Paralysis

<b>Fever?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>If Yes, specify highest fever</b>	<b>Scale</b> <input type="checkbox"/> °F <input type="checkbox"/> °C	<b>Other Symptoms?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Specify:</b>
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**Laboratory Information**

Specimen	Date Collected	Test Result	Test Name	Laboratory Name
Blood				
Stool				
Urine				
Other				

**Epidemiologic Information**

<b>High Risk Potential</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>If Yes, (Check all that apply)</b> <input type="checkbox"/> Contact w/confirmed case <input type="checkbox"/> Contact w/suspect case <input type="checkbox"/> Daycare Attendee <input type="checkbox"/> Food Handler <input type="checkbox"/> Direct Pt. Care Worker <input type="checkbox"/> Resident of Institutional Facility <input type="checkbox"/> Day Care Worker <input type="checkbox"/> Animal Handler <input type="checkbox"/> Other Name and Location of Facility attended or employed at _____
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<b>Travel (in/out state or international) in the past month?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>If Yes, Record Location and Date of travel</b>
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<b>Swimming in past month?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>If Yes, Location and Date</b>
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**Drinking Water Source**

<b>Home:</b> <input type="checkbox"/> Municipal <input type="checkbox"/> Well <input type="checkbox"/> Bottled <input type="checkbox"/> Other _____	<b>Work:</b> <input type="checkbox"/> Municipal <input type="checkbox"/> Well <input type="checkbox"/> Bottled <input type="checkbox"/> Other _____
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**Pets or Animal Contacts in the 2 weeks prior to onset:**

**Contact Information**

List all contact with persons having concurrent or similar illness (list additional information in comments section) OR other people who may have been present at an implicated event or meal. Please mark if they were ill.

Name of Contact	Ill?	Onset	Address & Phone	Relationship	High Risk Factor
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				
	<input type="checkbox"/>				

**Food Purchase Information**

List all places where the patient **purchased grocery items in the 2 weeks prior to illness onset:** (Include: Grocery Stores, Markets, Produce Stands, Convenience Stores, Home Delivery)

Date of Purchase <i>mm/dd/yyyy</i>	Name of Facility	Location or address	Foods purchased-be specific, (e.g. Brand X cereal, Brand Y milk, 'ground beef' rather than 'meat', 'apples' rather than 'fruit')

**Non-Home Consumption History**

List any other food and beverages consumed **OUTSIDE the home** in the **2 weeks prior** to illness onset- (Include: Carry Out, Events, Fast Foods, Parties, Restaurants, Travel or Work-Related Meals)

Date of Consumption <i>mm/dd/yyyy</i>	Name of Facility/Event	Food/beverages consumed	Address of facility/event

72-hour Food History Date of Onset (see pg. 1) _____ Time of Onset (see pg. 1) _____ <input type="checkbox"/> am <input type="checkbox"/> pm			
List <b>all</b> foods/beverages consumed <b>3 days</b> prior to illness onset: (prompt for typical foods if unable to recall) <b>If illness onset started before 12 Noon on Day One, begin by recording the food history from day before illness onset</b>			
<b>Day One (food consumed within 24 hours prior to onset) / Date _____</b>			
Meal/Time	Food/Beverages Consumed	Facility Name & Location	Meal Companions
Breakfast Time <input type="checkbox"/> am <input type="checkbox"/> pm			
Lunch Time <input type="checkbox"/> am <input type="checkbox"/> pm			
Dinner Time <input type="checkbox"/> am <input type="checkbox"/> pm			
Other/Snacks Time <input type="checkbox"/> am <input type="checkbox"/> pm			
<b>Day Two prior to Onset / Date _____</b>			
Meal/Time	Food/Beverages Consumed	Facility Name & Location	Meal Companions
Breakfast Time <input type="checkbox"/> am <input type="checkbox"/> pm			
Lunch Time <input type="checkbox"/> am <input type="checkbox"/> pm			
Dinner Time <input type="checkbox"/> am <input type="checkbox"/> pm			
Other/Snacks Time <input type="checkbox"/> am <input type="checkbox"/> pm			
<b>Day Three prior to Onset / Date _____</b>			
Meal/Time	Food/Beverages Consumed	Facility Name & Location	Meal Companions
Breakfast Time <input type="checkbox"/> am <input type="checkbox"/> pm			
Lunch Time <input type="checkbox"/> am <input type="checkbox"/> pm			
Dinner Time <input type="checkbox"/> am <input type="checkbox"/> pm			
Other/Snacks Time <input type="checkbox"/> am <input type="checkbox"/> pm			

**If report comes from ReportFoodPoisoning.com, food history information will be transferred from the website to this field and may be cut and pasted from here into 3-day Food History Section above.**

### Other Information

Local 1 (extra data field for LHD use)

Local 2 (extra data field for LHD use)

Name of Person Interviewed

Relationship to Patient

Date/Time of Investigation Initiation

*mm/dd/yyyy xx:xx am/pm*

Completed/Submitted by:

Date

Health Department

Phone #

Ext

**Comments or Additional Information Regarding Specific Complaint or Additional Notes from ReportFoodPoisoning.com report:**