Michigan Gastrointestinal Illness Complaint Interview Form

☐Ill ☐Well ☐Suspect case ☐Confirmed case Pathogen/Contaminant identified_____
If outbreak- #ill_____ Total # in party_____

Patient Information

Patient ID	RFP ID	First	Last	Middle

Street Address

City	County	State	Zip

Home Phone #	Other phone	Ext	Cell phone

Medications taken for this illness	Allergies

Parent/Guardian (required if pt under 18)

First	Last	Middle

Investigation Information

Investigation/complaint ID	Part of an outbreak? ☐*Yes* ☐*No* ☐*Unknown*	Outbreak Name	Date/Time Receipt initial rpt rec'd by LHD (accreditation) *mm/dd/yyyy* _____ _____ ☐am ☐pm

Investigation Status ☐*New* ☐*Active* ☐*Completed* ☐*Superceded* ☐*Cancelled*	Onset Date/Time _____ _____ ☐*am* ☐ *pm*	Incubation _____ ☐ hrs ☐ days

Demographics

Sex ☐*Male* ☐*Female* ☐*Unknown*	Date of Birth *mm/dd/yyyy*	Age	Age Units ☐*Days* ☐*Months* ☐*Years*

Race
☐*Caucasian* ☐*African American* ☐*Native American/Alaska Native* ☐*Hawaiian/Pacific Islander*
☐*Asian* ☐*Unknown* ☐*Other* _____

Ethnicity ☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Unknown	Worksite/School/Daycare	Occupation/School grade

Physician/Hospital Referral Information

Person providing referral

First	Last	Phone ###-###-####	Ext	Email

Primary Physician

First	Last	Phone ###-###-####	Ext	Email

Street Address	City	County	State	Zip

Name of LHD person receiving report	Title	Referred to whom in LHD for Investigation?

Illness & Hospital Information

Patient Hospitalized	Hospital Name	City	Hospital Record #
☐ *Yes* ☐ *No* ☐ *Unknown*			

Admission Date	Discharge Date	Days Hospitalized	Patient Deceased?
mm/dd/yyyy	*mm/dd/yyyy*		☐ *Yes* ☐ *No* ☐ *Unknown*

Date/Time Recovery	Lab Diagnosis	Diagnosis Date
☐ *am* ☐ *pm*		

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

Fever?	If Yes, specify highest fever	Scale	Other Symptoms? ☐ *Yes* ☐ *No*
☐ *Yes* ☐ *No* ☐ *Unknown*		☐ °*F* ☐ ℃	**Specify:**

Laboratory Information

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

Epidemiologic Information

High Risk Potential
☐ *Yes* ☐ *No*
☐ *Unknown*

If Yes, *(Check all that apply)*
☐ *Contact w/confirmed case* ☐ *Contact w/suspect case* ☐ *Daycare Attendee*
☐ *Food Handler* ☐ *Direct Pt. Care Worker* ☐ *Resident of Institutional Facility*
☐ *Day Care Worker* ☐ *Animal Handler* ☐ *Other*
Name and Location of Facility attended or employed at _____

Travel (in/out state or international) in the past month?	If Yes, Record Location and Date of travel
☐ *Yes* ☐ *No* ☐ *Unknown*	

Swimming in past month?	If Yes, Location and Date
☐ *Yes* ☐ *No* ☐ *Unknown*	

Drinking Water Source

Home:	Work:
☐ *Municipal* ☐ *Well* ☐ *Bottled* ☐ *Other* _____	☐ *Municipal* ☐ *Well* ☐ *Bottled* ☐ *Other* _____

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
	☐				
	☐				
	☐				
	☐				

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 *mm/dd/yyyy*	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 *mm/dd/yyyy*	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) ____ ☐am ☐pm

List all foods/beverages consumed 3 days prior to illness onset: (prompt for typical foods if unable to recall) **If illness onset started before 12 Noon on Day One, begin by recordingthe food history from day before illness onset**

Day One (food consumed within 24 hours prior to onset) / Date

Meal/Time	Food/Beverages Consumed	Facility Name & Location	Meal Companions
Breakfast Time ☐am ☐pm			
Lunch Time ☐am ☐pm			
Dinner Time ☐am ☐pm			
Other/Snacks Time ☐am ☐pm			

Day Two prior to Onset / Date ____

Meal/Time	Food/Beverages Consumed	Facility Name & Location	Meal Companions
Breakfast Time ☐am ☐pm			
Lunch Time ☐am ☐pm			
Dinner Time ☐am ☐pm			
Other/Snacks Time ☐am ☐pm			

Day Three prior to Onset / Date ____

Meal/Time	Food/Beverages Consumed	Facility Name & Location	Meal Companions
Breakfast Time ☐am ☐pm			
Lunch Time ☐am ☐pm			
Dinner Time ☐am ☐pm			
Other/Snacks Time ☐am ☐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: