North Carolina Public Health Department

FOODBORNE ILLNESS COMPLAINT WORKSHEET

Date: ____/____/____

Questions? Call
Gen Comm Disease Control 919-733-3419
DENR- Food/Inst. Sanitation 919-733-2905
State Lab of Public Health 919-733-7367

PERSON TAKING CALL

Name: _____ Phone: (_____) _____-_____

Agency: _____ Fax: (_____) _____-_____ Email: _____

Complainant Information:

Name:			
Caller name (if different):			Age:
Address:			
Phone:	Occupation:	Work Phone:	
Where were suspect foods eaten? (name, address)		Date:	Time:
Foods/beverages consumed:			
Please list any available remaining foods:			

Others in your party/household who are sick:

Name	Address/Town	Phone	Age (yrs)	Occupation	Med Provider
1					
2					
3					
4					

Symptoms:

Intoxications	Enteric	Generalized	Neurological
___ Nausea	___Abdominal cramps	___ Cough	___ Blurred vision
___ Vomiting	___Diarrhea	___ Dehydration	___ Difficulty speaking
___ Bloating	___ Bloody diarrhea	___ Swelling	___ Difficulty swallowing
___ Burning sensation (mouth)	___ Fever _____°F	___ Headache	___ Dizziness
___ Metallic taste in mouth	___ Chills	___ Jaundice	___ Double vision
___ Thirst		___ Rash	___ Numbness
___ Flushing		___ Weakness	___ Paralysis
___ Excessive sweating			___ Tingling

Other symptoms:

Date symptoms began:	Time:
Date symptoms ended:	Time:
Was medical attention received?	If yes, Dr/Clinic name:
Were specimens (stool, urine, blood) taken?	If yes, results:

General Information:

Have you traveled recently? If so, location/date:
Have you been exposed to any animals/reptiles recently? If so, what type/when?

FOOD HISTORY

Obtain history back 72 hours prior to symptoms, **OR,** if organism is identified - use average incubation period
If > 2 ill, follow above time frame for **common meals** (food) only

Date/Time[1]	# Exp[2]	Foods consumed	Restaurant/store where purchased (name/town)	Placed consumed
__B __L __D				__ Same as left __ Home __ Other (specify):
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__B __L __D				__ Same as left __ Home __ Other (specify):
__B __L __D				__ Same as left __ Home __ Other (specify):

1 Always record Time if possible; otherwise, choose B= breakfast, L= lunch, D= Dinner

2 Total # person (both ill and well) who consumed indicated food(s)

Investigated by: _____ **Date:** _____

Notes

_____

_____

_____

_____

_____

Food Testing

Food(s) available for testing? __ Yes __ No __ Unkn Send to SLPH? __ Yes __ No __ Unkn

If Yes, specify food(s) & source:

Product and Manufacturer Information for Commercially-Processed Food(s)

Product Name: _____ Code/lot # _____

Expiration date: ____/____/_____ Package size/type: _____

Manufacturer: _____ Phone # ( ) _____-_____

Address _____

City: _____ State: _____ Zip _____

Incubation Periods for Selected Organisms

	Min	Max		Min	Max		Min	Max
B. cereus (short)	1hr	6hrs	E.coli 0157:H7	3 days	8days	Staph aureus	30 min	8hrs
B. cereus (long)	6hrs	24hr	Hepatitis A	15 days	50 days	Shigella	12 hrs	96 hrs
Campylobacter	1 day	10 days	Salmonella (non typhi)	6hrs	72hrs	Vibrio cholerae	few hrs	5days
Cyclospora	1day	14 days	Salmonella typhi	1 wk	3wks	Viral GI	12hrs	48 hrs
C. perfringens	6hrs	24 hrs	Shellfish poisoning	min	few hrs	Yersinia	3 days	7 days