SUSPECT FOODBORNE ILLNESS QUESTIONNAIRE

Some participants of an event you attended recently reported being ill and we are asking you to fill out this questionnaire to get more information. All information you provide is confidential.

Your Name: ____ **Phone:** ______________________

1) At about what time did you start eating food from ***Bali Hai Restaurant*** on Wednesday, 7/29/15? ____ **AM / PM**

Method(s) Food Served *(please check all that apply)*

- Sit-down (waiter service) **YES / NO**
- Buffet served by food staff **YES / NO**
- Self-serve buffet **YES / NO**
- Self-serve by utensils **YES / NO**
- Self-serve by bare hands **YES / NO**
- Other **YES / NO** *If yes, please specify:* ____________________

2) Were you ill anytime during the week **BEFORE** the event? **YES / NO** (please circle)
If "No," please go to Question #3.

- Vomiting? **YES / NO** *If yes, specify onset date:* ___/___/___
- Diarrhea? **YES / NO** *If yes, specify onset date:* ___/___/___
- Fever? **YES / NO**
- Were you ill at event? **YES / NO**

3) Were you ill during the week **AFTER** the event? **YES / NO**
If "No," please go to Question #16.

4) Did your symptoms include **vomiting**? **YES / NO**

- Date started? ____ / ____ / ____ (date)
- Time started? ____ : ____ (time) **AM / PM** (please circle one)
- Highest # of episodes/day? ____
- Date when vomiting stopped ____ / ____ / ____ (date)

5) Did your symptoms include **diarrhea**? **YES / NO**

- Date started? ____ / ____ / ____ (date)
- Time started? ____ : ____ (time) **AM / PM** (please circle one)
- Highest # of episodes/day? ____
- Noticed blood in diarrhea? **YES / NO**
- Date when diarrhea stopped ____ / ____ / ____ (date)

6) Did your symptoms include **fever**? **YES / NO**

- Did you take your temperature? **YES / NO**
- Highest temp (if taken)? _______ (degrees)

7) Did you experience any of the following symptoms? (please circle all that apply)

- Chills **YES / NO**
- Nausea **YES / NO**
- Abdominal pain **YES / NO**
- Headache **YES / NO**
- Body aches **YES / NO**
- Weight loss **YES / NO**
- Weakness **YES / NO**
- Fatigue **YES / NO**
- Other signs & symptoms (please specify): ________________________________

8) Do you have any underlying medical conditions that may have contributed to these symptoms? **YES / NO**
If yes, please specify: ________________________________

9) Did you receive any medical care for your recent illness? **YES / NO** ***If "No," please skip to question #11.***

10) Did you submit a stool (feces) sample for testing? **YES / NO**
If yes, please specify culture results (if known): ___________________ *Health care provider:* _____________________

11) Did you take antibiotics or any other medications for this illness? **YES / NO**
If yes, please specify medication if known: _______________________ *and date started:* _____/_____/_____

12) Are you still experiencing diarrhea? **YES / NO** ***If "No," please skip to question #14.***

13) **Would you be willing to submit a stool specimen for testing? YES / NO**

14) **Approximately how long did the diarrhea &/or vomiting last?** ____ **Hours / Days** (please circle one)

15) Others ill in household with similar symptoms recently? **YES / NO**
If yes, please indicate their names and onset date: ____

16) ***Please specify below which food, beverage or dessert items you consumed at the restaurant:***

Entrees:

Jerk spiced and pineapple-rum glaze pork loin	**YES / NO / UNKNOWN**
Teriyaki roasted chicken	**YES / NO / UNKNOWN**
Blackened salmon	**YES / NO / UNKNOWN**
Roasted corn relish	**YES / NO / UNKNOWN**
Other *(if yes, please specify)*	**YES / NO / UNKNOWN**

Sides:

Vegetable fried rice	**YES / NO / UNKNOWN**
Garlic mashed potatoes	**YES / NO / UNKNOWN**
Other *(if yes, please specify)*	**YES / NO / UNKNOWN**

Salads:

House blend local greens	**YES / NO / UNKNOWN**
Ginger plum vinaigrette	**YES / NO / UNKNOWN**
Island style potato salad	**YES / NO / UNKNOWN**
Thai Caesar salad	**YES / NO / UNKNOWN**
Asian chopped salad	**YES / NO / UNKNOWN**
Other *(if yes, please specify)*	**YES / NO / UNKNOWN**

Condiments: **YES / NO / UNKNOWN**
If yes, please specify:

Desserts:

Carrot cake	**YES / NO / UNKNOWN**
Other *(if yes, please specify)*	**YES / NO / UNKNOWN**

Beverages:

Water	**YES / NO / UNKNOWN**
Coffee	**YES / NO / UNKNOWN**
Tea	**YES / NO / UNKNOWN**
Iced tea	**YES / NO / UNKNOWN**
Beer	**YES / NO / UNKNOWN**
Wine *(if yes, please specify type)*	**YES / NO / UNKNOWN**
Soda *(if yes, please specify type)*	**YES / NO / UNKNOWN**
Other *(if yes, please specify)*	**YES / NO / UNKNOWN**

Ice: →→→→→→→→→→→→→ **YES / NO / UNKNOWN**

Did you have any other food, beverage or dessert items not mentioned above?
If yes, please specify: ____

17) Was there anything you noticed about your meal that concerned you? **YES / NO**
If yes, please explain: ____

18) Did you notice anyone who had vomiting *(or complained of having stomach flu)* at the event? **YES / NO**
If yes, please explain: ____

19) Did you use the restroom at the facility? **YES / NO**

20) Did you get together with any of the people from this event, other than household members, during the week prior to this event? **YES / NO** *If yes, please specify with whom:* ____
Please also specify date, time, and nature of prior contact: ____

Age (years): _____ **Gender:** ______ **Occupation:** ________________________ **Date:** _____ /_____ /_____

Thank you so much for your time!