

Foodborne/Waterborne Illness Investigation
Form C-Clinical Data, Food History & Common Sources Report Form

SECTION 1: CLINICAL DATA (Complete for all cases)

Reported By:	Date Reported:	Client's Phone Number: Work: _____ Home: _____
Client Name:	Age	Type of Identifier Used: MCP <input type="checkbox"/> Other <input type="checkbox"/> (Please identify) _____
Home Address:	Female <input type="checkbox"/> Male <input type="checkbox"/>	Next of Kin:

Disease Name, if Known: _____	Date specimen collected: (month/day/year)
Laboratory Confirmed: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Date lab confirmed: _____	Type of specimen obtained:
Hospital Lab <input type="checkbox"/> Public Health Lab <input type="checkbox"/> Other <input type="checkbox"/> (Please identify) _____	

Attending Physician Consulted:	Address:	Tel:
Family Physician :	Address:	Tel:

Case Ill: <input type="checkbox"/> Yes <input type="checkbox"/> No Case Notified of Illness: <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalized: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Dates: _____	Hospital: _____
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Occupation: (Identify if case is a food handler, child care, adult care or health care worker)	Place of Work:
Date of Onset of Symptoms: (month/day/year)	Duration of Illness: <input type="checkbox"/> Ongoing (days)
Time of Onset of Symptoms: (include A.M. or P.M.)	Incubation Period: <input type="checkbox"/> Unknown (hours)

Medications Prescribed for Illness: <input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	Amount	Date Started:(month/day/year)	Duration: (Days)
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Known Allergies:	Special Dietary Habits, etc.:	Medication/Vaccine Prior to Illness:
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Signs and Symptoms: (check appropriate signs and symptoms and circle those that occur first)

Intoxication		Enteric Infections		Generalized Infections		Localized Infections		Neurological Illnesses	
nausea		abdominal cramps		lack of appetite		ear		blurred vision	
vomiting		diarrhea bloody <input type="checkbox"/> mucoid <input type="checkbox"/> greasy <input type="checkbox"/> water <input type="checkbox"/> No. / day:	headache		eye		dizziness		
bloating			muscular aching		itching		numbness		
dehydration			perspiration		mouth		tingling		
weight loss		chills		malaise		rash	difficulty swallowing		
other:		fever		weakness		skin lesion	difficulty breathing		
		constipation		other:		describe:	other:		

EHO Comment: Any Attempted call(s) or visit(s)? yes no If yes, please list date(s) & time(s)

SECTION 2: OPEN-ENDED FOOD HISTORY

Instructions: Please note that the detailed length of the food history will depend upon the maximum incubation period of the infectious agent. If infectious agent is unknown, please complete a 3 day food history. If you are unable to obtain at least 50 % or more of the meals for the required length of the food history then Section 3 must be completed

Please try to remember what you may have eaten in the days before you started feeling sick. We'll start with the day you got sick and work backwards. (If a meal was eaten out, specify where.)

DAY OF ILLNESS- Date: _____

Breakfast	Lunch	Dinner	Snacks/Water Ingested
Place _____ Hour: _____ Items Consumed:			
<input type="checkbox"/> Unable to Recall			
Companions at Meal (III & Well)	Companions at Meal (III & Well)	Companions at Meal (III & Well)	
Comments:			

DAY BEFORE ILLNESS- Date: _____

Breakfast	Lunch	Dinner	Snacks/Water Ingested
Place _____ Hour: _____ Items Consumed:			
<input type="checkbox"/> Unable to Recall			
Companions at Meal (III & Well)	Companions at Meal (III & Well)	Companions at Meal (III & Well)	
Comments:			

- **Instructions:** Please photocopy this page if the detailed length of the required food history is greater than three days before illness

DAYS BEFORE ILLNESS- Date: _____

<i>Breakfast</i>	<i>Lunch</i>	<i>Dinner</i>	<i>Snacks/Water Ingested</i>
Place_____	Place_____	Place_____	Place_____
Hour:_____	Hour:_____	Hour:_____	Hour:_____
Items Consumed:	Items Consumed:	Items Consumed:	Items Consumed:
<input type="checkbox"/> Unable to Recall			
Companions at Meal (III & Well)	Companions at Meal (III & Well)	Companions at Meal (III & Well)	
Comments:			

DAYS BEFORE ILLNESS- Date: _____

<i>Breakfast</i>	<i>Lunch</i>	<i>Dinner</i>	<i>Snacks/Water Ingested</i>
Place_____	Place_____	Place_____	Place_____
Hour:_____	Hour:_____	Hour:_____	Hour:_____
Items Consumed:	Items Consumed:	Items Consumed:	Items Consumed:
<input type="checkbox"/> Unable to Recall			
Companions at Meal (III & Well)	Companions at Meal (III & Well)	Companions at Meal (III & Well)	
Comments:			

SECTION 3: SPECIFIC FOOD ITEMS

- **Instructions:** Please complete this section, if you are unable to obtain a satisfactory detailed food history from Section 2 or directed by the Regional Medical Officer of Health. Please note that a satisfactory detailed food history is defined as obtaining information from at least 50 % or more of the meals for the required length of the food history

Now, I'd like to ask about specific food items. Did you eat any of the following during the week before your illness?

Dairy Products *Comments (variety/brand, how prepared, where bought/eaten, etc.)*

Milk	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	(don't know/not specified)	_____
Ice Cream	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____	_____
Yogurt	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____	_____
Cheese	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____	_____
Soft cheeses	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____	_____
• brie	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____	_____
• queso fresco	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____	_____
• cottage	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____	_____
• cream	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____	_____
• feta	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____	_____
• mozzarella	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____	_____
• ricotta	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____	_____
• other (soft)	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	specify _____	_____
Other cheeses	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	specify _____	_____

For Dairy Products, please indicate if the product is unpasteurized

Fish, Poultry, Eggs and Meats *Comments (variety/brand, how prepared, where bought/eaten, etc.)*

Fish	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Shellfish (such as shrimp, lobster, clams, etc.)	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	specify _____
Chicken	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Turkey	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Eggs	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Pork	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Veal	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Lamb	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Moose	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Caribou	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Rabbit	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Other Venison	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	specify _____
Sausage	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Hot dog	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____

Beef jerky	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Dried salami	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Steak	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Roast beef	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Other beef	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	specify _____
Other products	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	specify _____

Ground Meats

➤ Ground beef yes no dk/ns

If yes, was item eaten at home or out? at home out, where _____ both

How was the item cooked? rare (red in middle) medium (pink in middle) well done (no pink)

For item eaten in the home, was it made from (*also ask where item was purchased from,, % fat, etc*):

- Fresh (never frozen) raw food item yes no dk/ns _____
- Previously frozen raw food item yes no dk/ns _____
- Pre-made uncooked patties yes no dk/ns _____
- Pre-made, pre-cooked patties yes no dk/ns _____

Other ground item such as in a taco, meatloaf, etc. yes no dk/ns _____

If yes, specify dish _____, eaten at home or out, where _____

➤ Ground Chicken/Turkey yes no dk/ns

If yes, was item eaten at home or out? at home out, where _____ both

How was the item cooked? rare (red in middle) medium (pink in middle) well done (no pink)

For item eaten in the home, was it made from (*also ask where item was purchased from,, % fat, etc*):

- Fresh (never frozen) raw food item yes no dk/ns _____
- Previously frozen raw food item yes no dk/ns _____
- Pre-made uncooked patties yes no dk/ns _____
- Pre-made, pre-cooked patties yes no dk/ns _____

Other ground item such as in a taco, meatloaf, etc. yes no dk/ns _____

If yes, specify dish _____, eaten at home or out, where _____

➤ Ground Pork yes no dk/ns

If yes, was item eaten at home or out? at home out, where _____ both

How was the item cooked? rare (red in middle) medium (pink in middle) well done (no pink)

For item eaten in the home, was it made from (*also ask where item was purchased from,, % fat, etc*):

- Fresh (never frozen) raw food item yes no dk/ns _____
- Previously frozen raw food item yes no dk/ns _____
- Pre-made uncooked patties yes no dk/ns _____

- Pre-made, pre-cooked patties yes no dk/ns _____

Other ground item such as in a taco, meatloaf, etc. yes no dk/ns _____

If yes, specify dish _____, eaten at home or out, where _____

➤ **Other Ground Meats:** yes no dk/ns *If yes, please specify type* _____

If yes, was item eaten at home or out? at home out, where _____ both

How was the item cooked? rare (red in middle) medium (pink in middle) well done (no pink)

For item eaten in the home, was it made from (*also ask where item was purchased from, % fat, etc*):

- Fresh (never frozen) raw food item yes no dk/ns _____
- Previously frozen raw food item yes no dk/ns _____
- Pre-made uncooked patties yes no dk/ns _____
- Pre-made, pre-cooked patties yes no dk/ns _____

Other ground item such as in a taco, meatloaf, etc. yes no dk/ns _____

If yes, specify dish _____, eaten at home or out, where _____

Salads and Vegetables

Comments (variety/brand, how prepared where bought/eaten, etc.)

Cole slaw yes no dk/ns _____

Pasta salad yes no dk/ns _____

Potato salad yes no dk/ns _____

Pre-packaged/ Pre-bagged salad or lettuce

yes no dk/ns *specify type/brand* _____

Lettuce(*loose leaf, whole heads, not bagged*)

yes no dk/ns _____

- Iceberg yes no dk/ns _____
- Green leaf yes no dk/ns _____
- Red leaf yes no dk/ns _____
- Romaine yes no dk/ns _____
- Mesclun yes no dk/ns _____
- Other yes no dk/ns *specify type* _____

Alfalfa sprouts yes no dk/ns _____

Bean sprouts yes no dk/ns _____

Other sprouts yes no dk/ns *specify type* _____

Asparagus yes no dk/ns _____

Carrots yes no dk/ns *specify type (large, baby)* _____

Cabbage yes no dk/ns _____

Celery yes no dk/ns _____

Spinach yes no dk/ns _____

Tomatoes yes no dk/ns *specify type (large, plum, cherry)* _____

Onions	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Radishes	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Green onions	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Parsley	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Cilantro	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Basil	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Other	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	specify _____

Fresh Fruits	<i>Comments (variety/brand, how prepared where bought/eaten, etc.)</i>			
Watermelon	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	whole or precut? _____
Cantaloupe	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	whole or precut? _____
Honeydew melon	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	whole or precut? _____
Apples	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Grapes	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	red or green? _____
Strawberries	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Kiwi	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Mango	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Pineapple	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Avocado	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Other	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	specify _____

Juices	<i>Comments (variety/brand, where bought/eaten, etc.)</i>			
Apple juice/cider	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Orange juice	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	_____
Smoothie	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	specify type/ingredients _____
Other juices	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	specify type/ingredients _____
Other	<input type="checkbox"/> yes	<input type="checkbox"/> no	<input type="checkbox"/> dk/ns	specify _____

For Juices, please indicate if the product is unpasteurized

Cross Contamination/Handling Potential

INDIRECT EXPOSURE TO GROUND MEAT IN THE HOME SETTING

If client answered no to eating some type of ground meat, ask the following.

Was there any ground meat in your refrigerator (not freezer) in the 7 days before your illness?

yes no dk/ns

If yes, where was meat stored in the refrigerator? _____

Did you or someone in your household prepare a meal for others that contained ground meat?

yes no dk/ns

Did you handle any raw meat/fish at home or anywhere else in the 7 days before your illness?

yes no dk/ns

If yes, what kind of meat(s)/fish was it?

SECTION 4: RESTAURANTS, GROCERY STORES, EVENTS (Complete for all cases)

Now, I would like to ask you about events in the week before your illness.

- **Did you eat out at any restaurants (including take-outs, street vendors, home delivery meals) during the week before your illness?** yes no don't know/not specified (dk/ns)

Name _____ Date _____ Time:_____ Location_____

Foods eaten: _____

Name _____ Date _____ Time:_____ Location_____

Foods eaten: _____

Name _____ Date _____ Time:_____ Location_____

Foods eaten: _____

Name _____ Date _____ Time:_____ Location_____

Foods eaten: _____

Name _____ Date _____ Time:_____ Location_____

Foods eaten: _____

- **Where did you purchase groceries that were eaten during the week before your illness (including specialty stores, produce/fruit stands, dairy marts, butcher shop, etc.)?**

Name _____ Location_____

Name _____ Location_____

Name _____ Location_____

Name _____ Location_____

- **Did you attend any large gatherings (parties, festivals, fairs, etc.)?** yes no dk/ns

If yes, when ____/____/____ where/type function _____

Foods eaten: _____

SECTION 5: DRINKING AND RECREATIONAL WATER EXPOSURES (Complete for all cases)

- **Where does your household water supply come from?**

Private well Municipal/city Other: (specify) _____

- **Is your drinking water treated in any special way (e.g. softened, boiled, filtered)?**

yes no dk/ns

If yes, *check all that apply:* Softened Boiled Filtered, type of filter _____

- **Do you have a cottage or recreational vehicle?**

yes no dk/ns

If yes, specify the source of your recreational drinking water?

- **Did you drink any bottled water in the last two weeks before your illness? yes no dk/ns**

If yes, what brand? _____

- **Did you drink any untreated water in the last two weeks before your illness (e.g. water from pond, lake, river)?**

yes no dk/ns

If yes, where _____

- **Did you drink any water from roadside springs in the last two weeks before your illness ?**

yes no dk/ns

If yes, where _____

- **Did you do any swimming or wading in the last two weeks before your illness?**

yes no dk/ns

If yes, what type of swimming area was it? (*check all that apply*)

Wading or kiddie pool where _____

Outdoor swimming pool where _____

Indoor swimming pool where _____

Hot tub, jacuzzi or spa where _____

Pond, lake, river or stream where _____

Other (specify) _____ where _____

Did you submerge your head under water? yes no dk/ns

Did you swallow any water? yes no dk/ns

SECTION 6: TRAVEL (Complete for all cases)

- **Any routine travel (i.e. staying at a cottage) in the last two weeks before your illness? yes no dk/ns**

If yes, where? _____ When? from _____ to _____

- **Any non routine travel in the last two weeks before your illness? yes no dk/ns**

If yes, where? _____ When? from _____ to _____

- **If airline travel, what airline? _____**

Outgoing flight no. _____ Return flight no. _____

Foods eaten on plane going there: _____ return: _____

- **If you stayed at a resort, please provide resort name: _____**

- **If cruise ship, name of ship _____ Destinations _____**

SECTION 7: FARM AND ANIMAL EXPOSURES (Complete for all cases)

- **Did you visit a farm or petting zoo at which there were animals?** yes no dk/ns
If yes, where _____ What kind of animals were there? _____
- **Did you have direct contact with any farm animals?** yes no dk/ns
If yes, what kind of animal(s)? _____ Where _____
- **Did you do any gardening?** yes no dk/ns
- **Did you have contact with animal manure (as might occur during farming or gardening)?**
 yes no dk/ns
If yes, what kind of activity were you involved in? _____
- **Did you have contact with household pets (including reptiles)?** yes no dk/ns
If yes, what kind of animal(s) _____
Were the animal(s) sick with diarrhea? yes no dk/ns

SECTION 8: OCCUPATION/DAYCARE, HOUSEHOLD & OTHER CONTACT INFORMATION (Complete for all cases)

- **If you have children or if case is a child:**
Do your child/children attend daycare? yes no
If yes, name of daycare _____ Location _____
Did your child/children attend daycare while sick with diarrhea and/or vomiting, etc? yes no
If yes,
Dates attended _____
Type(s) of symptoms _____
Do your child/children need assisting with toileting? yes no
- **Do you have any member of your household who require home care, elder care, etc?** yes no
If yes, specify the member of your household? _____
- **Can you tell us about other household members, coworkers or/and others contacts who have been ill with a similar illness:**

Name	Relationship	Age	Occupation	Onset & symptoms

SECTION 9: EHO COMMENTS, ACTIONS & SIGNATURE (Complete for all cases)

Control Measures Discussed:

Besides Control Measures Discussed, List any Recommendation(s) made to the Person Interviewed:

Comments:

Person Interviewed:

case someone else, specify name & relationship to case _____

Probable Source of Infection _____ **Unknown**

Environmental Health Officer (EHO)Signature: Agency **Date Completed:**

GUIDANCE INSTRUCTIONS FOR COMPLETION OF FORM C:

In order to determine the cause of the enteric infection, it is paramount that the following be met:

- Form must be completed & returned as soon as possible after receiving it from the regional health authority**
- All details in each appropriate section of this form must be completed. Please note that the form may be sent back for completion by the regional health authority if it is deemed that the information is incomplete**

SECTION 1: CLINICAL DATA

- Complete for all cases
- Any attempted call(s) or visit(s) must be recorded with date(s) & time(s) in the EHO Comment Table located on the bottom of page

SECTION 2: OPEN-ENDED FOOD HISTORY

- Detailed length of the food history for this section will depend upon the maximum incubation period of the infectious agent. If infectious agent is unknown, please complete a 3 day food history.
- Please photocopy page # 3 if the detailed length of the required food history is greater than three days before illness

SECTION 3: SPECIFIC FOOD ITEMS

- Complete this section, if you are unable to obtain a satisfactory detailed food history from Section 2 or directed by the Regional Medical Officer of Health. Please note that a satisfactory detailed food history is defined as obtaining information from at least 50 % or more of the meals for the required length of the food history

SECTION 4: RESTAURANTS, GROCERY STORES, EVENTS

- Complete for all cases

SECTION 5: DRINKING AND RECREATIONAL WATER EXPOSURES

- Complete for all cases

SECTION 6: TRAVEL

- Complete for all cases

SECTION 7: FARM AND ANIMAL EXPOSURES

- Complete for all cases

SECTION 8: OCCUPATION/DAYCARE, HOUSEHOLD & OTHER CONTACT INFORMATION

- Complete for all cases

SECTION 9: EHO COMMENTS, ACTIONS & SIGNATURE

- Complete for all cases. If interview was completed by an EHO Trainee, the supervising EHO must review & also sign this document.

For waterborne disease cases such as giardiasis where a food history may not be necessary, the requirements is reduced to the completion of sections 1, 4, 5, 6, 7, 8 & 9. However, Sections 2 or 3 may be needed to be completed if it is determined during the interview there is a disease food link