

**Introduction**

If you are answering on behalf of *your child*, please remember that these questions refer to your child and not yourself. "No" and "not sure" answers are as important as "Yes" answers. If you leave a blank space we cannot interpret your intended answer.

**1. Interviewer details**

Name of interviewer: \_\_\_\_\_ Date of interview: \_\_\_\_\_

Interviewer Tel: \_\_\_\_\_ Department: \_\_\_\_\_

**2. Patient Details**

Surname: \_\_\_\_\_ First Name(s): \_\_\_\_\_

Sex: Male  Female  Race: Asian  Black  Coloured  White

Date of Birth ...../...../..... dd/mm/yy Age: \_\_\_\_\_ Units (tick):  days  months  years

House number & Street: \_\_\_\_\_

Town/City: \_\_\_\_\_ Province: \_\_\_\_\_ Postcode: \_\_\_\_\_

Tel: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

What is your current occupation(s)/job(s)? \_\_\_\_\_

Workplace name and address: \_\_\_\_\_

Do you do any full time, part time or voluntary work that involves (tick all that apply):

Handling food  Caring for/teaching children  Healthcare  Working in a nursing home

If yes, give details: \_\_\_\_\_

**3. Clinical Details**

When did you start to feel unwell? ...../...../..... dd/mm/yy Time (approx): \_\_\_\_\_

Are you still ill? Yes  No  If **NO** - How many days were you ill for? \_\_\_\_\_

Did you experience the following symptoms (ask about all):

	Yes	No		Yes	No
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Rigors (chills)	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal cramps	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>			

Other (specify): \_\_\_\_\_

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Version 1, updated 8 June 2010**

Did you consult your GP for treatment of your illness? Yes  No

Did you visit a hospital for treatment of your illness? Yes  No

If YES, which hospital? \_\_\_\_\_

Were you admitted to hospital for treatment? Yes  No

Date of Admission: ...../...../..... Discharge date: ...../...../.....

If exact dates are not known, how many days were you in hospital for? \_\_\_\_\_

Were you prescribed medication or treatment for this illness? Yes  No

If YES, please indicate which: \_\_\_\_\_ Unknown

Do you have any underlying medical conditions or allergies (list all)? \_\_\_\_\_

**3. Exposure History**

Did you spend any nights away from your home town/village before you became ill? Yes  No

If YES, please give details:

Dates of travel: departure .../.../... return .../.../...

Country(ies) visited: \_\_\_\_\_

Town(s)/City(ies) visited: \_\_\_\_\_

Name of hotel(s)/resort(s)/etc. visited: \_\_\_\_\_

Have you had any visitors at your home before you became ill? Yes  No

If YES, where did they come from (list all places) and when did they visit? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you had any contact with animals before you became ill? Yes  No

If yes, what type of animals (house pets, cattle, sheep, goats, chickens, pigs, etc)? \_\_\_\_\_

\_\_\_\_\_

Have you attended any social gatherings before your illness (weddings, funerals, church functions, etc.)?

Yes  No  If YES, list all and give details: \_\_\_\_\_

\_\_\_\_\_

Do you know of anyone else who became ill with similar symptoms before or after you started to feel unwell?

Yes  No  If YES list all and give details:

Names	Contact details (for those belonging to other households)

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**Please complete the table regarding history of ALL food and beverages consumed over the 3 days before illness:**

Date & Time	Meal / snack	Place food purchased or served	List all foods consumed (include details of combination foods (e.g. sandwiches with fillings)	Sauces (gravy, salad dressings, etc.)	Beverages consumed (type, hot or cold, incl. ice)	How long after purchase / preparation was food consumed?	Was food reheated before consumption? (Yes/No)	Was there sharing of food / beverage / eating utensils?	What was the condition of food/beverage (unusual taste / smell / appearance)?
	<b>Day 1:</b> Breakfast								
	Lunch								
	Supper								
	Other meals								
	<b>Day 2:</b> Breakfast								
	Lunch								
	Supper								
	Other meals								

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Date & Time	Meal / snack	Place food purchased or served	List all foods consumed (include details of combination foods (e.g. sandwiches with fillings)	Sauces (gravy, salad dressings, etc.)	Beverages consumed (type, hot or cold, incl. ice)	How long after purchase / preparation was food consumed?	Was food reheated before consumption? (Yes/No)	Was there sharing of food / beverage / eating utensils?	What was the condition of food/beverage (unusual taste / smell / appearance)?
	<u>Day 3:</u> Breakfast								
	Lunch								
	Supper								
	Other meals / snacks								

What do you believe caused your illness? \_\_\_\_\_

**3. Laboratory investigations**

**Did you have specimen(s) collected for laboratory investigations?** Yes  No

If YES, complete table:

Date taken	Specimen type (stool, vomitus, blood, other)	Specimen taken prior to antibiotic therapy? (Yes/No)	Testing lab name	Lab number	Test requested	Result