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	☐	☐	Rigors (chills)	☐	☐
Vomiting	☐	☐	Muscle pain	☐	☐
Abdominal cramps	☐	☐	Joint pain	☐	☐
Diarrhoea	☐	☐	Loss of appetite	☐	☐
Constipation	☐	☐	Headache	☐	☐
Fever	☐	☐			

Other (specify): _____

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: ...../...../.....dd/mm/yy Discharge date:

...../...../.....dd/mm/yy 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? Yes No If YES, 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 . . . ./. . . . ./. . . . .dd/mm/yy return . . . ./. . . . ./. . . . .dd/mm/yy

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)**

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)?
	Day 1: Breakfast								
	Lunch								
	Supper								
	Other meals								
	Day 2: Breakfast								
	Lunch								
	Supper								
	Other meals								

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)?
	Day 3: 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