Foodborne Illness Questionnaire

1. PERSONAL DETAILS		
Name:		
Address:		
Phone:	Home:	Mobile:

2. MEDICAL TREATMENT		
Have you consulted a Doctor for your illness?	☐ Yes	☐ No
Consulting Doctors name:		
Clinic address:		
Have you already provided a clinical specimen (faecal/vomitus, etc.) to your Doctor?	☐ Yes	☐ No

3. SYMPTONS		
Did you develop any of the following symptoms?		
☐ Nausea (feel like throwing up)	☐ Vomiting	☐ Stomach cramps
☐ Fever	☐ Diarrhoea	☐ Bloody Diarrhoea
☐ Headache	☐ Other	
Which symptom occurred first?		
When did this symptom occur?	Time:	Date:
Which was the main symptom?		
Do you still suffer from any of the above symptoms?	☐ Yes	☐ No
How long did your illness last *(in hours)*?		

4. WHAT HAVE YOU EATEN?		
Do you think your illness was related to any item of food or drink?	☐ Yes	☐ No
What was the item of food or drink?		
Where did you buy the food or drink from?		
When did you consume this item of food or drink?	Time:	Date:
Did anyone else consume this food or drink *(friends, flatmates or family)*?	☐ Yes	☐ No
Do you have any of the food or drink left?		

Please forward this questionnaire to Byron Shire Council, Attention: Environmental Health Officer

Email form Print form Clear form

E2018/51592