



GENERAL ENTERIC DISEASES INTERVIEW FORM

Revised 01/2015

Use this form for: Salmonella, Campylobacter, Cryptosporidium, Shigella, and Yersinia.

Completed by: _____		LHD: _____	Phone: _____
Date of first interview attempt: / /		Date interview completed: / /	
<input type="checkbox"/> Case was interviewed	Case was not interviewed because:		
	<input type="checkbox"/> Unreachable	<input type="checkbox"/> Refused	<input type="checkbox"/> No working phone <input type="checkbox"/> Other _____

Case Information:				
Last name: _____		First Name: _____		
Street: _____		City: _____		Zip: _____
Phone: () -	DOB: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other _____	
Date specimen collected: / /		Source: <input type="checkbox"/> Stool <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Other _____		
Pathogen: _____		Laboratory: _____		
	Yes	No	Unk	If yes, additional details:
Did you have any symptoms associated with this illness?				Date/time of onset: / / : AM PM
Vomiting				Date/time of onset: / / : AM PM
Diarrhea				Date/time of onset: / / : AM PM Number of days diarrhea lasted:
Bloody Diarrhea				
Fever				Highest temperature:
Total number of days illness lasted:				
	Yes	No	Unk	If yes, additional details:
Were you hospitalized? (Inpatient only, not just ED visit)				Hospital name: _____ Admit date: / / Discharge date: / /
Do you have any underlying medical conditions or are you immunocompromised?				Describe: _____
Outcome: <input type="checkbox"/> Survived <input type="checkbox"/> Died				

Occupation and Risk Factor Information:				
Occupation: _____				
	Yes	No	Unk	If yes, specify where:
Prepare foods outside the home:				
Provide direct patient care outside the home:				
Work in day care setting?				
Attend day care setting:				

Can you tell us about other household members, their ages, occupation, and whether they have been ill with a similar illness:					
Name	Relationship	Age	Occupation	Ill	If yes, onset date and symptoms
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

NOTE: If case or household contacts are involved in high risk occupations/activities, implement appropriate control recommendations. Refer to the "Reportable Diseases Reference Manual".

What is your race? <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown
Are you of Hispanic background? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Did you travel outside of the United States in the 7 days before illness?				
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
Country:	Depart CT:	/	/	Return CT:
Country:	Depart CT:	/	/	Return CT:
Did you travel to any other states in the 7 days before illness?				
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
City/State	Depart CT:	/	/	Return CT:
City/State	Depart CT:	/	/	Return CT:
Did you attend any large parties or gatherings (parties, fairs, festivals) in the 7 days before illness?				
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
Event:	City:	Date/Time:	/	/
			:	AM PM
Foods eaten:				
Did you eat out at any restaurants in the 7 days before illness?				
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
Name:	City:	Date/Time:	/	/
			:	AM PM
Foods eaten:				
Name:	City:	Date/Time:	/	/
			:	AM PM
Foods eaten:				
Name:	City:	Date/Time:	/	/
			:	AM PM
Foods eaten:				
Where did you purchase groceries eaten in the 7 days before illness?				
Store Name	City			
Special Diet	Yes	No	Unk	If yes, specify/describe:
Food allergies that prevent you from eating certain foods?				
Vegetarian or Vegan diet?				
Special or restricted diet? (weight-loss, cultural, religious)				
Did you have any of the following exposures in the 7 days before your illness?				
<i>(NOTE FOR INTERVIEWER: If yes, please ask any listed follow-up questions)</i>				
Water-Related Exposure	Yes	No	Unk	If yes, where:
Live in a home with a septic system?				
Use water from a private well as drinking water?				
Drink untreated water (pond, lake, river, etc.?)				
Swim or wade in untreated water?				
Swim or wade in treated water?				
Animal Contact	Yes	No	Unk	If yes, where/type of animal:
Dog?				
Cat?				
Other pet mammals? (rodent, ferrets, rabbits)				
Pet bird (not poultry)				
Reptiles/Amphibians (turtles, frogs, lizards)				
Other pets? (fish, hermit crabs)				
Live poultry? (chicken, turkey)				
Cattle, goats, sheep?				
Pigs?				
Contact with a pet that had diarrhea?				
Visit, work, or live on farm/ranch/petting zoo?				
Ill contacts	Yes	No	Unk	If yes, who:
Household or close contact with diarrhea?				

COMMENTS:

Please enter interview data into Maven or fax to DPH Epidemiology Program at 860-509-7910. Thank you.

Continue to next page for Salmonella and Campylobacter only*

ADDITIONAL EXPOSURE QUESTIONS FOR SALMONELLA AND CAMPYLOBACTER ONLY

Did you eat the following items in the 7 days before your illness?				
<i>(NOTE FOR INTERVIEWER: If yes, please ask any listed follow-up questions and specify Brand/type, where purchased/eaten)</i>				
Meats and Seafood	Yes	No	Unk	If yes, food details:
Chicken or foods containing chicken (deli, ground, jerky)				
Was chicken eaten outside the home?				
Any chicken at home bought fresh?				
Any chicken at home bought frozen?				
Was chicken ground?				
Turkey or foods containing turkey (deli, ground, jerky)				
Was turkey eaten outside the home?				
Was turkey ground?				
Beef or foods containing beef (deli, ground, jerky)				
Was beef eaten outside the home?				
Was beef ground?				
Was ground beef undercooked or raw?				
Pork or foods containing pork (deli, ground, jerky)				
Lamb or mutton				
Raw or undercooked liver				
Liver pate				
Fish or fish products				
Was fish undercooked or raw? (sushi)				
Shellfish (crab, shrimp, oysters, clams)?				
Was shellfish undercooked or raw?				
Did you or anyone in your household handle:	Yes	No	Unk	If yes, food details:
Raw meat				
Raw poultry				
Raw seafood				
Eggs and Dairy	Yes	No	Unk	If yes, food details:
Eggs				
Were eggs eaten outside of home?				
Were eggs undercooked or raw?				
Foods made with raw eggs				
Dairy Products				
Unpasteurized or Raw Milk				
Pasteurized cow's or goat's milk				
Soft cheese				
Was soft cheese unpasteurized?				
Other raw/unpasteurized dairy products?				
Fresh, Raw Produce	Yes	No	Unk	If yes, food details:
Cantaloupe				
Watermelon				
Berries (specify type:_____)				
Lettuce (specify type:_____)				
Was lettuce prepackaged/bagged?				
Was lettuce whole head or loose leaf?				
Spinach				
Tomatoes (specify type:_____)				
Sprouts (specify type:_____)				
Herbs (specify type:_____)				
Other fresh fruits				
Other Foods	Yes	No	Unk	If yes, food details:
Any juice not pasteurized and not from concentrate				
Raw nuts (not roasted, processed)				
Peanut butter				
Peanut butter-containing products (Crackers, candies)				
Frozen entrees (pot pies, stuffed chicken products, pizza)				