BOARD OF HEALTH
BELMONT COUNTY GENERAL HEALTH DISTRICT

68501 Bannock Road • St. Clairsville, Ohio 43950 • Phone (740) 695-1202 • Fax (740) 695-8890
www.BelmontCountyHealth.com

FOODBORNE DISEASE REPORT
INDIVIDUAL CASE HISTORY

DATE: _____

SUSPECTED FOOD SERVICE NAME & ADDRESS
_____
_____
_____

NAME: _____ ADDRESS: _____

AGE: _____ SEX: _____ PHONE #: _____ EMAIL: _____

SYMPTOMS	YES	NO	DON'T KNOW
CRAMPS			
DIARRHEA			
BLOODY DIARRHEA			
NAUSEA			
VOMITTING			
HEADACHE			
BODY ACHES			
CHILLS			
FEVER			

OTHER (SPECIFY): _____

WHEN DID YOUR FIRST SYMPTOM BEGIN? DATE: _____ TIME: _____
WHEN DID YOU EAT THE SUSPECT MEAL? DATE: _____ TIME: _____
WHEN DID YOU FEEL BETTER? DATE: _____ TIME: _____ DURATION: _____HRS
WAS A PHYSICIAN OR HOSPITAL CONSULTED? YES NO (CIRCLE)
PHYSICIAN OR HOSPITAL NAME: _____
WERE YOU HOSPITALIZED: YES NO (CIRCLE)
WAS ANY STOOL SAMPLE TAKEN FOR TESTING? YES NO (CIRCLE)
PLACE OF EATING SUSPECT MEAL: _____
WHAT DID YOU EAT AND DRINK (SUSPECT MEAL): _____
_____
_____

NUMBER OF PERSONS IN HOUSEHOLD WHO DID NOT EAT SUSPECT MEAL: _____
OF THESE NUMBER DID ANYONE IN HOUSEHOLD WITH SIMILAR SYMPTOMS AFTER THE CASE: YES NO
DATE(S) & TIME(S) OF ONSET: _____
DO YOU HAVE ANY LEFTOVER FROM THE SUSPECT MEAL? YES NO
PLEASE USE CONT. FORM FOR OTHERS MEALS EATEN PRIOR OR BEFORE SUSPECT MEAL: