ENCLOSURE 4: UNSPECIFIED GASTROINTESTINAL ILLNESS

Case Investigation Form

ID NUMBER:_____ INTERVIEWER:_____

AGENCY:_____

DATE OF INTERVIEW:____/_____/_____

PERSON INTERVIEWED: ☐Patient ☐Other

If other, Name of person _____

Telephone contact _____- _____- _____

Describe relationship _____

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____

SEX: ❒ Male ❒ Female DATE OF BIRTH: ____/____/____ AGE____

RACE: ❒ White ❒ Black ❒ Asian ❒ Other, specify _____ ❒Unknown

ETHNICITY: ❒ Hispanic ❒ Non-Hispanic ❒ Unknown

HOME TELEPHONE: ( ) _____-_____

WORK/OTHER TELEPHONE: ( ) _____-_____

HOME ADDRESS STREET: _____

CITY:_____ STATE:_____ZIP:_____

EMPLOYED: ❒ Yes ❒ No ❒ Unknown

OCCUPATION:_____

WORKPLACE/SCHOOL NAME:_____

WORK/SCHOOL ADDRESS: STREET: _____ CITY: _____

STATE:_____ZIP:_____

HOW MANY PEOPLE RESIDE IN THE SAME HOUSEHOLD? _____

LIST NAME(S), AGE(S), AND RELATIONSHIPS (use additional pages if necessary):

Name					
Age					
Relationship					

CLINICAL INFORMATION (as documented in admission history of medical record or from case/proxy interview)

Chief Complaint: _____

Date of illness onset: ____/_____/_____

Which was experienced first:? ❒ Vomiting ❒ Diarrhea

Onset time: ____:_____ ❒AM ❒PM

Currently experiencing vomiting or diarrhea? ❒Yes ❒No ❒Unknown

Willing to provide stool specimen? ❒Yes ❒No ❒Unknown

Date of last day of illness with vomiting or diarrhea : ____ / ____ / ____

Time of last episode of vomiting or diarrhea: ____:____ ❒AM ❒PM

Total number of days of diarrhea: _____ days

Briefly summarize History of present illness:

_____

_____

SIGNS AND SYMPTOMS:

Nausea	❒Yes	❒No	❒Unknown
Vomiting	❒Yes	❒No	❒Unknown
Diarrhea	❒Yes	❒No	❒Unknown
If yes, maximum number of stools in a 24-hour period: _____			
Bloody diarrhea	❒Yes	❒No	❒Unknown
Abdominal pain/cramps	❒Yes	❒No	❒Unknown
Gas	❒Yes	❒No	❒Unknown
Loss of appetite	❒Yes	❒No	❒Unknown
Fever	❒Yes	❒No	❒Unknown
If yes, maximum temp: _____ ❒°F ❒°C			
Chills	❒Yes	❒No	❒Unknown
Headache	❒Yes	❒No	❒Unknown
Muscle aches	❒Yes	❒No	❒Unknown
Fatigue	❒Yes	❒No	❒Unknown
Constipation	❒Yes	❒No	❒Unknown
Weight loss	❒Yes	❒No	❒Unknown
If yes, pounds lost: _____lbs in _____ days			
Other symptoms/ abnormality	❒Yes	❒No	❒Unknown
If yes,			
describe_____			

PAST MEDICAL HISTORY:

Food allergies	❒Yes	❒No	❒Unknown
If yes, specify: _____			
Diabetes	❒Yes	❒No	❒Unknown
Malignancy:	❒Yes	❒No	❒Unknown
If yes, specify type: _____			
Currently on treatment:	❒Yes	❒No	❒Unknown
Currently pregnant	❒Yes	❒No	❒Unknown
HIV Infection	❒Yes	❒No	❒Unknown
Other Immunocompromising condition (e.g. renal failure, cirrhosis, chronic steroid use)			
	❒Yes	❒No	❒Unknown
If yes, specify disease or drug therapy: _____			
Colitis/inflammatory bowel disease	❒Yes	❒No	❒Unknown
Surgery to remove part of the stomach or intestines	❒Yes	❒No	❒Unknown

Other underlying condition(s): _____

Prescription medications: _____

SOCIAL HISTORY:

Current alcohol abuse:	❒Yes	❒No	❒Unknown
Past alcohol abuse:	❒Yes	❒No	❒Unknown
Current injection drug use	❒Yes	❒No	❒Unknown
Past injection drug use	❒Yes	❒No	❒Unknown
Current smoker	❒Yes	❒No	❒Unknown
Former smoker	❒Yes	❒No	❒Unknown
Other illicit drug use	❒Yes	❒No	❒Unknown

If yes, specify: _____

HOSPITAL INFORMATION:

Hospitalized? ❒Yes ❒No ❒Unknown

Name of hospital: _____

Date of admission: ____/____/_____ Date of discharge: ____/____/_____

Attending physician:

Last name: _____ First name: _____

Office telephone: ( )____-_____ Pager: ( )____-_____ Fax: ( )____-_____

DIAGNOSTIC STUDIES:

Test	Results of tests done on admission (___/___/___)	Abnormal test result at any time (specify date mm/dd/yy)
Hemoglobin (Hb)		(____/____/____)
Hematocrit (HCT)		(____/____/____)
Platelet (plt)		(____/____/____)
Total white blood cell (WBC)		(____/____/____)
WBC differential:		(____/____/____)
% granulocytes (PMNs)		(____/____/____)
% bands		(____/____/____)
% lymphocytes		(____/____/____)
Blood cultures	☐ positive (specify_____) ☐ negative ☐ pending ☐ not done	☐ positive (specify_____) ☐ negative ☐ pending ☐ not done (____/____/____)
Stool cultures	☐ positive (specify_____) ☐ negative ☐ pending ☐ not done	☐ positive (specify_____) ☐ negative ☐ pending ☐ not done (____/____/____)
Fecal white blood cells	☐ positive ☐ negative ☐ pending ☐ not done	☐ positive ☐ negative ☐ pending ☐ not done (____/____/____)

Test	Results of tests done on admission (___/___/___)	Abnormal test result at any time (specify date mm/dd/yy)
Stool ova and parasite exam	☐ positive (specify_____) ☐ negative ☐ pending ☐ not done	☐ positive (specify_____) ☐ negative ☐ pending ☐ not done (____/____/____)
Chest radiograph	☐ normal ☐ unilateral, lobar/consolidation ☐ bilateral, lobar/consolidation ☐ interstitial infiltrates ☐ widened mediastinum ☐ pleural effusion ☐ abnormal (describe:_____) ☐ not done	☐ normal ☐ unilateral, lobar/consolidation ☐ bilateral, lobar/consolidation ☐ interstitial infiltrates ☐ widened mediastinum ☐ pleural effusion ☐ abnormal (describe:_____) ☐ not done
Other tests	☐ normal ☐ abnormal (describe:_____ _____) ☐ not done	☐ normal ☐ abnormal (describe:_____ _____) ☐ not done (____/____/____)
Other pertinent study results (e.g., toxin assays)		(____/____/____)

INFECTIOUS DISEASE CONSULT: ☐Yes ☐No ☐Unknown

Date:___/___/___

Name of physician: Last Name _____ First Name _____

Telephone or beeper number ( ) _____ - _____

HOSPITAL TREATMENT:

a. antibiotics ☐Yes ☐No ☐Unknown

If yes, check all that apply:

- ☐ Amoxicillin
- ☐ Ampicillin
- ☐ Ampicillin + sulbactam (Unasyn)
- ☐ Augmentin (amoxicillin + clavulanate)
- ☐ Cefotetan (Cefotan)
- ☐ Cefoxitin (Mefoxin)
- ☐ Cefotaxime (Claforan)
- ☐ Ceftazidime (Fortaz, Tazicef, Tazidime)
- ☐ Ceftizoxime (Cefizox)
- ☐ Ceftriaxone (Rocephin)
- ☐ Cefuroxime (Ceftin)
- ☐ Ciprofloxacin (Cipro)
- ☐ Clindamycin (Cleocin)
- ☐ Gentamicin (Garamycin)
- ☐ Levofloxacin (Levaquin)
- ☐ Metronidazole (Flagyl)
- ☐ Piperacillin + Tazobactam (Zosyn)
- ☐ Ticarcillin + clavulanate (Timentin)
- ☐ Trimethaprim-sulfamethoxazole (Bactrim, Cotrim, TMP/SMX)
- ☐ Other_____
- ☐ Other_____

Did patient require intensive care? ☐Yes ☐No ☐Unknown

If patient was admitted to Intensive Care Unit:

a. Length of stay in ICU, in days:_____

b . Was patient on mechanical ventilation? ☐Yes ☐No ☐Unknown

WORKING OR DISCHARGE DIAGNOSIS(ES) :

1) _____

2) _____

3) _____

OUTCOME:

☐Recovered/discharged

☐Died

☐Still in hospital: ☐ improving ☐ worsening

☐ Comment_____

ADDITIONAL COMMENTS: _____

Risk Exposure Questions

The following questions pertain to the 2 week period prior to the onset of your illness/symptoms:

Occupation (provide information for all jobs/ volunteer duties)

1. Please briefly describe your job/ volunteer duties:_____

2. Does your job involve contact with the public?
   Yes No If "Yes", specify_____

3. Does anyone else at your workplace have similar symptoms?
   Yes No Unk
   If "Yes", name and approximate date on onset (if known)_____

Knowledge of Other Ill Persons

4. Do you know of other people with similar symptoms? Y / N / Unk

(If Yes, please complete the following questions)

Name of ill person	Age	M/F	Address	Phone number (s)	Date of onset	Relation to you	Did they seek medical care? Where?	Were they diagnosed by a physician? Describe.

Travel*

*Travel is defined as staying overnight (or longer) at somewhere other than the usual residence

8. Have you traveled anywhere in the last two weeks? Y / N / Unk

   Dates of Travel: ____/____/____ to ____/____/____
   Method of Transportation for Travel: _____
   Where Did You Stay? _____
   Purpose of Travel? _____
   Did You Do Any Sightseeing on your trip? Yes ☐ No ☐

If yes, specify: _____

Did Anyone Travel With You? Yes ☐ No ☐

If yes, specify: _____

Are they ill with similar symptoms? Yes ☐ No ☐ Unk ☐

Information for Additional Trips during the past two weeks:

_____

_____

Public Functions/Venues (during 2 weeks prior to symptom onset)

Category	Yes/No/ Unknown (Y/N/U)	Description of Activity	Location of Activity	Date of Activity	Time of Activity (start, end)	Others ill? (Y/N/U)
9. Sporting Event						
10. Performing Arts (ie Concert, Theater, Opera)						
11. Movie Theater						
12. Religious Gatherings						
13. Picnics						
14. Political Events (including Marches and Rallies)						
15. Meetings or Conferences (work or personal)						
16. Family Planning Clinics						
17. Government Office Building						
18. Airports						
19. Shopping Malls						
20. Gym/Workout Facilities						
21. Casinos						
22. Beaches						
23. Parks						
24. Parties (including Raves, Prom, etc)						
25. Bars/Clubs						
26. Tourist Attractions (ie Sea World, Zoo, Disneyland)						
27. Museums						
28. Street Fairs, Swap Meets, Flea Markets						
29. Carnivals/Circus						
30. Campgrounds						

Transportation

Have you used the following types of transportation in the 2 weeks prior to onset?

31. Bus Yes ☐ No ☐ Unk ☐
Frequency of this type of transportation: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely
Bus Number: _____ Origin:_____
Any connections? Yes ☐ No ☐ (Specify: Location_____ Bus#_____)
Company Providing Transportation: _____
Destination:_____

32. Train/Metro Yes ☐ No ☐ Unk ☐
Frequency of this type of transportation: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely
Route Number: _____ Origin:_____
Any connections? Yes ☐ No ☐ (Specify: Location_____ Route #_____)
Company Providing Transportation: _____
Destination:_____

33. Airplane Yes ☐ No ☐ Unk ☐
Frequency of this type of transportation: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely
Flight Number: _____ Origin:_____
Any connections? Yes ☐ No ☐ (Specify: Location_____ Flight #_____)
Company Providing Transportation: _____
Destination:_____

34. Boat/Ferry Yes ☐ No ☐ Unk ☐
Frequency of this type of transportation: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely
Ferry Number: _____ Origin:_____
Any connections? Yes ☐ No ☐ (Specify: Location_____ Ferry #_____)
Company Providing Transportation: _____
Destination:_____

35. Van Pool/Shuttle Yes ☐ No ☐ Unk ☐
Frequency of this type of transportation: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely
Route Number: _____ Origin:_____
Any connections? Yes ☐ No ☐ (Specify: Location_____ Route #_____)
Company Providing Transportation: _____
Destination:_____

Food & Beverage

36. During the 2 weeks before your illness, did you eat at any of the following ***food establishments or private gatherings with food or beverages***? (If "yes", circle establishment(s); describe below)

Restaurant, fast-food or deli	Y / N / Unk	Grocery store or salad-bar	Y / N / Unk
Cafeteria at school, hospital, other	Y / N / Unk	Plane, boat, train, other	Y / N / Unk
Concert, movie, other entertainment	Y / N / Unk	Gas station or 24-hr store	Y / N / Unk
Sporting event or snack bar	Y / N / Unk	Street-vended food	Y / N / Unk
Outdoor farmers market or swap meet	Y / N / Unk	Beach, park or outdoor event	Y / N / Unk
Dinner party, barbecue or potluck	Y / N / Unk	Other food establishment	Y / N / Unk
Birthday party or other celebration	Y / N / Unk	Other private gathering	Y / N / Unk

If "YES" for any in question #36, provide date, time, location and list of food items consumed:
Date/Time: _____ Location: _____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain):_____

If "YES" for any in question #36, provide date, time, location and list of food items consumed:
Date/Time: _____ Location: _____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain): _____

If "YES" for any in question #36, provide date, time, location and list of food items consumed:
Date/Time: _____ Location: _____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain): _____

If "YES" for any in question #36, provide date, time, location and list of food items consumed:
Date/Time: _____ Location: _____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain): _____

37. During the 2 weeks before your illness, did you consume any free ***food samples*** from……..?

Grocery store	Y / N / Unk
Race/competition	Y / N / Unk
Public gathering?	Y / N / Unk
Private gathering?	Y / N / Unk

If "YES" for any in question #34, provide date, time, location and list of food items consumed:
Date/Time: _____ Location (Name and Address): _____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain): _____

If "YES" for any in question #34, provide date, time, location and list of food items consumed:
Date/Time: _____ Location (Name and Address):_____
Food/drink consumed: _____
Others also ill?: Y / N / Unk (explain): _____

38. *During the 2 weeks before your illness, did you consume any of the following **products**?*

Vitamins	Y / N / Unk	Specify (Include Brand Name):_____
Herbal remedies	Y / N / Unk	Specify (Include Brand Name):_____
Diet Aids	Y / N / Unk	Specify (Include Brand Name):_____
Nutritional Supplements	Y / N / Unk	Specify (Include Brand Name):_____
Other Ingested non-food	Y / N / Unk	Specify (Include Brand Name):_____

39. During the 2 weeks before your illness, did you consume any unpasteurized products (ie milk, cheese, fruit juices)? Y/N/Unk If yes, specify name of item:_____
Date/Time: _____ Location (Name and Address):_____
Others also ill?: Y / N / Unk (explain): _____

40. During the 2 weeks before your illness, did you purchase food from any internet grocers? Y/N/Unk
If yes, specify date / time of delivery:_____ Store/Site:_____
Items purchased:_____

41. During the 2 weeks before your illness, did you purchase any mail order food? Y/N/Unk
If yes, specify date/time of delivery:_____ Store purchased from:_____
Items purchased:_____

42. Please check the routine sources for drinking water (check all that apply):
☐ Community or Municipal ☐ Well (shared) ☐ Well (private family)
☐ Bottled water (Specify Brand:_____) ☐ Other (Specify:_____)

Recreation*

**Recreation is defined as non-work related activities*

43. In the past two weeks, did you participate in any outdoor activities? Y / N / Unk
(If "yes", list all and provide location)
_____
_____

44. Do you recall any insect or tick bites during these outdoor activities? Y / N / Unk
(If "yes", list all and provide location)
_____
_____

45. Did you participate in other indoor recreational activities (i.e. clubs, crafts, etc that do not occur in a private home)? Y / N / Unk
(List all and provide location)

_____

_____

Vectors

46. Do you recall any insect or tick bites in the last 2 weeks? Y / N / Unk
Date(s) of bite(s):_____ Bitten by ☐ Mosquito ☐ Tick ☐ Flea ☐ Fly ☐ Other
Where were you when you were bitten? _____

47. Have you had any contact with wild or domestic animals, including pets? Y / N / Unk
Type of Animal: _____ Explain nature of contact:_____
Is / was the animal ill recently: Y / N / Unk Symptoms:_____
Date / Time of contact:_____ Location of contact:_____

48. To your knowledge, have you been exposed to rodents/rodent droppings in the last 2 weeks? Y / N / Unk If yes, explain type of exposure:_____
Date/Time of exposure:_____
Location where exposure occurred:_____