Revised: 4/6/2011

Foodborne Illness Report
Minnesota Department of Health
Phone: (651) 201-5414 Fax: (651) 201-5082

Stool kit delivered ☐
Daily ☐

Complaint date: _____/_____/_____ **Hotline call:** ☐ **How you got #**_______________________ Tennessen: ☐

Agency: Minnesota Department of Health Reporter: Dawn Kaehler

First Name:______________________ Last Name: __________________________ Age: _____ ☐ Female ☐ Male

Address: ____ Zip: ___________ Email: _______________

Home phone: (______)___________________ Work phone: (______)___________________ Cell: (______)_____________

Establishment that the complainant suspects: ____

Number of persons exposed: ______ Number ill: ______

Did complainant call the establishment? : ☐Y ☐N If yes, who did they speak with: _______________________________

**If a retail food product is suspected, please fill out page 4 (Retail Food Product Complaint) in addition to the 4-day food history*

ILLNESS HISTORY Illness Onset: ____/____/____ Time: ______ Recovery: ____/____/____ Time: ______

Vomiting ☐Y ☐N Onset: ____/____/____ Time: ______ Recovery: ____/____/____ Time: ______

Diarrhea ☐Y ☐N Onset: ____/____/____ Time: ______ Recovery: ____/____/____ Time: ______

# of stools per 24-hr. period (max): _____ Cramps ☐Y ☐N Fever ☐Y ☐N (temp:____) Bloody stools ☐Y ☐N

Other symptoms: ____ Visited health care provider ☐Y ☐N

If yes, name and location: ____ Date of visit: ____/____/____

Provider requested stool sample ☐Y ☐N If yes, date stool submitted: ____/____/____ Hospitalized ☐Y ☐N

FOOD HISTORY

If only one person is ill or if all ill persons live in same household, complete the entire four-day food history.
If more than one person is ill and they live in different households, record only the common meals.

Meal Time **Date: ____/____/____** ***(work backward starting with onset date)*** **Hours to Illness Onset**

Brk: _______ location: ____ food/drinks: ________________ _____

____

Lun: _______ location: ____ food/drinks: ________________ _____

____

Sup: _______ location: ____ food/drinks: ________________ _____

____

Other: ______ location: ____food/drinks: ________________ _____

Meal Time **Date: ____/____/____** **Hours to Illness Onset**

Brk: _______ location: ____ food/drinks: _______________ ____

____

Lun: _______ location: ____ food/drinks: _______________ ____

____

Sup: _______ location: ____ food/drinks: _______________ ____

____

Other: ______ location: ____ food/drinks: _______________ ____

Meal Time **Date: ____/____/____** **Hours to Illness Onset**

Brk: _______ location: ____ food/drinks: ______________ ____

____

Lun: _______ location: ____ food/drinks: ______________ ____

____

Sup: _______ location: ____ food/drinks: ______________ ____

____

Other: ______ location: ____ food/drinks: _______________ ____

Meal Time **Date: ____/____/____** **Hours to Illness Onset**

Brk: _______ location: ____ food/drinks: ______________ ____

____

Lun: _______ location: ____ food/drinks: ______________ ____

____

Sup: _______ location: ____ food/drinks: ______________ ____

____

Other: ______ location: ____food/drinks: ______________ ____

Complainant occupation: ___________________________________ Daycare exposure: Y N

Have you been swimming in the past 2 weeks: Y N If yes, where________________________ Date: ____/____/____

Did you drink any well water in the past 2 weeks: Y N If yes, where _______________________________________

Any ill household members in the last week: Y N If yes, who___________________________ Date: ____/____/____

AGENCIES NOTIFIED ☐ MDH-EHS ☐ MDH-District Office ☐ MN Dept of Ag ☐ FDA ☐ USDA

☐ Local Agencies: ____

Comments ____

HISTORY OF OTHERS ILL **Original Complainant's Name:**______________________________

First name:______________________________ **Last name:**___________________________________ **Age:**____

Address: ____ **Phone:** __________________________

Illness Onset: ____/____/____ Time: ______ Recovery: ____/____/____ Time: ______

Vomiting ☐Y ☐N Onset: ____/____/____ Time: ______ Recovery: ____/____/____ Time: ______

Diarrhea ☐Y ☐N Onset: ____/____/____ Time: ______ Recovery: ____/____/____ Time: ______

# of stools per 24-hr. period (max): _____ Cramps ☐Y ☐N Fever ☐Y ☐N (temp:____) Bloody stools ☐Y ☐N

Other symptoms: ____

Meals in common: **Incubation**

Meal 1: location: _____________________________ food/drinks: ______________________________________ ____

____

Meal 2: location: _____________________________ food/drinks: ______________________________________ ____

____

Meal 3: location: _____________________________ food/drinks: ______________________________________ ____

____

First name:______________________________ **Last name:**___________________________________ **Age:**____

Address: ____ **Phone:** __________________________

Illness Onset: ____/____/____ Time: ______ Recovery: ____/____/____ Time: ______

Vomiting ☐Y ☐N Onset: ____/____/____ Time: ______ Recovery: ____/____/____ Time: ______

Diarrhea ☐Y ☐N Onset: ____/____/____ Time: ______ Recovery: ____/____/____ Time: ______

# of stools per 24-hr. period (max): _____ Cramps ☐Y ☐N Fever ☐Y ☐N (temp:____) Bloody stools ☐Y ☐N

Other symptoms: ____

Meals in common: **Incubation**

Meal 1: location: _____________________________ food/drinks: ______________________________________ ____

____

Meal 2: location: _____________________________ food/drinks: ______________________________________ ____

____

Meal 3: location: _____________________________ food/drinks: ______________________________________ ____

____

Original Complainant's Name:______________________________

RETAIL FOOD PRODUCT COMPLAINT ***(please fill in as much information as you can)***

Name of product (please be specific): ____

Brand of product: ____

Manufacturer and/or distributor information (name and address): ____

____

Container type, size and weight (18 oz. plastic bottle, 1 lb. paper carton, etc.): ______________________________

USDA establishment number (if a packaged meat product): ____

UPC code (12-digit bar code): ____

Product/Lot/Best if Used By Date (BIUB) code: ____________________

____

____

Purchase location (name of store): ____

Address of purchase location: ____

Purchase date: __________________________

Does consumer still have the product or other containers of the same product? : _________________________________

____

Other information: ____

____