Hypothesis Generating Questionnaire for Gastroenteritis Complaints

Patient name:____________________________ Sex: M F DOB:___/___/___

Race/Ethnicity: 9 White, non-Hispanic 9 Black, non-Hispanic
9 Asian/Pacific Islander 9 American Indian/Alaska native
9 Hispanic 9 Unknown

Phone #: (___)__________ Address:____

City:______________________________ County:____________________________________

If patient was a child:

Mother's Name:______________________ Maternal Occupation:_________________________

Father's Name:______________________ Paternal Occupation:_________________________

Has the patient had nausea, vomiting or diarrhea in the last 10 days? 9 Yes 9 No

If yes: Symptom Onset Date:___/___/___ Duration of symptoms:____________________

Symptoms: Check all that apply.

9 Fever (Highest temp ______) 9 Vomiting 9 Poor feeding 9 Irritable

9 Bloody diarrhea 9 Non-bloody diarrhea Q Watery diarrhea

9 Chills 9 Headache 9 Abdominal cramps 9 Nausea

If patient had diarrhea, how many loose stools per day?

9 1-3 per day 9 4-6 per day 9 7-10 per day 9 10+ per day

Was the patient ill enough to require a doctor visit? 9 Yes 9 No Physician visit date:__________________
Name of physician seen:_________________________________ MD phone:______________________

Was the patient hospitalized? 9 Yes 9 No Hospital admission date:___________________________

Was the patient treated with antibiotics? 9 Yes 9 No If yes, which Rx:___________________________
Rx start date:______________________________

Lab Specimens

Stool sample submitted for enteric culture? 9 Yes 9 No Collection date:__________________________
Lab:________________________________ Results:____

Stool sample submitted for Ova and Parasite (O&P)? 9 Yes 9 No Collection date:____________________

Lab:________________________________ Results:____

Exposure History

Has the patient traveled anywhere outside the area in the past two weeks? 9 Yes 9 No
If yes, where?____

____

Has the patient been exposed to any pets or livestock in the past two weeks? 9 Yes 9 No
If yes, describe?____

____

____

Has the patient attended any unusual events (weddings, banquets, potlucks, chili cook-offs, etc.) where food was served or catered in the past two weeks? 9 Yes 9 No
If yes, describe?____

____

____

Has the patient been swimming or had other recreational water exposures (fishing, skiing, rafting, etc.) in the two weeks prior to onset? 9 Yes 9 No
If yes, describe? ____

____

____

5 Day Food History

Please determine where and what the patient ate during the 5 days prior to onset, beginning with the day illness symptoms began.

Day 1 - Illness Onset Date

Meal Location? What did they eat?

Breakfast____

Lunch____

Supper____

Day 2 - day before Illness Onset Date

Meal Location? What did they eat?

Breakfast____

Lunch____

Supper____

Day 3

Meal	Location?	What did they eat?

Breakfast____

____

____

____

Lunch ____

____

____

____

Supper____

____

____

____

Day 4

Meal	Location?	What did they eat?

Breakfast____

____

____

____

Lunch____

____

____

____

Supper____

____

____

____

Day 5
Meal | Location? | What did they eat?

Breakfast____
____
____
____

Lunch____
____
____
____

Supper____
____
____
____

Other Exposures

Where does the patient usually shop for groceries?______________________________
____
____

What are the patient's usual/favorite beverages?______________________________
____
____

Does the patient know anyone else who is ill? 9 Yes 9 No
If yes, who?____
____
____
____
____
____

What is the water supply source for the patient's home or residence?
Q Municipal water Q Private well