



Foodborne Illness Complaint Form
Pacific County Department of Community Development
Internet Address: www.co.pacific.wa.us/dcd

Complainant Information

Name (last, first) _____ Age: _____ Sex: M F Occupation: _____
Address: _____ City: _____ Zip: _____
Work phone: (____) _____ - _____ Home phone: (____) _____ - _____ Other phone (____) _____ - _____

Complainant Symptoms (indicate name if different from complainant)

Name of ill person: _____ Date/Time of symptom onset: ____/____/____ Time ____ AM PM
Vomiting Y N If vomiting yes, onset date: ____/____/____ Time ____ AM PM
Diarrhea Y N If diarrhea yes, onset date: ____/____/____ Time ____ AM PM
Bloody diarrhea Y N Nausea Y N Shortness of breath Y N
Chills Y N Abdominal cramps Y N Numbness/tingling Y N
Fever Y N Headache Y N Other Y N
If fever, highest temp: _____ Body aches Y N Specify: _____
Date/Time symptoms ended: ____/____/____ Time: ____ AM PM Ongoing
Healthcare provider/ER visit? Y N If yes, name: _____ Phone: (____) _____ - _____
Hospitalized? Y N If yes, Hospital name: _____ Admit date: _____
Stool sample submitted? Y N If yes, laboratory where submitted and results: _____

Suspected Meal or Activities

Name of establishment or location where food was obtained: _____
Address _____ City _____ Zip: _____
Date/time of meal/exposure ____/____/____ Time ____ AM PM
Details of foods and beverages consumed: _____

Recent travel _____ Pets or recent animal exposure _____ Large group event _____
*For a single case of illness, record all food and drinks consumed in incubation period of suspected agent/organism on back of this paper

Other Affected Persons

of persons who ate suspected meal: _____ # of ill persons who ate suspected meal: _____
If >1 person ill, do any ill persons live together? Y N Do any ill persons work together? Y N
Did those ill have any other common meals in the previous five days? Y N (if yes, complete Food History on the back)
Name/relationship to caller Age Sex Day-time phone

Shortest known incubation _____ Longest known incubation _____ Estimated duration _____
General symptom profile of other affected parties: _____
Any hospitalized? Y N If yes, Hospital name: _____ Admit date: _____