



ST ALBANS DISTRICT COUNCIL
FOOD POISONING QUESTIONNAIRE

You are requested to complete and return this form quickly to assist in investigating possible food poisoning.

PLEASE COMPLETE IN BLOCK CAPITALS

1	NAME:	
2	DATE OF BIRTH:	
3	ADDRESS:	
	POSTCODE:	
4	TEL NO: HOME	WORK:
5	WHEN AND WHERE YOU CAN BE USUALLY CONTACTED:	
6	OCCUPATION:	
	PLACE OF WORK:	
	(PLEASE MAKE IT CLEAR WHETHER YOU ARE A FOOD HANDLER)	
7	FAMILY DOCTOR:	
	TELEPHONE NO:	
8	HAS YOUR DOCTOR BEEN CONSULTED IN THIS INCIDENT?	
9	HAVE YOU HAD A SPECIMEN TAKEN?	
10	ONSET OF SYMPTOMS:	
	DATE:	
	TIME:	

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11	PLEASE DESCRIBE ALL MEALS EATEN ON THE DAY SYMPTOMS BEGAN AND ON EACH DAY FOR THE THREE DAYS PRIOR TO THE ONSET OF SYMPTOMS:	
DAY SYMPTOMS STARTED:		
BREAKFAST	LUNCH	
DINNER	OTHER	
DAY BEFORE SYMPTOMS STARTED:		
BREAKFAST	LUNCH	
DINNER	OTHER	
TWO DAYS PRIOR TO SYMPTOMS STARTED:		
BREAKFAST	LUNCH	
DINNER	OTHER	

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THREE DAYS PRIOR TO SYMPTOMS STARTING:																					
BREAKFAST	LUNCH																				
DINNER	OTHER																				
12	<p>DESCRIPTION OF SYMPTOMS:</p> <table border="0"> <tr> <td>HEADACHES</td> <td><input type="checkbox"/></td> <td>DIARRHOEA</td> <td><input type="checkbox"/></td> </tr> <tr> <td>RASH</td> <td><input type="checkbox"/></td> <td>BLOOD STAINED DIARRHOEA</td> <td><input type="checkbox"/></td> </tr> <tr> <td>NAUSEA</td> <td><input type="checkbox"/></td> <td>DIZZINESS</td> <td><input type="checkbox"/></td> </tr> <tr> <td>VOMITING</td> <td><input type="checkbox"/></td> <td>TEMPERATURE</td> <td><input type="checkbox"/></td> </tr> <tr> <td>STOMACH CRAMPS</td> <td><input type="checkbox"/></td> <td></td> <td></td> </tr> </table>	HEADACHES	<input type="checkbox"/>	DIARRHOEA	<input type="checkbox"/>	RASH	<input type="checkbox"/>	BLOOD STAINED DIARRHOEA	<input type="checkbox"/>	NAUSEA	<input type="checkbox"/>	DIZZINESS	<input type="checkbox"/>	VOMITING	<input type="checkbox"/>	TEMPERATURE	<input type="checkbox"/>	STOMACH CRAMPS	<input type="checkbox"/>		
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13	<p>HOW LONG DID SYMPTOMS LAST? (Please state separately for Diarrhoea, Vomiting, and any other symptom).</p>																				
14	<p>NAME AND ADDRESS OF CLOSE FAMILY AND OTHER CONTACTS WHO YOU KNOW HAVE HAD SIMILAR SYMPTOMS:</p>																				
15	<p>PLEASE STATE IF ANY OF YOUR CLOSE CONTACTS ARE EMPLOYED IN FOOD HANDLING – IF SO PLEASE GIVE NAME, ADDRESS & TEL NOS.</p>																				
16	<p>ANY OTHER INFORMATION WHICH YOU FEEL COULD BE RELEVANT</p>																				