

ILLNESS/COMPLAINT GENERAL QUESTIONNAIRE (Geauga County Health District)

EPI Database#	ODRS#	<input type="checkbox"/> NA	HDIS#	<input type="checkbox"/> NA
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Reported by (name/number if different from case): _____

DEMOGRAPHIC INFORMATION

Last Name:	First Name	M.I.	Gender	Age	DOB (mm/dd/yyyy)	
Race (check) <input type="checkbox"/> White <input type="checkbox"/> Black/Afr. Amer. <input type="checkbox"/> Amer. Ind/ An <input type="checkbox"/> Asian/Pac. Islander <input type="checkbox"/> Other des. _____					Hispanic (check) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address	House No. (e.g. 12345)		Street Name (e.g. E 105th)		Street Ext. (e.g. Dr)	Apt No.
	City	State	Zip Code	County	Country of Origin	<small>If Not USA, Yrs in USA</small>
Home Phone: e.g. (216) 123-4567		Other Phone: e.g. (216) 123-4567		Other Phone Type (check) <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Pager <input type="checkbox"/> Other		
Occupation (Brief Description)	Sensitive Occupation (Check) <input type="checkbox"/> Not applicable <input type="checkbox"/> Food Handler <input type="checkbox"/> Direct Pt Care <input type="checkbox"/> Childcare Attendee/Staff <i>If Yes, where:</i>			Excluded (check) <input type="checkbox"/> Not applicable <input type="checkbox"/> Yes <input type="checkbox"/> No		

ILLNESS INFORMATION

Onset Date: (mm/dd/yyyy)	SYMPTOMS (Y=yes, N=no, U=unknown)	Duration (in hours)	(Y=yes, N=no, U=unknown)	Duration (in hours)
Onset Time: e.g. 10:30 am	Y N U		Y N U	
Illness Duration (in hours)	<input type="checkbox"/> Headache <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue	_____	<input type="checkbox"/> Other 1 (desc.) <input type="checkbox"/> Other 2 (desc.)	_____
Did you see a physician for this: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes,</i> Physician Name & Contact Info:	<input type="checkbox"/> Muscle weak. <input type="checkbox"/> Paralysis <input type="checkbox"/> Jaundice <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Abd. Cramps <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bloody stools <input type="checkbox"/> SOB <input type="checkbox"/> Wheezing <input type="checkbox"/> Sneezing <input type="checkbox"/> Wet cough <input type="checkbox"/> Dry cough <input type="checkbox"/> Itchy skin	_____	<input type="checkbox"/> Other 3 (desc.) <input type="checkbox"/> Other 4 (desc.) <input type="checkbox"/> Other 5 (desc.)	_____
Hospitalized: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If Yes (hospital name, admit date)</i>	<input type="checkbox"/> Rash <input type="checkbox"/> Hives <input type="checkbox"/> Watery eyes <input type="checkbox"/> Swelling eyes	_____		
Specimen Taken: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Date:				
Type:				

PLEASE CONTINUE ON BACK OF QUESTIONNAIRE

(Revised Jan 20, 2009)

ILLNESS INFORMATION (Continued)

Did you have contact with ill person prior to onset of symptoms: Yes No
 If yes, describe:

Do you know of others who are ill with the same symptoms: Yes No
 If yes, please provide names/contact info:

ENVIRONMENTAL EXPOSURES

Recent Exposure to:
 (check all that apply) *If Exposed, Please Describe*
 Chemical
 Biological
 Radiation

Residential Water Source:
 City Well Other _____

Recent Recreational Water Exposure: Yes No
 If Yes, Type: Pool Bathing Beach Other
 Spa Lake/River
 Where / Date(s):

Did you recently go camping, hiking, hunting, or fishing: Yes No
 If Yes, Where / Date(s):

Have you taken any trips recently: Yes No *If Yes, Where / Date(s):*
 If trips were taken, Did travel include airline/cruiseship/train/bus: Yes No
 If Yes, provide travel details (flight, destination, etc...):

Exposed to Animals/Pets: Yes No *If yes indicate type:* Dog Bird Cat Reptile Other _____
 If Yes, Where (Please describe, including contact at zoo, petting zoo, farm, fair, petshop, etc..):
 If Yes, Was animal/pet ill (or acting ill): Yes No *If yes, describe:*

Have you attended any gatherings/events recently (e.g. picnic, wedding, amusement/sporting park, funeral, etc..):
 Yes No *If Yes, Where / Date(s):*

WHAT TO DO NEXT

*****COMPLETE FOOD HISTORY FORM (if necessary)*****

*****COMPLETE CONFIDENTIAL FORM if Suspect, Probable, or Confirmed Case*****

Please fax completed reports to (440) 285-4305

Questions? Call Geauga County Health District (440) 279-1950

ACTION TAKEN (Check all that apply)

<input type="checkbox"/> Filed in E&S / Comm Dz	Date _____	<input type="checkbox"/> Referred to Other Health Jurisdiction	Referral Date _____
<input type="checkbox"/> Referred to Nursing	Date _____	Jurisdiction Name:	
<input type="checkbox"/> Referred to Env. Health	Date _____		

Investigator's Name (print) _____ **Initials** _____ **Date** _____