



# GENERAL ENTERIC DISEASES INTERVIEW FORM

## YERSINIA

January 2019

Reporting Health Department			
Completed by:	LHD:	Phone:	
Date of first interview attempt:    /    /	Date interview completed:    /    /		
<input type="checkbox"/> Case was interviewed	Case was not interviewed because: <input type="checkbox"/> Unreachable <input type="checkbox"/> Refused <input type="checkbox"/> No working phone <input type="checkbox"/> Other _____		

**NOTE: Even if case could not be interviewed, please complete above information and enter into CTEDSS or fax this page to the DPH Epidemiology Program at 860-509-7910.**

Case Information			
Last name:	First Name:		
Street:	City:		Zip:
Phone: (    )    -	DOB:    /    /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other _____
Date specimen collected:    /    /	Source: <input type="checkbox"/> Stool <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Other _____		
Pathogen:	Laboratory:		

Before we ask about your illness, we would like to get some information on your race and ethnicity.

What is your race?     White     Black     Asian     Native Hawaiian/Pacific Islander  
 American Indian/Alaska Native     Other \_\_\_\_\_     Unknown

Are you of Hispanic background?     Yes     No     Unknown

Illness Information	Yes	No	Unk	If yes, additional details:
Did you have any symptoms associated with this illness?				Date/time of onset:    /    /    :    AM    PM
Vomiting				Date/time of onset:    /    /    :    AM    PM
Diarrhea				Date/time of onset:    /    /    :    AM    PM Number of days diarrhea lasted:
Bloody Diarrhea				
Fever				Highest temperature:
Are you still experiencing symptoms?				If no, total number of days illness lasted:
	Yes	No	Unk	If yes, additional details:
Were you hospitalized? (Inpatient only, not just ED visit)				Hospital name: Admit date:       /    / Discharge date:       /    /
Do you have any underlying medical conditions or are you immunocompromised?				Describe:
During the 14 days before illness: Did you receive a blood transfusion or donate blood?				If yes, provide date, donated/received, blood product and location:
Outcome: <input type="checkbox"/> Survived <input type="checkbox"/> Died				

Occupation and Risk Factor Information				
What is your occupation?				
	Yes	No	Unk	If yes, specify name and address of the facility
Do you work or volunteer in a facility that prepares/serves/handles/sells food?				
Provide direct patient care outside the home				
Work in day care setting				
Attend day care setting				

**Can you tell us about other household members, their ages, occupation, and whether they have been ill with a similar illness:**

Name	Relationship	Age	Occupation	Ill	If yes, onset date and symptoms
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

**NOTE: If case or household contacts are involved in high risk occupations/activities, implement appropriate control recommendations. Refer to the “Reportable Infectious Diseases Reference Manual”.**

<b>Did you travel to any other states in the 14 days before illness?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
City/State:	Depart CT: / /	Return CT: / /		
City/State:	Depart CT: / /	Return CT: / /		
<b>Did you travel outside of the United States in the 14 days before illness?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
Country:	Depart CT: / /	Return CT: / /		
Country:	Depart CT: / /	Return CT: / /		
<b>Did you attend any large parties or gatherings (parties, fairs, festivals) in the 14 days before illness?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
Event:	City:	Date/Time: / / : AM PM		
Foods eaten:				
<b>Did you eat out at any restaurants in the 14 days before illness?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
Name:	City:	Date/Time: / / : AM PM		
Foods eaten:				
Name:	City:	Date/Time: / / : AM PM		
Foods eaten:				
Name:	City:	Date/Time: / / : AM PM		
Foods eaten:				
<b>Where did you purchase groceries eaten in the 14 days before illness</b> (including farmer’s markets, home delivery service)				
<b>Store Name</b>		<b>City</b>		
<b>Special Diet</b>	<b>Yes</b>	<b>No</b>	<b>Unk</b>	<b>If yes, specify/describe, brand/type:</b>
Food allergies that prevent you from eating certain foods				
Vegetarian or vegan diet				
Special or restricted diet (weight-loss, cultural, religious)				
If infant, formula or baby food				
<b>Did you have any of the following exposures in the 14 days before your illness?</b> <i>(Note for interviewer: If yes, please ask any listed follow-up questions)</i>				
<b>Water-Related Exposure</b>	<b>Yes</b>	<b>No</b>	<b>Unk</b>	<b>If yes, where:</b>
Live in a home with a septic system				
Use water from a private well as drinking water				
Drink untreated water (natural spring, pond, lake, river)				
Swim, wade, or play in untreated water (ocean, lake, pond, river, stream, or natural spring)				
Swim, wade, or play in treated water (pool, hot tub/spa, fountain, splash pad, or waterpark with treated or chlorinated water)				
<b>Animal Contact</b>	<b>Yes</b>	<b>No</b>	<b>Unk</b>	<b>If yes, where/type of animal:</b>
Dog				
Cat				
Other pet mammals (rodent, ferrets, rabbits)				
Pet bird (not poultry)				
Reptiles/Amphibians (turtles, frogs, lizards)				
Other pets (fish, hermit crabs)				
Live poultry (chicken, turkey)				
Cattle, goats, sheep				
Pigs				
Contact with a pet that had diarrhea				
Visit, work, or live on farm/ranch/petting zoo				
Visit or work on slaughterhouse				
<b>Ill Contacts</b>	<b>Yes</b>	<b>No</b>	<b>Unk</b>	<b>If yes, who:</b>
Household or close contact with diarrhea				

The food exposure section below can be omitted if case traveled internationally during the entire 14-day period before onset. If case was out of the country only for part of the 14-day period before onset, please collect information on foods eaten while in US.

<b>Did you eat the following items in the 14 days before your illness?</b>				
<i>(Note for interviewer: If yes, please ask any listed follow-up questions and specify brand/type, where purchased/eaten.)</i>				
<b>Meats and Seafood</b>	<b>Yes</b>	<b>No</b>	<b>Unk</b>	<b>If yes, food details:</b>
Chicken or foods containing chicken (deli, ground, jerky)				
Was chicken undercooked?				
Beef or foods containing beef (deli, ground, jerky)				
Was beef ground?				
Was ground beef undercooked or raw?				
Pork or foods containing pork (deli, ground, jerky)				
Was pork undercooked?				
Chitlins (pork intestines - also known as chitterlings)				
Lamb or mutton				
Sausage				
Hot dogs				
Raw or undercooked liver				
Liver pate				
Game meat (bison, elk, rabbit/hare, venison)				
Fish or fish products				
Was fish undercooked or raw (sushi)?				
Shellfish (crab, shrimp, oysters, clams)				
Was shellfish undercooked or raw?				
Anyone in household handle raw meat, including chitlins?				
Anyone in household handle raw poultry?				
<b>Eggs and Dairy</b>	<b>Yes</b>	<b>No</b>	<b>Unk</b>	<b>If yes, food details:</b>
Eggs				
Were eggs undercooked or raw?				
Foods made with raw eggs (mayonnaise, cookie dough)				
Unpasteurized or raw milk				
Other raw/unpasteurized dairy products (yogurt, ice cream)				
Soft cheeses				
Was soft cheese unpasteurized?				
Pasteurized cow's or goat's milk				
Powdered milk				
Any dairy products				
<b>Fresh, Raw Produce</b>	<b>Yes</b>	<b>No</b>	<b>Unk</b>	<b>If yes, food details:</b>
Lettuce, specify type:				
Was lettuce prepackaged/bagged?				
Was lettuce whole head or loose leaf?				
Mushrooms				
Cabbage				
Celery				
Carrots				
Sprouts, specify type:				
Other fresh vegetables				
Tofu				

**That completes the interview. Thank you for taking the time to answer these questions. Your responses may be helpful in preventing others from becoming sick.**

**COMMENTS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please enter interview data into CTEDSS or fax to DPH Epidemiology Program at 860-509-7910. Thank you.**