ILLNESS/COMPLAINT GENERAL QUESTIONNAIRE (Ashtabula County Health Department)

EPI Database#	ODRS# ☐ NA	HDIS# ☐ NA

Reported by (name/number if different from case): _____

DEMOGRAPHIC INFORMATION

Last Name:	First Name	M.I.	Gender	Age	DOB (mm/dd/yyyy)

Race (check)
☐ White ☐ Black/Afr. Amer. ☐ Amer. Ind/ An ☐ Asian/Pac. Islander ☐ Other des. _____

Hispanic (check)
☐ Yes ☐ 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	*If Not USA*, Yrs in USA

Home Phone: e.g. (216) 123-4567	Other Phone: e.g. (216) 123-4567	Other Phone Type (check) ☐ Work ☐ Cell ☐ Pager ☐ Other

Occupation (Brief Description)	Sensitive Occupation (Check)	Excluded (check)
	☐ Not applicable ☐ Food Handler ☐ Direct Pt Care ☐ Childcare Attendee/Staff *If Yes, where:*	☐ Not applicable ☐ Yes ☐ No

ILLNESS INFORMATION

Onset Date: (mm/dd/yyyy)

Onset Time: e.g. 10:30 am

Illness Duration (in hours)

Did you see a physician for this:
☐ Yes ☐ No

If Yes,

Physician Name & Contact Info:

Hospitalized: ☐ Yes ☐ No

If Yes (hospital name, admit date)

Specimen Taken: ☐ Yes ☐ No

Date:

Type:

SYMPTOMS (Y=yes, N=no, U=unknown)	Y	N	U	Duration (in hours)
Headache	☐	☐	☐	_____
Chills	☐	☐	☐	_____
Fever	☐	☐	☐	_____
Fatigue	☐	☐	☐	_____
Muscle weak.	☐	☐	☐	_____
Paralysis	☐	☐	☐	_____
Jaundice	☐	☐	☐	_____
Nausea	☐	☐	☐	_____
Vomiting	☐	☐	☐	_____
Abd. Cramps	☐	☐	☐	_____
Diarrhea	☐	☐	☐	_____
Bloody stools	☐	☐	☐	_____
SOB	☐	☐	☐	_____
Wheezing	☐	☐	☐	_____
Sneezing	☐	☐	☐	_____
Wet cough	☐	☐	☐	_____
Dry cough	☐	☐	☐	_____
Itchy skin	☐	☐	☐	_____
Rash	☐	☐	☐	_____
Hives	☐	☐	☐	_____
Watery eyes	☐	☐	☐	_____
Swelling eyes	☐	☐	☐	_____

(Y=yes, N=no, U=unknown)	Y	N	U	Duration (in hours)
Other 1 (desc.)	☐	☐	☐	_____
Other 2 (desc.)	☐	☐	☐	_____
Other 3 (desc.)	☐	☐	☐	_____
Other 4 (desc.)	☐	☐	☐	_____
Other 5 (desc.)	☐	☐	☐	_____

PLEASE CONTINUE ON BACK OF QUESTIONNAIRE

Form: AshtCoDis1

(Revised March 2017)

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) 576-0001

Questions? Call Ashtabula County Health Department (440) 576-3023

ACTION TAKEN (Check all that apply)

☐ Filed in E&S / Comm Dz Date _____
☐ Referred to Nursing Date _____
☐ Referred to Env. Health Date _____

☐ Referred to Other Health Jurisdiction
Jurisdiction Name: Referral Date _____

Investigator's Name (print) _____ Initials_____ Date_____

Form: AshtCoDis1

Fax completed form to: 440-576-0001 or email completed form to: JBecker@ashtabulacountyhealth.com or mail completed form to: Ashtabula County Health Department c/o Jay Becker, 12 West Jefferson Street, Jefferson, Oh 44047