FOODBORNE ILLNESS
COMPLAINT REPORT FORM

Complainant:_____Location:_____

Name:_____Date/Time:_____

Street:_____Telephone:_____

City, State, Zip:_____

Is Complainant a regular customer:_____Number of Persons Ill:_____

Names of Ill Persons Ages Symtoms

_Nausea

_Headache

_ Vomiting

_ Loss of Appetite

_ Abdominal Cramps

_ Fever

_ Diarrhea

_ Blood in Stool

_ Muscle/Body Aches

_ Chills

_ Severe Weakness

_ Other (specify)

Duration of Symtoms:
_No
Less than 24 Hours_
24-48 Hours_
More than 48 Hours_
_____
Unknown_
Admitted:_____

Medical Attention: _Yes
Physician's
Name:_____
Physician's
Phone:_____
Hospital/Clinic:
Date

Diagnosis:_____Confirmed _Yes _No

Laboratory Reports Available: _____

Foods eaten prior to onset of symptoms:_____

Leftovers (refrigerate do not freeze) _Yes _No

Product Brand Name:_____Size/Package Type:_____Package Code/Serial:
____

Manufacturer/Distributor Name & Address:_____

Date/Time Consumed:_____ Date/Time Onset:_____

Other Agencies notified: _____ Person_____ Phone _____

Remarks:_____

_____