Establishment: _____ Date of Suspected Meal: ____/____/____ Log#: _____

Foodborne Illness Investigation: Food Worker Interview

The Florida Department of Health is investigating an outbreak of gastrointestinal illness among persons who that had food prepared by the _____. We are interviewing all food workers who helped prepare/serve the food. We understand that some people did not become ill, but it is important that we talk with everyone in order to determine what caused the illness. The questionnaire will take about 5-10 minutes to complete. All information shall remain strictly confidential.

Date of Interview: _____/_____/_____

Food worker name: _____ Position: _____

Address: _____ Phone: _____

Work History:

• How long have you worked at this establishment? _____ Years _____Months _____Days

• Do you work as a food worker anywhere else? ☐ Yes ☐ No
  – **If Yes**, where? _____

Time period of concern: (usually 10 days prior to suspect meal)

• When did you work during this time period? (Indicate hours worked)

Sun_____ Mon_____ Tues_____ Wed_____ Thurs_____ Fri_____ Sat_____
Sun_____ Mon_____ Tues_____ Wed_____ Thurs_____ Fri_____ Sat_____
Sun_____ Mon_____ Tues_____ Wed_____ Thurs_____ Fri_____ Sat_____

Illness History:

• Did you have any of the following symptoms during this time period? (Check all that apply) ☐ Yes ☐ No

☐ Nausea ☐ Vomiting ☐ Abdominal cramps ☐ Fever
☐ Chills ☐ Muscle ache ☐ Headache
☐ Diarrhea: # of episodes/day_____

If any of the above symptoms experienced:

• When did the symptoms begin? Date and time: ____/_____/____ ____:____ AM/PM

• When did the symptoms end? Date and time: ____/_____/____ ____:____ AM/PM

• Did you see a doctor or go to the hospital? ☐ Yes ☐ No
  – **If Yes**, who was your healthcare provider? _____
  Diagnosis?_____

• When did you return to work after being ill? _____

• Has anyone in your household been ill during this same time period? ☐ Yes ☐ No
  – **If Yes**, which symptoms did the person experience?

☐ Nausea ☐ Vomiting ☐ Abdominal cramps ☐ Fever
☐ Chills ☐ Muscle ache ☐ Headache
☐ Diarrhea: # of episodes/day_____

If any of the above symptoms experienced by household member:

• When did the symptoms begin? Date and time: ____/_____/____ ____:____ AM/PM

• When did the symptoms end? Date and time: ____/_____/____ ____:____ AM/PM

• What is the occupation of the ill household member?_____

• Do you know of anyone else (co-workers, friends, etc.) with a similar illness during the same time period?
☐ Yes ☐ No
If yes, who? _____ Telephone: _____

• Did you eat any foods prepared on the date of the suspected meal(s)? ☐ Yes ☐ No
If yes, indicate foods eaten: _____

• What foods do you prepare/serve? _____

_____

If the employee prepared/served any of the suspected foods, complete the Food Preparation Review Worksheet.