TCEH FOOD ILLNESS COMPLAINT FORM

DATE: _____

NAME: _____

PHONE: _____

DATE OF CONSUMPTION: _____

NAME OF ESTABLISHMENT: _____

LOCATION: _____

NAME/DESCRIPTION OF MEAL CONSUMED: _____

_____

DRINKS CONSUMED:_____

Were any members of your household ill in the past week? _____

Which of the following symptoms did you have and for how long?

Nausea:	**Vomit:**	**Diarrhea:**
Fever:	**Headache:**	**Cramps:**

Earliest onset of illness: **Date:____/____/_____** **Time:___:___ __m**

Latest onset of illness: **Date:____/____/_____** **Time:___:___ __m**

Sought care at which MDs/Ers: _____

Others who ate at same restaurant/facility:

Name	Phone	What did they eat?	Did they become ill?