CD-7
Rev. 12/05

West Virginia Department of Health & Human Resources
_____ Health Department

Form A **Case History**

Name of Person:		Address:	
Occupation:	Age:	Sex:	Phone:

Did individual partake of the suspected meal? ☐ Yes ☐ No If yes, date and hour food eaten:

Did individual become ill? ☐ Yes ☐ No If yes, date and hour of onset:

Below is a list of foods and beverages served at the suspect meal or consumed 72 hours prior to onset (check only those which were eaten).

Date:	Date:	Date:
Food Item	Food Item	Food Item
Breakfast*	Breakfast*	Breakfast*
Lunch*	Lunch*	Lunch*
Dinner*	Dinner*	Dinner*

*Indicate place eaten

Which of the following symptoms did the individual have, and how long (in hours) did they last?

☐ Nausea or Vomiting: ☐ Diarrhea: ☐ Fever: ☐ Abdominal cramps & pain:
☐ Bloody Stool: ☐ Paralysis: ☐ Other:

Was a physician consulted? ☐ Yes ☐ No Diagnosis:
If yes, physician's name: Address:
Name of hospital, if hospitalized:
Names of other persons who ate suspected meal:

Date: Investigator: _____