



ENHANCED SURVEILLANCE E. COLI O157: H7 QUESTIONNAIRE

This questionnaire has been developed to guide E. Coli case investigations. This questionnaire is very comprehensive and is intended to help to identify possible sources of exposure and detect outbreaks in a timely fashion. This questionnaire is to be used **in addition** to the regular Communicable Disease Control Investigation form.

FAX completed forms to: Surveillance Unit, Manitoba Health 948-3044

DEMOGRAPHIC INFORMATION

Community Area: _____

Name: _____ Address: _____

DOB: dd/mm/yyyy _____ Sex: M F

Name of person completing questionnaire: _____ Telephone #: _____

CLINICAL INFORMATION

Date of onset of first symptom: (dd/mm/yyyy): _____

Hospitalized: yes no unknown

Number of days hospitalized: _____

Outcome: survived died unknown

Date of death: (dd/mm/yyyy): _____

Epi Linkage

During the exposure period (10 days), was the case....

A close contact of a confirmed or presumptive case?

yes no unknown

Check all that apply:

Diarrhea yes no unknown

Maximum # of stools in 24 hours: _____

Bloody Diarrhea yes no unknown

Hemolytic uremic syndrome (HUS)

yes no unknown

Thrombotic thrombocytopenic purpura (TTP)

yes no unknown

Other symptoms: _____

OPEN ENDED FOOD HISTORY

Please try to remember what you may have eaten in the 5-day period before you started feeling sick. We'll start with the day (or day before) you got sick and work backwards. (If a meal was eaten out, specify where they ate and what was eaten.)

Please ask about: prepared in-home or eaten out; if in-home - variety/brand, how prepared, where bought/eaten, routine meals

Day 1 _____, (dd/mm/yyyy) ____/____/____

Breakfast

home or out _____

Lunch

home or out _____

Dinner

Home or out _____

Other/snacks

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OPEN ENDED FOOD HISTORY

Day 2 _____, **(dd/mm/yyyy)** ____/____/____

<i>Breakfast</i>	<i>Lunch</i>	<i>Dinner</i>	<i>Other/snacks</i>
home or out _____	home or out _____	Home or out _____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Day 3 _____, **(dd/mm/yyyy)** ____/____/____

<i>Breakfast</i>	<i>Lunch</i>	<i>Dinner</i>	<i>Other/snacks</i>
home or out _____	home or out _____	Home or out _____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Day 4 _____, **(dd/mm/yyyy)** ____/____/____

<i>Breakfast</i>	<i>Lunch</i>	<i>Dinner</i>	<i>Other/snacks</i>
home or out _____	home or out _____	Home or out _____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Day 5 _____, **(dd/mm/yyyy)** ____/____/____

<i>Breakfast</i>	<i>Lunch</i>	<i>Dinner</i>	<i>Other/snacks</i>
home or out _____	home or out _____	Home or out _____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

EPIDEMIOLOGIC INFORMATION

In the 10 days before the illness began, did the case eat or drink any of the following items at home, in a restaurant, or in any other place?

	Yes	No	Unknown	Comments (Please include place of purchase or consumption, brand name and date of purchase or consumption)
Raw (unpasteurized) milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other dairy products made from (unpasteurized milk i.e. cheese)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Well water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other unchlorinated water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Apple cider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Any ground beef or hamburger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, was it rare, undercooked, or raw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Any steak or roast beef	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pink or red steak or roast beef	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Beef or pork sausage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Salami /Bratwurst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Beef jerky	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Deli Meats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specify:				
Meals which include ground beef (Shepard's Pie, Tacos)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sprouts (alfalfa, clover, bean, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lettuce	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specify:				
Spinach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Carrots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cucumbers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tomatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specify:				
Green Peppers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Red Peppers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Apples	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Berries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specify:				
Peaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cantaloupe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other Fresh Produce	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Specify:				

RESTAURANT/FAST FOOD MEALS

For the 10 days before illness, list each meal eaten. Full menu details are not necessary. Ask if the case ate 1) any ground beef, 2) any other beef products, 3) any self-serve salad bar items, or 4) salad prepared in the kitchen.

Date (dd/mm)	Name/Location (type of establishment)	Ground Beef	Other Beef	Salad Bar	Salad From Kitchen	Comments
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

MEALS AT HOME

For the 10 days before illness, list all ground beef/hamburger consumed at home or other private gatherings. Specify the store where purchased, the dates of purchase and consumption, and description of the product.

Product Description (please specify type and brand name)	Date Consumed	Purchase Date	Store or source/location (including address)

Was any other ground beef prepared or eaten in the home that was not eaten by the case? yes no If yes, itemize as above:

Did the case eat any beef or pork sausage or dried meat products (salami, jerky, etc) ? yes no If yes, itemize as above:

In the 10 days before illness began, did the case:

	Yes	No	Unknown
Visit or live on a farm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visit petting zoo?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have contact with any cows or cattle?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Touch any cow manure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with a family pet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with pet treats (e.g. pig ears, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swim in a Pool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have contact with any children who attend a day care centre?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change any diapers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have contact with any children who use diapers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel outside the province?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, where?			
Date departed:		Date returned:	
Travel to another country?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, where?			
Date departed:		Date returned:	