Food-borne Illness Form

Date: ______________________ Store Location: ____

Customer's Name: ____ Phone:___________________________

Street Address: ____City/State/Zip: ___________________

Date/Time of Meal:________________________________ Date/Time Onset of Illness:_________________________

What exactly did the customer eat and drink? (provide as much detail as possible).

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What symptoms is the customer experiencing?

Circle: Nausea Fever Blurred Vision Vomiting Dizziness Abdominal Cramps Diarrhea Headache
Other: ____

Did the customer seek medical attention? Yes No Date/Time of Appointment: _________________

Physician Name: ____
Street Address: ____
City/State/Zip: ____
Office Phone: ____

What was the diagnosis and/or treatment provided?

What other food did the customer consume before and/or after eating at our location?

Were there other guests in the dining party? Yes No

Are they experiencing similar symptoms? Yes No

(If yes, complete a separate form for each individual that is ill.)

Provide the names, address and phone number of all members of the dining party.
(If additional room is needed, attach a separate piece of paper.)

Guest 1: _________________________________ Food Ordered: ____

Guest 2: _________________________________ Food Ordered: ____

Guest 3: _________________________________ Food Ordered: ____

Guest 4: _________________________________ Food Ordered: ____

Are there any leftovers? Yes No If yes, save the food and mark it DO NOT USE.

Date:_______________________ **Signature:**____