

TRICHINOSIS CASE INVESTIGATION - Page 1 of 4

Indiana State Department of Health
State Form 49695 (R2/1-05)

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

- 1 Print firmly and neatly.
- 2 Only use pens with blue or black ink.
- 3 Fill in circles like this: ☐ Not like this: ☒ Mark mistakes like this: ☒
- 4 Print capital letters only and numbers completely inside boxes. A 2 C 3
- 5 Please complete all items on form.
- 6 Date format: MM/DD/YY

Section 1. Demographic Information

Last Name			
First Name	MI	Phone Number	
Number & Street Address			
City	State	ZIP Code	
County	Date of Birth		Age
Race: ☐ Asian ☐ Black or African American ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander		Ethnicity: ☐ White ☐ Other/Multiracial ☐ Unknown ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	
Sex: ☐ Male ☐ Female ☐ Unknown		Is Age in day/mo/yr? ☐ Days ☐ Months ☐ Years	
Occupation		Phone of Employer/School/Day Care	
Name of ☐ Employer ☐ School ☐ Day Care			
Address of Employer/School/Day Care			
City	State	ZIP Code	

Section 2. Clinical Information

Symptoms: ☐ Fever • (degrees) ☐ Diarrhea ☐ Abdominal Cramps ☐ Nausea ☐ Vomiting ☐ Muscle Pain ☐ Eye Swelling/Pain ☐ Eosinophilia ☐ Other, specify:	Source of Positive Specimen: ☐ Muscle Biopsy ☐ Serum, if serum list dates collected: / / / / Acute Titer Convalescent Titer
/ / Date of Onset Duration of Symptoms in Days / / Date First Positive Specimen Collected	

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Section 2. Clinical Information (continued)

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City State ZIP Code

Physician/Hospital Phone

Was the patient hospitalized?

☐ Yes ☐ No

If Yes, admission date: ____/____/____

Discharge date: ____/____/____

Hospital: _____

Was the patient treated with an anthelmintic for this illness? ☐ Yes ☐ No

If Yes, antimicrobial

____/____/____ Date started
____/____/____ Date ended

Did patient die? ☐ Yes ☐ No

Section 3. Epidemiologic Information

List all commercial food establishments serving ready-to-eat food that the patient patronized during the 30 days prior to illness onset.

1. _____
Establishment Name

Address

Foods Eaten (list) Date ____/____/____

2. _____
Establishment Name

Address

Foods Eaten (list) Date ____/____/____

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3.

/ /

1. _____
Type of Gathering

Responsible Person

_____-_____-_____ ____ / ____ / ____
Phone Number No. of Persons Date

Store Name:	Street Address:	Date:
		/ /
		/ /
		/ /

Food Item:	Date Consumed:	Brand Name:	Name of Place Purchased:
☐ Pork sausage	____/____/____	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____
☐ Pork chops	____/____/____	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____
☐ Pork roast	____/____/____	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____
☐ Ham	____/____/____	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____
☐ Bacon	____/____/____	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____
☐ Hamburger	____/____/____	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____
☐ Dried jerky	____/____/____	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____

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Section 4. Risk Factors

During the 30 days prior to illness onset, did the patient:

Consume undercooked pork?

☐ Yes ☐ No ☐ Unknown

If Yes, date: / /

Consume undercooked beef?

☐ Yes ☐ No ☐ Unknown

If Yes, date: / /

Consume undercooked wild game?

☐ Yes ☐ No ☐ Unknown

If Yes, date: / /

If Yes, type of meat

Travel outside of Indiana? ☐ Yes ☐ No ☐ Unknown

If Yes, where

/ / / /

Date of departure

Date of return

Does the patient know of anyone else who has recently had an illness characterized by diarrhea, fever, or abdominal pain?

☐ Yes ☐ No ☐ Unknown

If Yes, name

Relationship

- - / /

Phone number

Onset date

Was this person exposed to any of the same commercial food establishments, group gatherings, food history, or travel history listed above?

☐ Yes ☐ No ☐ Unknown

If Yes, describe

Section 5. Comments/Follow-up

Comments:

Investigator Name

Agency

- - / /

Phone Number

Date