**Questionnaire for Holiday Buffet**

*The following information is being collected to help study a possible foodborne illness outbreak that may have occurred after eating food from the Holiday Buffet on December 10, 2014 at Maitland Colonnade. The Florida Department of Health in Orange County is attempting to determine how participants became ill so that we can prevent others from getting sick in the future. In order to do this we need to ask as many people as possible who attended the holiday buffet a series of questions on health status and possible exposures. We would like to collect this information for anyone who attended this event whether you were ill or well. Your help in this study is extremely important, but your participation is voluntary. All information you give will be kept confidential to the extent legally possible, and your name will not appear in any published reports.*

***Please Print the form out and fill out your responses. Please either fax your completed questionnaire to the Florida Department of Health in Orange County secure fax number at 407-858-5517 or hand your hard copy to your manager for pick-up by the Florida Department of Health in Orange County.***

**Demographics/Contact Information**

Name

DOB

Gender (circle) **M or F**

Phone Number

Email

Work at Maitland Colonnades (circle) **Y or N**

Company

Job Title/Duties

**Before Holiday Party**

1. In the week before the start of the holiday party at noon on 12/10/2014, were you ill with gastrointestinal symptoms? (circle) **Yes or No**

If yes,

* Onset date and time
* Describe symptoms

1. In the week before the start of the holiday party at noon on 12/10/2014, did you have a household member or close contact with symptoms of gastrointestinal illness? (circle) **Yes or No**

If yes,

* Onset date and time
* Describe symptoms

1. Did you help setup or assist in any way with the 12/10/2014 holiday party preparation? **Yes or No**

If yes, describe.

1. Before the start or during serving of the food at the holiday party at noon on 12/10/2014, did you notice a co-worker or caterer who was ill with gastrointestinal illness? (circle) **Yes or No**

If yes,

* Describe illness
* Name and contact information of ill person

1. In the week before the 12/10/2014 holiday party, did your company have another holiday party or gathering? (circle) **Yes or No**

If yes,

* Describe type of food served and where from

**Holiday Party**

1. Did you or anyone else you know, other than the caterer, bring food that was served at the holiday party in the lobby at noon on 12/10/2014? **Yes or No**

If yes, describe.

1. Did you eat at the holiday party on 12/10/2014? (circle) **Yes or No**

If no, skip to Illness background on page 5.

1. On 12/10/14 at the holiday party, what time did you eat?
2. If you were standing outside looking into the building, which buffet line did you get your food from? (circle) **Left or Right**
3. Did you go through the buffet line more than once? (circle) **Yes or No**

How many times? Same buffet line?

1. Did you wash your hands with soap and water before you ate? (circle) **Yes or No**
2. Did you use gel hand sanitizer before you ate? (circle) **Yes or No**

**Holiday Party Menu**

These items are listed in the order they were served on the buffet line.

**Below are the items that were served by the caterers**

1. Ham (circle) **Yes or No**

* How many slices
* Did you eat it all (circle) **Yes or No**
  + If no, how much leftover?

1. Turkey – white meat (circle) **Yes or No**

* How many slices
* Did you eat it all (circle) **Yes or No**
  + If no, how much leftover?

1. Turkey – dark meat (circle) **Yes or No**

* How many slices
* Did you eat it all (circle) **Yes or No**
  + If no, how much leftover?

1. Green Beans (circle) **Yes or No**

* How many scoops
* Did you eat it all (circle) **Yes or No**
  + If no, how much leftover?

1. Corn Bread Stuffing (circle) **Yes or No**

* How many scoops
* Did you eat it all (circle) **Yes or No**
  + If no, how much leftover?

1. Mash potatoes (circle) **Yes or No**

* How many scoops
* Did you eat it all (circle) **Yes or No**
  + If no, how much leftover?

1. Sweet Potato Casserole (circle) **Yes or No**

* How many scoops
* Did you eat it all (circle) **Yes or No**
  + If no, how much leftover?

**Below are the self-served items**

1. Gravy (circle) **Yes or No**

* Did you use the bowl **nearest you** or **further away** (circle)?
* How many scoops
* Did you eat it all (circle) **Yes or No**
  + If no, how much leftover?

1. Cranberries (circle) **Yes or No**

* Did you use the bowl **nearest you** or **further away** (circle)?
* How many scoops
* Did you eat it all (circle) **Yes or No**
  + If no, how much leftover?

1. Rolls (circle) **Yes or No**

* Did you use the **tongs** or **hands** to grab the roll (circle)?
* How many rolls
* Did you eat them all (circle) **Yes or No**
  + If no, how much leftover?

1. Salad (circle) **Yes or No**

* How many scoops
* Did you eat it all (circle) **Yes or No**
  + If no, how much leftover?

1. Devil Chocolate cake (circle) **Yes or No**

* How many slices
* Did you eat it all (circle) **Yes or No**
  + If no, how much leftover?

1. German Chocolate Cake (circle) **Yes or No**

* How many slices
* Did you eat it all (circle) **Yes or No**
  + If no, how much leftover?

1. Pecan Pie (circle) **Yes or No**

* How many slices
* Did you eat it all (circle) **Yes or No**
  + If no, how much leftover?

1. Pumpkin Pie (circle) **Yes or No**

* How many slices
* Did you eat it all (circle) **Yes or No**
  + If no, how much leftover?

1. Apple Pie (circle) **Yes or No**

* How many slices
* Did you eat it all (circle) **Yes or No**
  + If no, how much leftover?

1. Water (circle) **Yes or No**

* With ice? (circle) **Yes or No**
* How many cups
* Did you drink it all (circle) **Yes or No**
  + How much left over

1. Sweetened Tea (circle) **Yes or No**

* With ice? (circle) **Yes or No**
* How many cups
* Did you drink it all (circle) **Yes or No**
  + How much left over

1. Unsweetened Tea (circle) **Yes or No**

* With ice? (circle) **Yes or No**
* How many cups
* Did you drink it all (circle) **Yes or No**
  + How much left over

**Illness Background**

1. Did you become ill? (circle) **Yes or No**

If no, thank them for their time and end interview.

1. Date/Time of onset of illness?
2. Date/Time of cessation of illness? Or is illness ongoing?
3. Hospitalized? (circle) **Yes or No**

* Date admitted?
* Which hospital?
* Duration of hospitalization?

1. Emergency department only? (circle) **Yes or No**

* Date seen in emergency department?
* Which emergency Department?

1. Saw primary care physician? (circle) **Yes or No**

* Date seen primary care physician?
* Name of Physician
* Physician Phone number

1. Clinical samples taken? (circle) **Yes or No**

* If yes, describe

1. Did a physician give you a diagnosis for your illness? (circle) **Yes or No**

* If yes, what was the diagnosis?

**Symptoms**

1. Nausea (circle) **Yes or No**

* Date/Time onset

1. Vomiting(circle) **Yes or No**

* Number times in a 12 hour period
* Date/Time onset

1. Diarrhea – watery (circle) **Yes or No**

* Date/Time onset

1. Diarrhea – bloody (circle) **Yes or No**

* Date/Time onset

1. Diarrhea – mucousy (circle) **Yes or No**

* Date/Time onset

1. Diarrhea – loose (circle) **Yes or No**

* Date/Time onset

1. Diarrhea number times in a 12 hour period
2. Abdominal cramps (circle) **Yes or No**

* Date/Time onset

1. Fever (circle) **Yes or No**

* Date/Time onset
* Max temperature

1. Chills (circle) **Yes or No**

* Date/Time onset

1. Fatigue (circle) **Yes or No**

* Date/Time onset

1. Weakness (circle) **Yes or No**

* Date/Time onset

1. Headache (circle) **Yes or No**

* Date/Time onset

1. Numbness (circle) **Yes or No**

* Date/Time onset

1. Sweating (circle) **Yes or No**

* Date/Time onset

1. Tingling in mouth or extremities (circle) **Yes or No**

* Date/Time onset

1. Dizziness (circle) **Yes or No**

* Date/Time onset

1. Fainting (circle) **Yes or No**

* Date/Time onset

1. Metallic Taste (circle) **Yes or No**

* Date/Time onset

1. Other (circle) **Yes or No**

* Date/Time onset
* If yes, describe.

1. Medical Complications (circle) **Yes or No**

* If yes, describe

Other comments

If we have additional questions in the future, can we contact you? (circle) **Yes or No**

**Thank you for your time and participation in this important public health investigation.**

**If you have any additional questions please call the Florida Department of Health in Orange County at 407-858-1420**