CASE HISTORY: CLINICAL DATA **Form C—Part 1**	**S**ource of Place of Outbreak, if known	Complaint Number	Case ID#	Ill: ☐ **Yes** ☐**No**	Case: **Confirmed**☐ **Probable**☐ **Possible**☐

Name | Address | Phone: Home / Work

Age | Sex M☐ F☐ | Occupation | Place of Work | Ethnic Group: Special Dietary Habits, Other Pertinent Data

Sign and Symptoms * (*Mark appropriate signs and symptoms and **bold** those that happened first. *****Ask if these symptoms occurred, if not mentioned by person)*

INTOXICATIONS (Acute and chronic)	ENTERIC INFECTIONS	GENERALIZED INFECTIONS	LOCALIZED INFECTIONS	NEUROLOGICAL ILLNESSES
Nausea***** ☐	Abdominal Cramps***** ☐	Cough ☐	Ear ☐	Blurred Vision ☐
Vomiting***** ☐	Diarrhea***** ☐	Edema ☐	Eye ☐	Coma ☐
Anemia ☐	bloody ☐	Headache ☐	Itching ☐	Delirium ☐
Bloating ☐	watery ☐	Jaundice ☐	Mouth ☐	Difficulty with: ☐ Speaking?
Burning in mouth ☐	greasy ☐	Lack of Appetite ☐	Rash ☐	☐ Swallowing? ☐Breathing?
Cyanosis ☐	mucoid ☐	Malaise ☐	Skin lesion ☐	Dizziness ☐
Dehydration ☐	No./day	Muscular aches ☐	Pneumonia ☐	Double vision ☐
Excessive salivation ☐	Chills ☐	Perspiration ☐	_____	Irritability ☐
Flushing ☐	Constipation ☐	Stiff neck joints ☐	_____	Numbness ☐
Thirst ☐	Fever °C/°F*****	Swollen lymph nodes ☐	_____	Paralysis ☐
Metallic taste ☐	Difficult: ☐urination	Weakness ☐	_____	Pupils ☐dilated ☐fixed ☐constricted
Pallor ☐	☐defecation		_____	Tingling ☐
Fainting ☐				
Others symptoms (specify)				

Date of Onset | Time of Onset (hour) | Incubation Period | Duration of Illness HOURS | Residual Symptoms | Fatal? ☐Yes ☐No

Physician Consulted? ☐Yes ☐ No | Physician Name | Address | Phone | Hospital/Clinic Attended | Address | Phone

Types of Specimens Obtained	1)	2)	3)
Date Collected:	1)	2)	3)
Specimen Number:	1)	2)	3)
Lab Results:	1)	2)	3)

Contacts with Known Case BEFORE illness (names, phone numbers)	Contacts with Known Cases AFTER Illness (names, phone numbers)