**Investigation record of cases**

Suspect case: Any patient with signs and symptoms of intoxication

**( ) Patient record ( ) Hospitalized ( ) Community**

Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ ID number\_\_\_\_\_\_\_\_\_\_\_\_

1. **Demographic data**

First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: ( ) M ( ) F Age:\_\_\_\_ Yrs Weight\_\_\_\_ (Kg) Height \_\_\_\_\_ (m)

 Address (Neighborhood) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reference point: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital status: Profession/occupation:

Educational level:

1. **Exposure data**

**We would like to know everything about what you drank and ate last Friday** (01/09/2015)?**.**

**Did you eat breakfast last Friday? ( ) Yes ( ) No**

If Yes what did you eat? Where did you eat?

What amount did you eat? What time did you eat breakfast?

**Did you eat lunch last Friday? ( ) Yes ( ) No**

If Yes what did you eat? Where did you eat?

What amount did you eat? What time did you eat lunch?

**Did you eat dinner last Friday? ( ) Yes ( ) No**

If Yes what did you eat? Where did you eat?

What amount did you eat? What time did you eat dinner?

**Write the answer in the table below:**

|  |  |  |  |
| --- | --- | --- | --- |
| Type of food | Where | How much | Time |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Did you drink anything last Friday morning? ( ) Yes ( ) No

Did you drink anything last Friday afternoon? Did you drink anything at night?

If Yes, what did you drink (Phombe, water, beer, soda, milk, or other drinks)?

 Where did you drink? What amount did you drink? What time did you drink?

**Write the answer in the table below:**

|  |  |  |  |
| --- | --- | --- | --- |
| Beverage | Where | Amount | Time  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Did you attend the funeral at Dona Adelia’s family’s house last Friday (01/09/2015)? ( ) Yes ( ) No

What time did you arrive at the ceremony? \_\_\_\_ : \_\_\_\_\_\_\_ ?

At what time did you leave? \_\_\_\_\_: \_\_\_\_\_\_\_\_

Did you attend by yourself? ( ) Yes ( ) No .

If No, list the people that were there with you?

|  |  |  |
| --- | --- | --- |
| Name | Degree of kinship | Address |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Did you drink phombe last Friday? ( ) Yes ( ) No

If Yes, complete the table:

|  |  |  |  |
| --- | --- | --- | --- |
| Amount | Where did you drink | Where did you drink | Did you share with someone? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Did you find that the phome had a different flavor than usual? ( ) Yes ( ) No**

**If Yes, how was the flavor? (select one)**

1. **Metallic flavor**
2. **Bitter flavor**
3. **Bad flavor**
4. **Burning sensation**
5. **More sweet than usual**
6. **Other (describe)**

**Did you find that the phome had a different odor than usual? ( ) Yes ( ) No**

**If Yes, describe how it was different:**

1. **Clinical history**

**Signs and symptoms:**

Have you been sick with any other illness during the last 30 days? Yes\_\_\_ Nao \_\_\_

If Yes, describe the illnesses and symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been taking any medication for this disease? ( ) Yes ( ) No

If Yes Tradicional medication ( ) Which?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Conventional medication ( ) Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the medications that you took:

|  |  |  |
| --- | --- | --- |
| Medication | Frequency | Took for what illness? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Do you have any disease or chronic health condition, for example HIV, hypertention, liver problems, asthma, TB, heart problems or others? ( ) Yes ( ) No

Do you take any medication for this disease? ( ) Yes ( ) No

If Yes Tradicional medication ( ) Which?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Conventional medication ( ) Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

With what frequency do you take the medication?

|  |  |  |
| --- | --- | --- |
| Medication | Frequency | Disease treated |
|  |  |  |
|  |  |  |
|  |  |  |

Did you have one or more of the following symptoms beginning last Friday (01/09/2015)?

What time did your first symptoms start? (Interviewrs should stress if a person really had this symptom)?

|  |  |  |  |
| --- | --- | --- | --- |
| **Symptoms** | **Yes/No** | **Date symptom started** | **Time symptoms started** |
| **Heart symptoms** |
| Chest pain |  |  |  |
| Palpitations |  |  |  |
| **Respiratory symptoms** |
| Cough |  |  |  |
| Difficulty breathing (dyspnea) |  |  |  |
| Rapid breathing |  |  |  |
| Rhonchi |  |  |  |
|  |  |  |  |
| **Mental status symptoms** |
| Agitation |  |  |  |
| Confusion |  |  |  |
| Headache |  |  |  |
| Vertigo |  |  |  |
| Loss of consciousness |  |  |  |
| Weakness/lack of energy |  |  |  |
| Torpor/grogginess |  |  |  |
| Convulsions/ tremor |  |  |  |
| Paresthesia |  |  |  |
| Hallucinations |  |  |  |
| **Skin symptoms** |
| Cutaneous eruption (rash) |  |  |  |
| Sweating (more than normal)  |  |  |  |
| Skin irritation |  |  |  |
| **Abdominal symptoms** |
| Abdominal pain |  |  |  |
| Nausea |  |  |  |
| Vomiting |  |  |  |
| Diarrhea |  |  |  |
|  **Eye symptoms** |
| Eye irritation |  |  |  |
| Tearing of the eyes |  |  |  |
| Vision problems |  |  |  |
| Yellow eyes |  |  |  |
| Red eyes |  |  |  |
| **Other symptoms** |
| Chest wall pain  |  |  |  |
| Decreased urine output |  |  |  |
| Loss of hair |  |  |  |
| Fever |  |  |  |
| Other? |  |  |  |
|  |  |  |  |

**Are you receiving treatment for these symptoms? ( ) Yes ( ) No**

If Yes, what type of treatment?

**Patient hospitalized?** ( )Yes ( ) No

If hospitalized when admitted? \_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_ Received treatment? ( ) Yes ( ) No

Describe the type of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Laboratory findings:**

**Final disposition:** Date of discharge \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Discharged home ( )

Transferred ( )

Left without being discharged ( )

Died ( )

Name of investigator:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Category:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Interview date:**  \_\_\_\_\_/\_\_\_\_\_\_\_\_/15