Form Approved
OMB No. 0920-1011
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Investigation record of cases

Suspect case: Any patient with signs and symptoms of intoxication

( ) Patient record ( ) Hospitalized ( ) Community

Date_____/_____/____ ID number_____

I. 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:

II. 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)

a. **Metallic flavor**
b. **Bitter flavor**
c. **Bad flavor**
d. **Burning sensation**
e. **More sweet than usual**
f. **Other (describe)**

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

If Yes, describe how it was different:

III. 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