Investigation record of cases

Suspect case: Any patient with signs and sy	emptoms of intoxication	
() Patient record () Hospital	lized () Community	
Date/	ID number	
I. Demographic data		
First Name	Last Name	
Sex: () M () F Age: Yrs V	Veight (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? () Y	Tes () 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?	

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN: PRA (0920-1011)

Write the answer in the table below:

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	Type of food	Where	How much	Time
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	() No What time did you arri	ive at the ceremony? _	•	iday (01/09/2015)? () Yes
Name Degree of kinship Address	() No What time did you arri At what time did you l	eave?:	:?	iday (01/09/2015)? () Yes
	() No What time did you arri At what time did you l Did you attend by you	eave?:: rself? () Yes	:? () No .	iday (01/09/2015)? () Yes

Did you drink phombe la	st Fridav?()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 pl	nome had a differen	t flavor than usual? () Y	es () No
If Yes, how was the flav	or? (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 pl	ome had a differen	t odor than usual? () Ye	s () No
If Yes, describe how it v	was different:		
III. Clinical histo	ry		
Signs and symptoms:			
Have you been sick with any other illness during the last 30 days? Yes Nao			_ Nao
If Yes, describe the illnesses and symptoms:			
Have you been taking any medication for this disease? () Yes () No			
If Yes Tradicional med	ication () Which?_		
Conventional medication () Which?			
Describe the medications that you took:			
Medication	Frequency	Took for what illness?	

Do you have any disease or problems, asthma, TB, hear		ondition, for example HIV, hypertention, liver ers? () Yes () No	
Do you take any medication	n for this disease?	() Yes () No	
If Yes Tradicional medica	ation () Which?_		
Conventional med	dication () Whicl	ch?	
With what frequency do yo	u take the medicat	tion?	
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
	II.a.		started
	near	t symptoms	
Chest pain			
Palpitations			
	Respira	tory 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		
Ab	dominal 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?No	/ Received treatment? () Yes ()
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: /1	5