Form approved OMB No: 0920-XXXX Expiration Date: XX/XX/20XX

Passenger Crew Crew



Gastrointestinal Illness Surveillance System Questionnaire



(To be completed if you experienced gastrointestinal illness)

vessei name:		voyage No. :		Date:	
Last Name:		First Name:			
Date of Birth:	(mm/dd/yyyy)	Age:	(in years)	Sex M/F	
Cabin Number:		Total Number of	People in Cabin:		
Dining Seating:		Dining Table Number:			
Symptoms Started Date:	(mm/dd/yyyy)	Time:	(hh:mm)	AM / PM	
Do you know other people ill with th	e same sym	ptoms?		Yes / No	
If yes, please list their names:					
Did you stay overnight or longer in	a boarding ci	tv before vou ioine	d the vessel?	Yes / No	
If yes, where? City:	<u></u>	State:	Country:		
Was the overnight stay in a hotel/m	otel/commer		,	Yes / No	
If yes, what was the name and a	address of th	e hotel, motel/com	mercial residence		
Name:					
Address:					
City:	State:		Country:		
How did you travel to the city where	you boarde	d the ship for this c	ruise? Select all the	at apply.	
[] Airplane Airlin		•	Flight No.:	11 2	
[] Automobile					
[] Bus/Motorcoach					
[] Train					
[] Other Pleas	se specify:				
Are you a member of a tour group?			Yes / No		
Prior to boarding the ship, did you p	articipate in	a pre-embarkation	tour/package?	Yes / No	
If yes, which tour(s)/package(s) did you participate in? (list all)					
Prior you your illness, did you go as	shore at any o	of the ports of call?)	Yes / No	
If yes, please list the ports of ca				1007710	
Did participate in any shore excursions at any port of call?				Yes / No	
If yes, which shore excursions of				1007110	
you, miles onor onourone and you participate in. (not any					
Did you eat anything while you were ashore at any port of call?				Yes / No	
Did you drink anything (including drinks with ice) while ashore at any port of call?			Yes / No		
What did you think is the cause of your illness?:			163/110		
vvnat uiu you tiiink is the cause of your lilliess?.					

PLEASE TURN THIS FORM OVER TO PROVIDE FOOD AND SHIPBOARD ACTIVITIES HISTORY

CDC estimates the average public reporting burden for this collection of information as 10 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATN: PRA (0920-XXXX)

Passenger Crew	
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Last Name	First Name	

Meals and Activities Aboard Vessel Prior to Illness Please list the *specific* vessel locations of the meals you consumed and the vessel activities you participated in before you

Day of illness onset			/ou participated in before you became ill	
Give Date:	Day before illness onset	Two days before illness onset	Three days before illness onset	
Breakfast Place: Time: Items eaten/drank	Breakfast Place: Time: Items eaten/drank	Breakfast Place: Time: Items eaten/drank	Breakfast Place: Time: Items eaten/drank	
	Tions edicinately	Tems edicinatalin		
Lunch	Lunch	Lunch	Lunch	
Place:	Place:	Place:	Place:	
Time:			Time:	
Items eaten/drank	Items eaten/drank	Items eaten/drank	Items eaten/drank	
Dinner	Dinner	Dinner	Dinner	
Place:		Place:	Place:	
Time:	Place: Time:	Place: Time:	Time:	
Items eaten/drank	Items eaten/drank	Items eaten/drank	Items eaten/drank	
Snack	Snack	Snack	Snack	
Place: Time: Items eaten/drank	Place: Time: Items eaten/drank	Place: Place: _ Time: Items eaten/drank	Time: Items eaten/drank	
Activities	Activities	Activities	Activities	
AM PM	AM PM	AM PM	AM PM	