

# Pickaway County Public Health

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**PICKAWAY COUNTY  
PUBLIC HEALTH**

*We Care.*

## FOODBORNE ILLNESS REPORTING

Name of Person Sick: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Date illness began: \_\_\_\_\_ Was Person Seen by a doctor? \_\_\_\_\_

If so was a diagnosis given? \_\_\_\_\_ What was the cause of the Illness? \_\_\_\_\_

Did anyone else fall ill at the same time? \_\_\_\_\_ Did all parties eat the same food? \_\_\_\_\_

If so please fill out separate form for each person.

Please give a 3 day food history below.

Day 1	Breakfast	Lunch	Evening Meal	Snack / Drinks
Day 2				
Day 3				

\*\*\*\*\*DO NOT WRITE BELOW THIS LINE\*\*\*\*\*

Health Department Sanitarian Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Sanitarian \_\_\_\_\_

Date \_\_\_\_\_