

Trichinellosis Investigation Form

Case | _____ | Year | _____ |

Section 1. Personal Data

Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth ___/___/___
Nationality	Occupation	Institution
Caza	Locality	Phone

Section 2. Diagnostic Data

Date of illness ___/___/___	Thirst <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Sweating <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Periorbital edema <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Nausea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Photophobia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Myalgia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	Other:

Laboratory Testing:

	Date	Laboratory	Results
Eosinophilia			Count /mm3:
Muscle biopsy			<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not done
Serology			<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Not done
Serology			<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Not done
Other			<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal <input type="checkbox"/> Not done

Outcome:

<input type="checkbox"/> Recovered	<input type="checkbox"/> Died, date ___/___/___	<input type="checkbox"/> Unknown
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Section 3. Food product Data

Suspected food:	<input type="checkbox"/> Type Pork (specify): <input type="checkbox"/> Store bought pork <input type="checkbox"/> Pork from farm-raised pig <input type="checkbox"/> Wild boar <input type="checkbox"/> Other: <input type="checkbox"/> Not specified	<input type="checkbox"/> Type non Pork (specify): <input type="checkbox"/> Bear meat <input type="checkbox"/> Hamburger (Ground meat) <input type="checkbox"/> Horse meat <input type="checkbox"/> Other: <input type="checkbox"/> Not specified	<input type="checkbox"/> Unknown
Date of consumption: ___/___/___			
Left over: <input type="checkbox"/> Yes	<input type="checkbox"/> No		<input type="checkbox"/> Unknown
Storage method:			
Where meat obtained:	<input type="checkbox"/> Supermarket/grocery store <input type="checkbox"/> Restaurant <input type="checkbox"/> Other (specify):	<input type="checkbox"/> Butcher shop <input type="checkbox"/> Direct from farm	<input type="checkbox"/> Hunted /trapped <input type="checkbox"/> Unknown
Preparation after purchase:	<input type="checkbox"/> No further processing <input type="checkbox"/> Smoked <input type="checkbox"/> Other (specify):	<input type="checkbox"/> Ground cow meat <input type="checkbox"/> Dried Jerky	<input type="checkbox"/> Marinated <input type="checkbox"/> Unknown
Method of cooking:	<input type="checkbox"/> Uncooked <input type="checkbox"/> Unknown	<input type="checkbox"/> Fried <input type="checkbox"/> Other (specify):	<input type="checkbox"/> BBQ

Food Laboratory Testing:

Tested food item	Date	Laboratory	Result
			Larvae in food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> Not done
			Larvae in food: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk. <input type="checkbox"/> Not done

Investigator:

Date: