Maryland Department of Health and Mental Hygiene
Epidemiology and Disease Control Program

GASTROENTERITIS SURVEILLANCE FORM (For Employees)

**Name of Facility, Date_____

Name:_____Age:_____Sex:_____

Address:_____

_____ Phone:_____

Type of Work:_____

Wing/Floor of Work:_____

Working Hours:_____

Do you work in any other facilities?____ If yes, where:_____

_____

**Have you developed diarrhea and/or vomiting since _____?(Date)

___Yes ___No If yes, what date did the diarrhea and/or vomiting start?_____

Please check if you have or had any of these symptoms:

	Yes	No	
Diarrhea	_____	_____	
Vomiting	_____	_____	
Abdominal Cramps	_____	_____	
Nausea	_____	_____	
Fever	_____	_____	How high?____
Blood in Stools	_____	_____	
Headache	_____	_____	
Chills	_____	_____	
Muscle ache	_____	_____	
Other	_____		

How long did your diarrhea and/or vomiting last?_____days

Were you seen by a physician for the above symptoms? Yes_____No_____

If yes, by: Name:_____Phone:_____

Did you take this medicine? Yes_____ No_____ If yes, list:_____

Were you hospitalized for this problem? Yes_____ No_____

If seen by a physician or hospitalized, was a stool culture taken? Yes____ No____

**Note: Complete Name of Facility and Dates prior to distributing this form