

### GASTROINTESTINAL ILLNESS SURVEILLANCE LOG

NOAA SHIP	DAY ____ of ____	PAGE ____ of ____
MEDICAL OFFICER / MPIC	VOYAGE START DATE	VOYAGE END DATE

DATE	GASTROINTESTINAL ILLNESS SURVEILLANCE CASE # _____	GASTROINTESTINAL ILLNESS SURVEILLANCE CASE # _____	GASTROINTESTINAL ILLNESS SURVEILLANCE CASE # _____
LAST NAME			
FIRST NAME			
POSITION			
STATEROOM			
AGE / GENDER			
DATE / TIME of ONSET			

DIARRHEA	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
# in the LAST 24 HOURS	_____ EPISODES	_____ EPISODES	_____ EPISODES
BLOOD in STOOLS	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
VOMITING	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
# in the LAST 24 HOURS	_____ EPISODES	_____ EPISODES	_____ EPISODES
FEVER	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
TEMPERATURE	_____ °F	_____ °F	_____ °F
ABDOMINAL CRAMPS	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEADACHES	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
MUSCLE ACHES	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
OTHER:			
ANTI-DIARRHEAL MEDICATIONS			
UNDERLYING ILLNESS			