



# Listeria monocytogenes Trawling Questionnaire (For use in the North West ONLY)

Version 1 June 2005

- Any information supplied will be treated as strictly confidential.
- Please tick boxes () , or write in the spaces (\_\_\_\_) provided.
- Please use black or dark blue biro/pen.
- **If you are answering on behalf of someone else, please remember that these questions refer to the *person that is/was ill* and not yourself.**
- "No" and "Not sure" answers are as important as "Yes" answers. If you leave a blank space we cannot interpret the intended answer.

Interviewee: Patient  Proxy  (relationship to patient) \_\_\_\_\_

Interviewer's name \_\_\_\_\_ Date of interview \_\_\_\_/\_\_\_\_/\_\_\_\_

## SECTION 1. PERSONAL DETAILS

1.1 Forename (s): \_\_\_\_\_ 1.2 Surname: \_\_\_\_\_

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

\_\_\_\_\_ 1.4 Postcode. \_\_\_\_\_

1.5 Daytime telephone number: \_\_\_\_\_

1.6 Gender: Male  Female

1.7 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ dd/mm/yy 1.8 Age \_\_\_\_ years

1.9 Describe your ethnic background (please tick one):

*White:*

British  Irish  Other (please state) \_\_\_\_\_

*Mixed:*

White/Black Caribbean  White/Black African  
 White/Asian  Other (please state) \_\_\_\_\_

*Asian/Asian British:*

Indian  Pakistani  Bangladeshi  
 Other (please state) \_\_\_\_\_

*Black/Black British:*

Caribbean  African  Other (please state) \_\_\_\_\_

*Chinese or other ethnic group:*

Chinese  Other (please state) \_\_\_\_\_

1.10 GP's name: \_\_\_\_\_

1.11 Practice address: \_\_\_\_\_

1.12 Occupation (if currently unemployed, what was your most recent occupation; if retired, what was your main occupation):

\_\_\_\_\_  
\_\_\_\_\_

1.13 Name and address of workplace/school/nursery/playgroup (as applicable):

\_\_\_\_\_  
\_\_\_\_\_

## SECTION 2. MEDICAL DETAILS

2.1 Did you have any acute or significant health problems in the month before your illness?

Yes  No  Not sure

If yes, please describe \_\_\_\_\_

2.2 Did you have any other ongoing or long-standing medical conditions before your *Listeria* infection (e.g. heart problems, diabetes etc)?

Yes  No  Not sure

If yes, please describe \_\_\_\_\_

2.3 Were you taking any medicine, either prescribed by your Doctor or bought from a chemist etc, in the two weeks before your illness?

Yes  No  Not sure

If yes, please describe \_\_\_\_\_

2.4 Did you attend a health care facility (e.g. a hospital or a nursing home) in the 30 days before you became ill?

Yes  No  Not sure

If yes please give details: (place, dates, food eaten etc.)

Hospital/nursing home visit or treatment	Date of visit/treatment	Discharge Date (if treated)
_____	____/____/____	____/____/____
_____	____/____/____	____/____/____
_____	____/____/____	____/____/____

### SECTION 3. CASE HISTORY

3.1 When did you start to feel unwell with Listeria? \_\_\_/\_\_\_/\_\_\_ dd/mm/yy

3.2 Did you have any of the following symptoms (can tick more than one):

	Yes	No		Yes	No
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Muscle aches	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	Joint aches	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Backache	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Neck stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Confusion	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>			

If other please specify: \_\_\_\_\_

3.3 Are you still ill with Listeria? Yes  No  Not sure

If no, how many days were you ill for? \_\_\_\_\_ days

3.4 Were you admitted to hospital for this illness? Yes  No

If yes, which hospital? \_\_\_\_\_

3.5 Date of admission \_\_\_/\_\_\_/\_\_\_ Date of discharge \_\_\_/\_\_\_/\_\_\_

If exact dates are not known, how many days were you in hospital for? \_\_\_\_\_ days

### SECTION 4. TRAVEL HISTORY

4.1 Did you spend any nights outside the UK in the **30 DAYS** before you became ill?

Yes  No

If **YES**, give details:

Country(ies) visited: \_\_\_\_\_

Dates of travel: departure \_\_\_/\_\_\_/\_\_\_ return \_\_\_/\_\_\_/\_\_\_

Addresses of places stayed (e.g. towns, hotels, campsites etc):

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4.2 Did you spend any nights away from home within the UK in the **30 DAYS** before you became ill? (e.g: includes staying at friends/relatives, business trips etc)

Yes

No

Dates of travel: departure \_\_\_\_/\_\_\_\_/\_\_\_\_ return \_\_\_\_/\_\_\_\_/\_\_\_\_

Addresses of places stayed : (eg: friend's house, towns, hotels, campsites etc)

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4.3 Did you go on any day trips within the UK in the **30 DAYS** before you became ill? (e.g. business/shopping trips etc)

Yes

No

Names and addresses of places visited (include post code if known or area e.g. Central London)

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## SECTION 5. FOOD HABITS

5.1 Do you follow any particular diets or only eat certain types of food?

No

Yes - vegetarian

Yes - vegan

Yes - Kosher

Yes - Halal

Yes - organic food

Yes - other

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5.2 Do you avoid any of the following foods? (tick any that apply)

Soft/blue cheese

Paté

Raw fish (e.g. sushi)

Smoked fish (e.g: smoked salmon etc.)

Sliced uncooked meats (e.g: parma ham etc.)

Butter

Pre-cut/pre-packed fruits (e.g. fruit salad, melon etc.)

**SECTION 6. FOOD HISTORY**

6.1 Did you eat any foods from any of the following in the **30 DAYS** before you started to feel ill?

	<b>No</b>	<b>Yes</b>	<b>Date/location/brand etc</b>
Coffee shop	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bakers shop	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sandwich bar	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pub	<input type="checkbox"/>	<input type="checkbox"/>	_____
Canteen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hospital canteen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hospital snack bar	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burger bar	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pizza parlour	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fast food restaurants	<input type="checkbox"/>	<input type="checkbox"/>	_____
Delicatessen	<input type="checkbox"/>	<input type="checkbox"/>	_____
British restaurant	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ethnic restaurants	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reception/wake	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hotel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mobile caterer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Airport	<input type="checkbox"/>	<input type="checkbox"/>	_____
Railway station/train	<input type="checkbox"/>	<input type="checkbox"/>	_____
Petrol station	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SECTION 6. FOOD HISTORY - BEEF**

6.2 Did you eat any of the following **unheated/ready to eat** beef items in the **30 DAYS** before you became ill?

	<b>No</b>	<b>Yes</b>	<b>Date/location/brand etc</b>
Cold cooked beef	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prepacked sliced beef	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loose-sold sliced beef	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prepacked salt beef	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loose-sold salt beef	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prepacked pastrami	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loose-sold pastrami	<input type="checkbox"/>	<input type="checkbox"/>	_____

	No	Yes	Date/location/brand etc
Potted beef	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tongue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brawn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SECTION 6. FOOD HISTORY - PORK**

6.3 Did you eat any of the following **unheated/ready to eat** pork items in the **30 DAYS** before you became ill?

	No	Yes	Date/location/brand etc
Cold roast pork	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prepacked sliced ham	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loose-sold sliced ham	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prepacked smoked ham	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loose-sold smoked ham	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry cured ham	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry fermented sausages	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sausages	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frankfurter sausages	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sausage rolls	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pork pies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scotch eggs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver sausage	<input type="checkbox"/>	<input type="checkbox"/>	_____
Paté	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SECTION 6. FOOD HISTORY - POULTRY**

6.4 Did you eat any of the following **unheated/ready to eat** poultry items in the **30 DAYS** before you became ill?

	No	Yes	Date/location/brand etc
Cold roast chicken	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prepacked cooked chicken	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prepacked sliced chicken	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken sandwich meat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken pies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cold roast turkey	<input type="checkbox"/>	<input type="checkbox"/>	_____

	No	Yes	Date/location/brand etc
Prepacked cooked turkey	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prepacked sliced turkey	<input type="checkbox"/>	<input type="checkbox"/>	_____
Goose liver pate (foie gras)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Duck liver pate (foie gras)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SECTION 6. FOOD HISTORY - FISH & SEAFOOD**

6.5 Did you eat any of the following **unheated/ready to cook** seafoods in the **30 DAYS** before you became ill?

	No	Yes	Date/location/brand etc
Smoked salmon <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mackerel fillets	<input type="checkbox"/>	<input type="checkbox"/>	_____
Smoked mackerel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Salmon pâté/terrine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Smoked trout	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fish pâté/paste	<input type="checkbox"/>	<input type="checkbox"/>	_____
Jellied eels	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other fish	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cold seafood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oysters	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prawns	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mussels	<input type="checkbox"/>	<input type="checkbox"/>	_____
Squid/calamari	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mixed seafood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other seafood	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SECTION 6. FOOD HISTORY - MILK & DAIRY**

6.6 Did you drink or have in cereal any of the following milk products in the **30 DAYS** before you became ill?

	No	Yes	Date/location/brand etc
<b>Cows milk</b>			
Unpasteurised	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pasteurised	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sterilised/UHT	<input type="checkbox"/>	<input type="checkbox"/>	_____

	No	Yes	Date/location/brand etc
<b>Goats milk</b>			
Unpasteurised	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pasteurised	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soya milk	<input type="checkbox"/>	<input type="checkbox"/>	_____
Powdered milk	<input type="checkbox"/>	<input type="checkbox"/>	_____
Flavoured milk	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other milk	<input type="checkbox"/>	<input type="checkbox"/>	_____

6.7 Did you eat any of the following dairy products in the **30 DAYS** before you became ill?

	No	Yes	Date/location/brand etc
Cream	<input type="checkbox"/>	<input type="checkbox"/>	_____
Butter	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dairy spread (e.g. Clover etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Home made ice cream	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other dairy products	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SECTION 6. FOOD HISTORY - CHEESE**

6.8 Did you eat any of the following types of cheese in the **30 DAYS** before you became ill?

	No	Yes prepacked	Yes sold loose	Date/location/brand etc
Cheddar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other hard cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blue cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Camembert	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brie	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other soft cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cheese spread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Goats cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Goats soft cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SECTION 6. FOOD HISTORY - SANDWICHES**

6.9 Did you eat any sandwiches, rolls or filled baguettes that were **bought or served** away from home in the **30 DAYS** before you became ill?

Yes  No

If **YES** did the sandwiches contain:

	<b>Yes</b>	<b>No</b>	<b>Don't know</b>
Butter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Margarine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**6.10** If **YES** did you eat any of the following types of sandwich?

	<b>No</b>	<b>Yes prepacked</b>	<b>Yes custom made</b>	<b>Date/location/brand etc</b>
Ham	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Beef	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bacon/BLT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chicken	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Turkey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuna sandwich	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Salmon sandwich	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prawn/other seafood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Egg mayonnaise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other egg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hard cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brie	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**6.11** Did any of these sandwiches include any of the following extras?

	<b>Yes</b>	<b>No</b>
Cucumber	<input type="checkbox"/>	<input type="checkbox"/>
Lettuce	<input type="checkbox"/>	<input type="checkbox"/>
Onions	<input type="checkbox"/>	<input type="checkbox"/>
Tomato	<input type="checkbox"/>	<input type="checkbox"/>
Cress	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION 6. FOOD HISTORY - SALAD VEGETABLES & HERBS**

**6.12** Did you eat any of the following raw vegetables in the **30 DAYS** before you became ill?

	<b>No</b>	<b>Yes prepacked</b>	<b>Yes sold loose</b>	<b>Date/location/brand etc</b>
Basil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bean sprouts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Broccoli	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cabbage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

	No	Yes prepacked	Yes sold loose	Date/location/brand etc
Carrots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cauliflower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coriander leaves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Courgettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cucumber	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gherkins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lettuce	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mixed salad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mushrooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Onions (any)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Parsley	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Peppers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Radishes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spinach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tomatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Water cress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SECTION 6. FOOD HISTORY - FRUIT**

6.13 Did you eat any of the following fresh fruit in the **30 DAYS** before you became ill?

	No	Yes	Date/location/brand etc
Ready-to eat fruit salads	<input type="checkbox"/>	<input type="checkbox"/>	_____
Precut apples	<input type="checkbox"/>	<input type="checkbox"/>	_____
Precut peaches/nectarines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Precut pineapple	<input type="checkbox"/>	<input type="checkbox"/>	_____
Precut mango	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strawberries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Raspberries	<input type="checkbox"/>	<input type="checkbox"/>	_____
Precut melon	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other precut fruit	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SECTION 6. FOOD HISTORY - SHOPS**

6.14 Have you bought any food from the following **shops** recently?

	No	Yes	Name/Branch/location
Aldi	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asda	<input type="checkbox"/>	<input type="checkbox"/>	_____
Budgens	<input type="checkbox"/>	<input type="checkbox"/>	_____
Co-op	<input type="checkbox"/>	<input type="checkbox"/>	_____
Iceland	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kwiksave	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lidl	<input type="checkbox"/>	<input type="checkbox"/>	_____
Marks & Spencer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Morrisons (Safeway)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Netto	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sainsbury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Somerfield	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spar	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tesco	<input type="checkbox"/>	<input type="checkbox"/>	_____
Waitrose	<input type="checkbox"/>	<input type="checkbox"/>	_____
Local butchers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Local bakers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Local green grocers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Local fish monger	<input type="checkbox"/>	<input type="checkbox"/>	_____
Corner shop/mini mkt	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cheese shop	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chinese grocers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Indian grocers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Greek grocers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ethnic grocers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____

**SECTION 6. FOOD HISTORY - BUYING HABITS**

**6.15** When you purchase food do you check the use by or sell by dates printed on the food items?

Always  Sometimes  Never

**6.16** Have you ever purchased food that has been sold AFTER the use by or best before date printed on the items?

Yes  No

**6.17** Do you adhere to use by or best before dates on food you have purchased?

Always  Sometimes  Never

**6.18** Do you check the dates on tinned foods before consumption?

Always  Sometimes  Never

**6.19** How long do you keep loose meat products after purchasing from a butcher or butcher/deli counter at a supermarket?

Never  < 3 days  3 to 6 days  > 7 days

**6.20** In the last **30 DAYS** have you eaten any food that was **bought abroad?**  
(e.g. bought by yourself or given to you as a gift)

Yes  No

If **YES**, please specify type of food and country of purchase

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**Thank you for completing this questionnaire**

Would you mind if we contacted you at some point in the future for additional information, should the need arise?

Yes  No

**Please return completed form by post or fax to:**

Mrs Kathy Chandler  
Health Protection Agency North West  
DBH House  
105 Boundary Street  
Liverpool L5 9YJ  
Tel: 0151 482 5734  
Fax: 0151 482 5689

**If you have any specific questions about this investigation either now or in the future please call or write to:**

Iain Gillespie  
Health Protection Agency Centre for Infections  
61 Colindale Avenue  
London NW9 5EQ  
Tel: 020 8327 7486