MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF ENVIRONMENTAL HEALTH SERVICES

FOOD PRODUCT COMPLAINT RECORD

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Mail or Fax Completed Form to: Missouri Department of Health and Senior Services, Bureau of Environmental Health Services, P.O. Box 570, Jefferson City, Missouri 65102. Our fax number is (573) 526-7377. Email: foodsafetycomplaints@health.mo.gov

1. COMPLAINANT IDENTIFICATION (DOES COMPLAINANT EXPECT ☐ DHSS / ☐ FDA CONTACT? ☐ YES ☐ NO)

COMPLAINANT'S NAME	ADDRESS (INCLUDE ZIP CODE)	
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	E-MAIL ADDRESS

2. FORM OF COMPLAINT

☐ TELEPHONE ☐ VISIT ☐ LETTER ☐ INTERNET/E-MAIL (attach letter/email include pictures if available)

3. ☐ ILLNESS/INJURY COMPLAINT ☐ FOREIGN OBJECT COMPLAINT ☐ OTHER

DESCRIBE

DATE PURCHASED	DATE/TIME PRODUCT OPENED	DATE/TIME PRODUCT CONSUMED/USED

4. DID COMPLAINANT HAVE SYMPTOMS? ☐ YES ☐ NO (If no, skip to section 5)

☐ Vomiting	ONSET DATE/TIME	☐ Nausea	ONSET DATE/TIME	☐ Dizzy/Blurred Vision	ONSET DATE/TIME
☐ Diarrhea	ONSET DATE/TIME	☐ Chills	ONSET DATE/TIME	☐ Abdominal Cramps	ONSET DATE/TIME
☐ Headache	ONSET DATE/TIME	☐ Skin/Eye Irritation	ONSET DATE/TIME	☐ Other - Describe	ONSET DATE/TIME
☐ Fever _____°F	ONSET DATE/TIME	WHEN DID SYMPTOMS END?	ONSET DATE/TIME		

MEDICAL CONSULTATION
☐ YES ☐ NO ☐ UNKNOWN (If "yes", give hospital or physician's name, address, phone numbers, dates and names of persons treated.)

LABORATORY SPECIMEN TAKEN
☐ YES ☐ NO ☐ UNKNOWN

WERE OTHERS AFFECTED BY THIS PRODUCT? DESCRIBE WHO WAS AFFECTED, HOW THEY WERE AFFECTED AND THEIR RELATIONSHIP TO COMPLAINANT

5. PRODUCT AND LABELING

FULL PRODUCT NAME (INCLUDE FLAVOR)	SIZE AND TYPE PACKAGE	LOT NUMBER
UPC CODE	CODE/SERIAL NUMBER	CODE DATE (IF ANY)
AMOUNT OF PRODUCT CONSUMED	AMOUNT OF PRODUCT REMAINING	WHAT WAS DONE WITH REMAINING PRODUCT

NAME AND LOCATION OF STORE WHERE PURCHASED (COMPLETE ADDRESS AND TELEPHONE NUMBER IF AVAILABLE)

6. PREPARER, MANUFACTURER/DISTRIBUTOR OF PRODUCT

IS PRODUCT FROM A FOREIGN COMPANY? ☐ YES ☐ NO ☐ UNKNOWN	NAME AND LOCATION OF FIRM FROM LABEL (INCLUDE ZIP CODE AND PHONE NUMBER IF AVAILABLE)		
DID COMPLAINANT CONTACT STORE ☐ YES ☐ NO ☐ UNKNOWN	DID COMPLAINANT CONTACT MANUFACTURER? ☐ YES ☐ NO ☐ UNKNOWN	WHEN?	CASE REFERENCE NUMBER ISSUED BY COMPANY, IF ANY.

7. REMARKS (ATTACH ADDITIONAL PAGES IF NECESSARY)

DID DHSS OR LPHA CONTACT STORE?
☐ YES ☐ NO IF YES, DESCRIBE:

8. RECORD COMPLETED BY

NAME	ADDRESS AND TELEPHONE NUMBER	DATE