APPENDIX I
PRE-TEST QUESTIONNAIRE

Form Approved
OMB No. 0920-XXXX
Exp. Date xx/xx/20xx

UNIQUE ID:

DATE:

EMERGENCY POINT OF CONTACT: (NAME & PHONE NUMBER):

_____

GENERAL HEALTH?	
1. Do you feel well today	O Yes O No
2. Have you had a cold or flu within the last two weeks? (if no, skip to Question 4)	O Yes O No
3. How long has it been since you recovered from the cold or flu? days _	_____
4. Have you eaten today?	O Yes O No
5. Have you had at least 8 ounces of fluid in the past four hours?	O Yes O No
6. Have you started or stopped taking any medications, including vitamins, supplements, herbal preparation/compounds, or naturopathic remedies (or changed doses) since your last physical exam with our doctor	O Yes O No
7. Take a few minutes to review the activity sheet(s) for the test you will be performing today. Is there any reason why performing the tasks described may be unsafe for you?	O Yes O No
8. Have you had any illness or injury that required you to see a doctor or go to a hospital for treatment since your last physical exam with our doctor?	O Yes O No
9. Have you experienced any of the following conditions since your last physical exam with our doctor?	
O Shortness of breath	**O** Fainting or dizzy spells
O Wheezing	**O** Any other lung or heart problems
O Pregnancy (or possibility of pregnancy)	**O** Unusual, severe headaches
O Pain or tightness in your chest	**O** Numbness or tingling in extremities
O Irregular heartbeat	**O** Any musculoskeletal pain or discomfort
O High or low blood pressure	**O** Hemorrhoids
O Seizures	

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ALCOHOL

During the past 24 hours, about how many alcoholic drinks did you drink?

(One drink is equivalent to a 12-oz beer, 5-oz glass of wine, or a drink with one shot of liquor).

_____ drinks

ACUTE DIARRHEAL ILLNESS

Please check any illnesses you have had <u>over the past 24 hours</u>

O Nausea and vomiting	**O** Diarrhea
O Fever	

Please list any medications (including over the counter) that you are taking for this illness.

_____
_____

SLEEP

About what time do you think you fell asleep last night or earlier today?	_____ AM / PM
About what time did you wake up today?	_____ AM / PM
If you woke up in the middle of the night, how long were you awake?	_____ Minutes

How would you rate your sleep quality overall last night?

O Very Good	**O** Fairly Good
O Fairly Bad	**O** Very Bad

HEALTH CONCERNS

Do you have any health-related concerns you want to discuss with our doctor prior to your participation in the study today?

O Yes **O** No

WORK CONDITIONS

In the LAST WEEK THAT YOU WORKED, how would you describe the air temperature in your work area?

O Very cold O Cold O Slightly cool O Neutral O Slightly warm O Warm O Hot O Very hot

In the LAST WEEK THAT YOU WORKED, how would you describe the humidity at your work area?

O Dry O Neutral O Humid

In the LAST WEEK THAT YOU WORKED, how would you describe the air circulation in your

work area? **O Cold air flow O Cool air flow O No air flow O Warm air flow O Hot air flow**
In the LAST WEEK THAT YOU WORKED , how much did you sweat, in general? **O I did not sweat O I sweat a little (i.e. armpits, face) O I sweat a moderate amount (armpits, face, chest, back) O I sweat a lot (clothes get completely wet)**
In the LAST WEEK THAT YOU WORKED , how thirsty did you get? **O Not thirsty at all O I got thirsty occasionally O I got thirsty frequently O I was thirsty all the time**
In the LAST WEEK THAT YOU WORKED, how hot did you get in your work area? **O Not hot at all O A little warm O Warm O Hot O Very hot**
In the LAST WEEK THAT YOU WORKED, how physically fatigued were you at the end of your work day? **O Not tired at all O A little tired O Tired O Extremely tired**
How many days have you worked in an area that you felt was warm or hot: 1) In the past week? _____ days 2) In the past 2 weeks? _____ days
In the PAST WEEK, how many days have you worked? _____ days
How many days ago was your last shift or work day? _____ day(s) ago

Subject's Signature _____

Resting Heart Rate _____

Resting Blood Pressure (Left or Right Arm) _____

Medical officer's Signature _____

Pre-test USG _____ Post-test USG _____

Pre-test weight _____ Post-test weight_____

Post-test Heart Rate _____ Post-test Blood Pressure _____

Post-test Core Temp _____ Body fat % _____