**Appendix I**

**Pre-test questionnaire**

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**Unique Id:**

**Date:**

**Emergency point of contact: (name & phone number):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

CDC estimates the average public reporting burden for this collection of information as 5 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

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| **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? O Yes O No (if no, skip to Question 4)  |
| 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, O Yes O No supplements, herbal preparation/compounds, or naturopathic remedies (or changed doses) since your last physical exam with our doctor |
| 7. Take a few minutes to review the activity sheet(s) for the test you will be O Yes O No performing today. Is there any reason why performing the tasks described may  be unsafe for you? |
| 8. Have you had any illness or injury that required you to see a doctor or go to a O Yes O No hospital for treatment since your last physical exam with our doctor? |
| 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 |

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| **ACUTE diarrheal ILLNESS** |
| **Please check any illnesses you have had over the past 24 hours** |
| **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 % \_\_\_\_\_\_\_\_\_