

APPENDIX I
PRE-TEST QUESTIONNAIRE

UNIQUE ID:

DATE:

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

GENERAL HEALTH?

1. Do you feel well today No	<input type="radio"/> Yes <input type="radio"/> No
2. Have you had a cold or flu within the last two weeks? No (if no, skip to Question 4)	<input type="radio"/> Yes <input type="radio"/> No
3. How long has it been since you recovered from the cold or flu? days _	_____
4. Have you eaten today? No	<input type="radio"/> Yes <input type="radio"/> No
5. Have you had at least 8 ounces of fluid in the past four hours? No	<input type="radio"/> Yes <input type="radio"/> No
6. Have you started or stopped taking any medications, including vitamins, No supplements, herbal preparation/compounds, or naturopathic remedies (or changed doses) since your last physical exam with our doctor	<input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> No	<input type="radio"/> Yes
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? <input type="radio"/> No	<input type="radio"/> Yes
9. Have you experienced any of the following conditions since your last physical exam with our doctor?	
<input type="radio"/> Shortness of breath	<input type="radio"/> Fainting or dizzy spells
<input type="radio"/> Wheezing	<input type="radio"/> Any other lung or heart problems
<input type="radio"/> Pregnancy (or possibility of pregnancy)	<input type="radio"/> Unusual, severe headaches
<input type="radio"/> Pain or tightness in your chest	<input type="radio"/> Numbness or tingling in extremities
<input type="radio"/> Irregular heartbeat	<input type="radio"/> Any musculoskeletal pain or discomfort
<input type="radio"/> High or low blood pressure	<input type="radio"/> Hemorrhoids
<input type="radio"/> Seizures	

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 over the past 24 hours

Nausea and vomiting

Diarrhea

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?

Very Good

Fairly Good

Fairly Bad

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?

Yes No

WORK CONDITIONS

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

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

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

Dry Neutral Humid

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

work area?

Cold air flow Cool air flow No air flow Warm air flow Hot air flow

In the LAST WEEK THAT YOU WORKED , how much did you sweat, in general?

I did not sweat I sweat a little (i.e. armpits, face) I sweat a moderate amount (armpits, face, chest, back) I sweat a lot (clothes get completely wet)

In the LAST WEEK THAT YOU WORKED , how thirsty did you get?

Not thirsty at all I got thirsty occasionally I got thirsty frequently I was thirsty all the time

In the LAST WEEK THAT YOU WORKED, how hot did you get in your work area?

Not hot at all A little warm Warm Hot Very hot

In the LAST WEEK THAT YOU WORKED, how physically fatigued were you at the end of your work day?

Not tired at all A little tired Tired 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 % _____