APPENDIX II

BASELINE MEDICAL QUESTIONNAIRE
HEAT STUDY
Baseline Medical Background Questionnaire

1. SEX: Male ___ Female ___

2. DATE OF BIRTH: ___/___/___
   Mo. Day Yr.

3. RACE:
   White ___
   Black ___
   Hispanic ___
   Asian ___
   Other ______

4. Have you smoked cigarettes? ___ Yes ___ No
   (yes means more than 20 packs of cigarettes or 12 oz. of tobacco in your life)
   If "no," go on to question 5. If "yes," answer questions 4a-4e

   4a. Do you smoke now? ___ Yes ___ No
   4b. How old were you when you started smoking regularly? ___
   4c. If you stopped, how old were you when you stopped? ___
   4d. How many packs per day do you smoke now? ___
   4e. On the average, how many packs per day have you smoked? ___

5. Have you ever had to have medical treatment for heat exhaustion or heat stroke? Yes: ___
   a. If "yes" how many times? ___
   b. What was the last year this happened? 19 ___
   No: ___
6. Do you experience any of the following when you work in the heat?
   a. A period of feeling faint or dizzy? Never: ___ Sometimes: ___ Regularly: ___ All the time: ___
   b. Loss of consciousness? Never: ___ Sometimes: ___ Regularly: ___ All the time: ___
   c. Blurred vision? Never: ___ Sometimes: ___ Regularly: ___ All the time: ___
   d. Nausea or vomiting? Never: ___ Sometimes: ___ Regularly: ___ All the time: ___
   e. A growing feeling of panic? Never: ___ Sometimes: ___ Regularly: ___ All the time: ___

7. How well do you tolerate working when it is hot? (Check the best answer)
   a. I tolerate the heat better than most other people. ___
   b. I do about as well as most others in the heat. ___
   c. I get more uncomfortable than most others in the heat. ___
   d. I easily and quickly get sick in the heat. ___

8. How well informed are you about the effects of heat? (check the one best answer)
   a. I am an expert ___
   b. I know more than most other people. ___
   c. I know about as much as anyone else. ___
   d. I don’t know very much about the effects of heat. ___

9. Have you been told by a doctor you have:
   a. Emphysema? Yes: ___ No: ___ If yes, what year? 19___
   b. Asthma? Yes: ___ No: ___ If yes, what year? 19___
   If yes, describe: ___________________________
   e. Angina? Yes: ___ No: ___ If yes, what year? 19___
   f. Hepatitis? Yes: ___ No: ___ If yes, what year? 19___
   g. Cirrhosis? Yes: ___ No: ___ If yes, what year? 19___
   h. Cancer? Yes: ___ No: ___ If yes, what year? 19___
   If yes, describe: ___________________________
   i. Diabetes? Yes: ___ No: ___ If yes, what year? 19___
   If yes, how are you treated: Diet ___ Pills ___ Insulin ___
   If yes, describe: ___________________________
HEAT STUDY Base Line Questionnaire Page 3 Participant ID#: __________

10. Has a doctor ever told you that you had a heart attack? Yes: ___ No: ___

11. Has a doctor ever told you that you had any other kind of heart trouble? Yes: ___ No: ___
   If "yes," specify ________________________________

12. Do you have irregular or skipped heart beats? Yes: ___ No: ___

13. Has a doctor ever told you that you had high blood pressure? Yes: ___ No: ___

14. Have you had any treatment for high blood pressure (hypertension) in the past 10 years? Yes: ___ No: ___
   If "yes," please list what medication you take for this condition ________________________________

15. List all medications you take on a regular basis (include those you can buy without a prescription). If you don't know the name, list what the pill is for (i.e., "heart pill" or "water pill," etc.): ________________________________
   ________________________________
   ________________________________
   ________________________________
   ________________________________
   ________________________________
   ________________________________
   ________________________________
   ________________________________

   List others on back of page

16. Do you drink alcohol? Yes: ___ No: ___
   a. If "yes," on the average how many days a week? ______
   b. If "yes," on the average when you drink how many drinks? ______
   c. Do you usually drink (circle all that apply) Beer, Liquor, Wine.

17. Do you get any physical exercise other than that required to do your job? Yes: ___ No: ___
   a. If "yes," what activities ____________________________
   b. If "yes," on the average how many days a week? ______
   c. If "yes," on the average, when you exercise, how many minutes do you exercise? ______
HEAT STUDY  Base Line Questionnaire  Page 4  Participant ID#: __________

18. How many years have you been working at your current job or similar type of work? ______

19. How many years have you been using a respirator? ______

20. How many years have you been wearing impermeable protective clothing? ______

21. Do you consider yourself to be in good health? Yes: __ No: ___
If “no,” state reasons: ____________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________