Questionnaire

Name: 
Number: 
Age: 
Gender: 
Address: 
Occupation: 
Exposure to heat ☐ or direct sun ☐
Duration of Exposure per hours: 

Medical history:

1. Renal problems or dysfunction ☐
2. Cardiac problems ☐
3. Diabetes ☐
4. Vomiting or severe diarrhea ☐

Family history:

1. Cardio vascular disease ☐
2. Renal failure ☐
3. Diabetes ☐

Nutritional factors: