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:
