INDOOR AIR QUALITY

Occupant Health and Comfort Questionnaire

1. NAME (Optional): _____

Job Title: _____

Department: _____

Phone: _____

2. Area or room where you spend the most time in the building:

3. Do any of your work activities produce dust or odor? ☐ YES ☐ NO

4. Gender: ☐ Female ☐ Male

Age: ☐ Under 25 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55 and over

5. Do you...

Smoke?	☐ YES	☐ NO
Have hay fever/pollen allergies?	☐ YES	☐ NO
Have skin allergies/dermatitis?	☐ YES	☐ NO
Have a cold/flu?	☐ YES	☐ NO
Have sinus problems?	☐ YES	☐ NO
Have other allergies?	☐ YES	☐ NO
Wear contact lenses?	☐ YES	☐ NO
Operate video display terminals?	☐ YES	☐ NO
Operate photocopiers 10% (or more) of the time?	☐ YES	☐ NO
Use other special office machines?	☐ YES	☐ NO

Specify:

Take medication for asthma, allergies, sinus, lung or immune system problems? ☐ YES ☐ NO

Reason:

6. Office Characteristics....

Number of persons sharing same room/work area. _____

Number of windows in room/work area. _____ Do windows open? ☐ YES ☐ NO

Please rate adequacy of workspace per person

Poor		Average		Excellent
1	2	3	4	5
☐	☐	☐	☐	☐

Please rate room temperature

Poor		Average		Excellent
1	2	3	4	5
☐	☐	☐	☐	☐

Do others smoke in your work area? ☐ YES ☐ NO

7. How many years or months have you worked...

In this room/area? _____ In this building? _____

8. Symptoms: Select symptoms you have experienced in this building. More than one answer may apply (for example, headache may occur frequently, and improve on vacation.)

Symptom	Approximate date of first noted	Occasionally	Frequently	Daily	Occurs at home	Occurs on vacation
Difficulty in concentrating		☐	☐	☐	☐	☐
Memory loss		☐	☐	☐	☐	☐
Aching Joints		☐	☐	☐	☐	☐
Muscle twitching		☐	☐	☐	☐	☐
Back pain		☐	☐	☐	☐	☐
Hearing problems		☐	☐	☐	☐	☐
Dizziness		☐	☐	☐	☐	☐
Dry, flaking skin		☐	☐	☐	☐	☐
Discoloring skin		☐	☐	☐	☐	☐
Skin irritation		☐	☐	☐	☐	☐
Itching		☐	☐	☐	☐	☐
Heartburn		☐	☐	☐	☐	☐
Nausea		☐	☐	☐	☐	☐
Sore throat		☐	☐	☐	☐	☐
Sinus congestion		☐	☐	☐	☐	☐
Sneezing		☐	☐	☐	☐	☐
Sneezing		☐	☐	☐	☐	☐
High stress levels		☐	☐	☐	☐	☐
Chest tightness		☐	☐	☐	☐	☐
Eye irritation		☐	☐	☐	☐	☐
Nose burning or irritation		☐	☐	☐	☐	☐
Cough		☐	☐	☐	☐	☐
Shortness of breath		☐	☐	☐	☐	☐
Wheezing		☐	☐	☐	☐	☐
Fainting		☐	☐	☐	☐	☐
Headache		☐	☐	☐	☐	☐
Fatigue/drowsiness		☐	☐	☐	☐	☐
Temperature too hot		☐	☐	☐	☐	☐
Temperature too cold		☐	☐	☐	☐	☐
Difficulty wearing contacts		☐	☐	☐	☐	☐
Other specify		☐	☐	☐	☐	☐

Have you seen a health care practitioner for any or all of these symptoms? ☐ YES ☐ NO

If yes, did your health care provider relate this to work, and if so, what were the diagnosis and recommendations.

When did you experience relief from these symptoms?

9. When do these problems usually occur? TIME OF DAY DAY OF WEEK MONTH SEASON

10. Do symptoms disappear? ☐ YES ☐ NO

When?

11. In your opinion, what is the cause of perceived indoor air quality problems?

12. Comments: Please take this opportunity to comment on any factors you consider important concerning the quality of your work environment.