Indoor Air Quality Questionnaire

Please note that all information provided below is optional; however, the more information you give, the more it will help in our investigation to correct any indoor air quality issues you may be having.

1. Name: _____ Phone Number: _____

2. Location (Building and room #): _____

3. What are your concerns or complaints? Check all that apply:

   ☐ Temperature (too hot/too cold): _____
   ☐ Air circulation (stuffy/drafty): _____
   ☐ Noticeable odors, please describe: _____
   ☐ Lighting (not enough, too bright): _____
   ☐ Dry/Humid (air feels dry or humid): _____
   ☐ Dust in the air, please describe: _____
   ☐ Disturbing noise, please describe: _____
   ☐ Other, please specify: _____

4. What kind of symptoms or discomforts are you experiencing that you feel are related to the work environment?
   Briefly describe each symptom or adverse health effect you experience more than two times per week.
   Example: Runny Nose, eye irritation, headache, fatigue/drowsiness, sneezing, etc.

   Symptom #1: _____

   Symptom #2: _____

   Symptom #3: _____

   Symptom #4: _____

5. When do these problems occur?

   ☐ Morning ☐ Afternoon ☐ All Day ☐ Daily ☐ No Noticeable Trend

   ☐ Specific day(s) of the week - which days? _____

6. Do the above symptoms clear up within one hour after leaving work? ☐ Yes ☐No

   If no, which symptom or symptoms persist (noted at home or at work) throughout the week:

   Symptom ☐*#1* ☐*#2* ☐*#3* ☐*#4*

   If yes, please describe: _____

7. Do you have seasonal allergies? ☐ Yes ☐No

   If yes, do you take prescription allergy medication? ☐ Yes ☐No
   If yes, do you take over-the-counter allergy medication? ☐ Yes ☐No

8. Do you have any health conditions that may make you particularly susceptible to environmental problems (i.e., asthma, sinusitis, emphysema, etc.)? ☐ Yes ☐ No

   If yes, please describe (this information is optional): _____

9. Does any of the following apply to you?

   ☐ Wear contact lenses.
   ☐ Operate video display terminal (computer) at least 10% of work day.
   ☐ Operate a photocopy machine at least 10% of work day.
   ☐ Have multiple plants in your work space
   ☐ Use or operate other special office equipment.

   Specify: _____

10. Are you a smoker? ☐ Yes ☐ No
11. Does anyone in your immediate work area smoke? ☐ Yes ☐ No
12. Are you aware of other people who have similar concerns? ☐Yes ☐ No
13. Any renovation or construction activities occurred in the area recently? (i.e., carpet replacement, painting, new furniture, etc.)

    ☐ Yes ☐ No If yes, please describe: _____

14. Are there any water leaks, visible signs of moisture, or mold found in your space?

    ☐ Yes ☐ No If yes, please describe: _____

15. What is your job title or position? _____
16. Briefly describe your primary job tasks: _____
17. What tasks are you performing during the onset of symptoms? _____

    _____

    _____

18. If different from your tasks, describe the work being done in the surrounding area: _____

    _____

    _____

19. If work involves use of hazardous materials (i.e. chemicals, biologicals, etc.) please list them: _____

    _____

    _____

20. Do you have any hobbies? Please describe: _____

    _____

    _____

21. Can you offer any other comments or observations concerning your office environment? _____

    _____

    _____

Upon completing this survey, please return it to:

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