INDOOR AIR QUALITY FORM

NAME:_____ TITLE: _____ PHONE:_____

LOCATION:_____ DATE:_____

On the form below, please record each occasion when you experience a symptom of ill-health or discomfort that you think may be linked to an environmental condition in this building.

It is important that you record the time and date and your location within the building as accurately as possible, because that will help to identify conditions (e.g., equipment operation) that may be associated with your problem. Also, please try to describe the severity of your symptoms (e.g., mild, severe) and their duration (the length of time that they persist). Feel free to attach additional pages or use more than one line for each event if you need more room to record your observations.

Time & Date	Location	Symptom(s)	Severity/Duration	Temperature/Humidity

Please answer the questions listed on this form as completely as possible. All responses will be kept confidential. Thank you for your assistance and cooperation. Note: Medical information is at your discretion, and not mandatory.

BUILDING NAME:_____

ADDRESS: _____

SYMPTOM PATTERNS

Are you experiencing symptoms or discomfort within your workplace? Yes_____ No _____

Are you aware of other people with similar symptoms or concerns? Yes_____ No _____

If so, what are their names and work locations: _____

_____

_____

Do you have any health conditions that may make you particularly susceptible to environmental problems? Circle the related health conditions.

Contact lenses | Chronic cardiovascular disease | Undergoing chemotherapy or radiation therapy

Allergies | Chronic respiratory disease | Immune system suppressed by disease or other causes

Chronic neurological problems

TIMING PATTERNS

When did your symptoms start? _____

When are they generally worse? _____

Do they go away? If so, when? _____

Have you noticed any other events (such as weather, temperature or humidity changes, or activities in the building) that tend to occur around the same time as your symptoms? _____

_____

SPATIAL PATTERNS

Where are you when you experience symptoms or discomfort? _____

Where do you spend most of your time in the building? _____

ADDITIONAL INFORMATION

Do you have any observations about building conditions that might need attention or might help explain your symptoms (e.g., temperature, humidity, draft, stagnant air odors)? _____

_____

Have you sought medical attention for your symptoms? Yes _____ No _____

Do you have any other comments? _____

_____

_____

_____

_____

Are there any animals in your building (e.g., gerbils, hamsters)? Yes _____ No _____

Does anyone in your building use a strong smelling perfume? Yes _____ No _____

Does anyone in your building use scented air fresheners? Yes _____ No _____

INDOOR AIR QUALITY OCCUPANT SURVEY

Please answer the questions listed on the survey as completely as possible. All responses will be kept confidential. Thank you for your assistance and cooperation.

DEMOGRAPHIC DATA

Name: _____

Age: _____ Sex: Female_____ Male _____

Do you smoke? Yes _____ No _____

WORK EXPERIENCE

What is your job classification? _____

In which building and department do you work? _____

How long have you worked in the space you now occupy? _____

WORK ENVIRONMENT

How many employees work in your area? _____

Do you work in: (check those that apply)

_____ Different areas of the building/office during the course of the workday

_____ The same desk all day

_____ An open office area

_____ A closed office area

Does your work area have a problem with roaches, rodents, or flies? Yes _____ No _____

Is your work area routinely sprayed with pesticides by an applicator? Yes _____ No _____

If yes, how often? _____

Does your work area have windows that open? Yes _____ No _____

If yes, are you allowed to open these windows? Yes _____ No _____

Is there a noticeable accumulation of dust on the furniture? Yes _____ No _____

Have you ever smelled odors coming through the vents? Yes _____ No _____

Are there noticeable dust/dirt stains around the air vents? Yes _____ No _____

Are the photocopiers and other machines that emit fumes placed in a separate room? Yes _____ No _____

Is your work area frequently:

_____ Too hot

_____ Too cold

_____ Comfortable

HEALTH EFFECTS

Over the last twelve months, how many days of work have you missed because of health effects which you feel may be related to poor interior air quality? _____

Have you ever sought medical attention for any of the above indicated effects? Yes_____ No _____

If yes, the number of visits. _____

Do you have any known or diagnosed allergies?

Yes _____ No _____ To what? _____

Doctor's Name (optional): _____

How often have you experienced any of the symptoms listed below while working? Also check those symptoms which you feel may clear up or disappear after you leave the building/office environment.

	DAILY	SEVERAL TIMES DAILY	RARELY	SYMPTOMS DISAPPEAR AFTER YOU LEAVE THE BUILDING ENVIRONMENT
Headache				
Dry Mouth				
Eye Irritation				
Eye Strain				
Sore Throat				
Nausea				
Hay Fever				
Allergies				
Dizziness				
Fatigue				
Coughing				
Runny Nose				
Colds				
Asthma				
Sneezing				
Skin Irritation				

Submitted By

Signature of Supervisor

Thank You,

Thomas (Tuck) Powers
Director of School Facilities

TGP/cvr