

Occupant Health and Comfort Questionnaire

Note: This questionnaire will be used to aid in the development of an indoor air quality assessment.

1. Name: _____
Job Title: _____

2. Area or room where you spend the most time in the building:
If you work in more than one primary area, please provide an approximate percentage of time spent in each room.

3. Do you notice excessive dust or unusual odors in your work area? Yes No

Describe: _____

4. Do any of your work activities produce dust or odor? Yes No

Describe: _____

5. Gender: Male Female

Age: Under 25

25-34

35-44

45-54

55 and over

6. 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

Wear contact lenses? Yes No

Have other allergies, such as mold, dust, animal dander, etc?

..... Yes No

Specify: _____

Take medication currently? Yes No

Reason: _____

7. Room characteristics:

_____ Room Number
 _____ Number of persons/students in the room/work area during normal occupancy
 _____ Number of windows in room/work area
 Do windows open? Yes No

Please rate air movement in the room:

Poor Average Excellent
 1 2 3 4 5

Please rate room temperature:

Poor Average Excellent
 1 2 3 4 5

Floor Finish:

Carpet
 Tile
 Other _____

8. Have there been any recent or ongoing moisture issues in your area? Yes No
 Describe: _____

9. How long have you worked:

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

10. Symptoms: Select symptoms you have experienced in this building. This is a random list – not all symptoms listed have been noted in this building.

Symptom	Occasionally	Frequently	Not related to building	Appeared after arrival	Increased after arrival
Skin irritation					
Itching					
Nausea					
Noticeable odors					
Sinus congestion					
Sneezing					
Coughing					
High stress levels					
Chest tightness					
Eye irritation					
Fainting					
Hyperventilation					
Problems with contacts					
Headaches					
Fatigue/drowsiness					
Temperature too hot					
Temperature too cold					
Other (specify)					

Have you seen a doctor for any or all of these symptoms? Yes No

11. When do these problems usually occur?

Time of Day:				<i>Morning</i>				<i>Afternoon</i>				<i>Evening</i>	
Day of Week:		<i>Sun</i>		<i>Mon</i>		<i>Tues</i>		<i>Wed</i>		<i>Thurs</i>		<i>Fri</i>	<i>Sat</i>
Month:	<i>Jan</i>	<i>Feb</i>	<i>Mar</i>	<i>Apr</i>	<i>May</i>	<i>Jun</i>	<i>Jul</i>	<i>Aug</i>	<i>Sep</i>	<i>Oct</i>	<i>Nov</i>	<i>Dec</i>	
Season:			<i>Spring</i>			<i>Summer</i>			<i>Fall</i>			<i>Winter</i>	

12. Do symptoms disappear? Yes No

When? _____

13. In your opinion, is there a possible indoor air quality problem in your work area?

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

Thank you very much for your cooperation.