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: _____ Building: _____

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:
   _____Number of persons/students in the room/work area during normal occupancy
   _____Number of windows in room/work area
   _____Please rate air movement in the room on a scale of 1-5 with 1 being poor and 5 being excellent.
   _____Please rate room temperature on a scale of 1-5 with 1 being poor and 5 being excellent.
   _____Number of windows in area
   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? _____ Months _____Years
In this building? _____ Months _____Years

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: *Morning* *Afternoon* *Evening*

Day of Week: *Sun* *Mon* *Tues* *Wed* *Thurs* *Fri* *Sat*

Month: *Jan* *Feb* *Mar* *Apr* *May* *Jun* *Jul* *Aug* *Sep* *Oct* *Nov* *Dec*

Season: *Spring* *Summer* *Fall* *Winter*

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.