Indoor Air Quality Occupant Interview

Building Name: ______________________________ Work Location Room No(s): ___________

Completed by: ______________________________ Title: ________________________________

Date: ____

SYMPTOM PATTERNS

What kind of health concerns or discomfort are you experiencing?

____ headache
____ nausea
____ dizziness
____ tiredness
____ irritation of throat
____ irritation of eyes
____ irritation of nose
____ skin irritation

____ breathing problems
____ coughing
____ sneezing
____ wheezing
____ sinus congestion
____ shortness of breath
____ blurred vision

pain and discomfort in:
____ back
____ neck
____ hands
____ shoulders
____ wrist
____ joints

____ other: ____

Are you aware of other co-workers with similar health concerns? Yes _____ No _____

Do you have any health conditions that may make you particularly susceptible to environmental problems? (i.e. contact lenses, asthma, allergies, etc.) Do not answer this if you are not comfortable.

____

____

____

____

TIMING PATTERNS

When did your symptoms start?

____ mornings ____ afternoons ____ all day long ____ no noticeable patterns

Do they go away? If so, when?

____

____

When are they generally worse? (i.e. seasonal, certain days of the week)

____

____

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

____

____

SPATIAL PATTERNS

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

____

____

How long have you been at the current work location?

____

When did you first notice these health concerns?

____

Where are you when you experience health concerns or discomfort?

____ in my work area ____ in the lavatory ____ in the lounge ____ in the office

____ no particular place ____ other: ______________________________

When do you experience these health concerns?

____ only at work ____ at home and work

ADDITIONAL INFORMATION

Do you have any observations about building conditions that might need attention or might help explain your health concerns?

____ air circulation
____ drafts
____ humidifier/dehumidifier
____ air conditioning
____ machinery/equipment
____ renovations
____ particulates, dust
____ chemicals used
____ temperature
____ humidity
____ noise
____ illumination/lighting
____ smoking
____ new carpeting, furniture
____ cleaning and maintenance
____ plants or animals in the room
____ foul odours
____ water damage
____ irritants in air
____ outdoor contaminants
____ overcrowding
____ perfumes, deodourizers
____ carpet, draperies

____ other ____

Have you sought medical attention for your health concerns?

____ No ____ Yes What did the doctor say? ______________________________

____

Have you had to leave work early or miss work because of your health concerns?

____ No ____ Yes How many times in the past month? ____

How many days were you away from work? ____

Do you have any other comments?

____

____

____

____

____

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