

Occupant Questionnaire – Indoor Air Quality

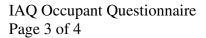
Date:			
Name:			
Building/Room:			
	Classroom	Laboratory	Dormitory Residence
How long have you	occupied the space	mentioned above?	
Approximately how	many hours per we	ek do you spend in	the affected space?
Are there any other a describe in detail bel		lding which you free	quent on a routine basis? If so
Personal Information			
What kind of sympto	oms or discomfort a	are you experiencing	? Please mark all that apply:
Coughing	Sneezing	Eye Irritatio	n
Lethargy	Congestion	Skin Irritation	
Headache	Dizziness	Nausea	
Other flu-like sym			
Other respiratory	symptoms:		
-			

Which would you rate as the most severe?

Are the above symptoms experienced only within your work/living space or other locations within the building as well? Please list other locations if appropriate.

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Are you aware of oth	ner people with similar symptoms of	or concerns? Yes	No
If you answered yes locations:	to the above question and are so w	illing, please share their n	names and
If willing to share, pl	ease note whether you have any of	f the following health con	ditions:
contact lenses allergies Other:	asthma chronic respiratory disease	suppressed immune s chronic cardiovascula	
Are you currently take	king any medication for your symp	otoms?	
Have you sought pro	fessional medical attention for you	ır symptoms?	
Are you a cigarette/c	igar/pipe smoker or do you live wi	th a smoker?	
Timing Patterns:			
Approximately how	often do you experience any or all	of the symptoms noted ab	oove?
Once a day Once a week Once a month Other:			
When did your symp	toms start?		
When are they gener week, summer, winter	ally at their worst? For example, rer, etc.	norning, afternoon, a part	icular day of the
Do they go away? If	so, when?		

IAQ Occupant Questionnaire



Have you noticed any other 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?

Building Conditions:

Is your work/living area carpeted or tiled? Please rate the condition of the flooring. For example, is the carpet worn, floor tile damaged, etc.

Do you have operable windows in your work/living area?

Please list any electronic devices in your work/living area such as photocopiers, computer printers, fax machines, etc. If such devices are present, how often are they used?

Are persistent odors an issue? If so, when and how often are they noticed and can you describe the odor (i.e. chemical, oil, exhaust, etc.)?

Have you experienced any water leaks in your work/living area? If so, please describe the incident(s) including date of occurrence, impacted building materials, response actions, etc.

Have there been any recent renovation activities in the vicinity that you are aware of? If so, please describe.

Are the temperate conditions, to include temperature and relative humidity, of your work/living area satisfactory? Is it too warm, too cold, too dry, drafty, etc. on a regular basis?

