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	____ breathing problems	pain and discomfort in:
____ nausea	____ coughing	____ back
____ dizziness	____ sneezing	____ neck
____ tiredness	____ wheezing	____ hands
____ irritation of throat	____ sinus congestion	____ shoulders
____ irritation of eyes	____ shortness of breath	____ wrist
____ irritation of nose	____ blurred vision	____ joints
____ skin irritation		

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

____ 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?

_____

_____

_____

_____

_____

_____