INDOOR AIR QUALITY QUESTIONNAIRE

1. Name: ____________________________  Phone Number: ______________________

2. Location (Office Address): ____________________________________________________

3. Do you have any complaints?  □ Yes  □ No - If yes, please check from the following:
   □ Temperature too cold
   □ Temperature too hot
   □ Lack of air circulation (stuffy feeling)
   □ Noticeable odors
   □ Dust in the air
   □ Disturbing noise
   □ Other, please specify: ______________________________________________________

4. What kind of symptoms or discomforts are you experiencing?  __________________
   __________________________________________________________________________

5. When do these problems occur?
   □ Morning  □ Afternoon  □ All Day  □ Daily  □ No Noticeable Trend
   □ Specific day(s) of the week - which days? ____________________________________

6. Health Problems or Symptoms:
   Briefly describe each symptom or adverse health effect you experience more than two times per week.
   Example: Runny Nose
   
   Symptom #1: ________________________________________________________________
   Symptom #2: ________________________________________________________________
   Symptom #3: ________________________________________________________________
   Symptom #4: ________________________________________________________________

7. Do the above symptoms clear up within one hour after leaving work?  □ Yes  □ No
   If no, which symptom or symptoms persist (noted at home or at work) throughout the week, please indicate by drawing a circle around the symptom number:

   Symptom  #1  #2  #3  #4

   If yes, please describe: ______________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
8. Are you aware of other people who have similar symptoms or concerns? □ Yes □ No

9. If yes, what are their names and locations?

Name: _____________________________ Location: _____________________________
Name: _____________________________ Location: _____________________________
Name: _____________________________ Location: _____________________________
Name: _____________________________ Location: _____________________________

10. Do you have any health conditions or allergies that may make you particularly susceptible to environmental problems? □ Yes □ No

If yes, please describe: _____________________________________________
________________________________________________________________
________________________________________________________________

11. Do any of the following apply to you?

□ Wear contact lenses.
□ Operate video display terminal at least 10% of work day.
□ Operate a photocopy machine at least 10% of work day.
□ Use or operate other special office machines or equipment.
Specify: _____________________________________________________________

□ Currently taking medication? □ Yes □ No
Specify: _____________________________________________________________
Reason: _____________________________________________________________

12. Are you a smoker? □ Yes □ No

13. Does anyone in your immediate work area smoke? □ Yes □ No

14. What is your job title or position? _________________________________

15. Briefly describe your primary job tasks: _______________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
16. Can you offer any other comments or observations concerning your office environment? __________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Upon completing this survey, please return it to:

Evan Rousseau  
Industrial Hygienist  
Environmental Health & Safety Department  
Forchheimer Bldg. Room 800  
Phone: 718.430.4152  
FAX: 718.430.8740  

Thank you for your participation.