

In-Door Air Quality Questionnaire

Last name _____ First name _____ Employee ID Number _____

Department _____ Dept Street address _____ Locator code _____

Suite/room # _____ Campus _____ Dept phone (_____) _____

Supervisor name _____ Job Title _____ How long? _____

Previous job duties _____ How long? _____

Number of people in department _____ Number of individuals (other than yourself) with complaints _____

Describe your complaint _____

Where were you when you first experience above complaint? _____

Are the symptoms getting worse or better? _____ What time of the day is it worst? _____

What do you think makes it worst? _____

- a. Have you done anything to relieve the problem? Yes No
- b. Did it help? Yes No
- c. Does your symptom/s subside after you've been home from work for a few hours? Yes No
- d. Do you feel better on weekends or your days off from work? Yes No
- e. Do you notice improvement while on vacation? Yes No
- f. Anyone in the same household has the same complaint? Yes No

What do you think is the reason for your health concerns _____

Present Medications _____

Do you have history of:

- | | |
|--|--|
| 1. Smoking <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Regular exercise program <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Hay fever <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Eczema <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. Undergoing chemotherapy or radiation therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Being treated for allergies by a healthcare provider? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Taking medication for allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Household member with allergy complaints? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Chronic cough <input type="checkbox"/> Yes <input type="checkbox"/> No | 22. Household member who smokes? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No | 23. Large family <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Contact dermatitis <input type="checkbox"/> Yes <input type="checkbox"/> No | 24. Increased financial responsibility <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Allergy to food/drug/other <input type="checkbox"/> Yes <input type="checkbox"/> No | 25. Marriage conflicts <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Sinusitis <input type="checkbox"/> Yes <input type="checkbox"/> No | 26. Conflicts with children/parents/ sibling <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Suppressed immune system <input type="checkbox"/> Yes <input type="checkbox"/> No | 27. Recent loss of a loved one <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Chronic illness <input type="checkbox"/> Yes <input type="checkbox"/> No | 28. Increased job responsibility <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No | 29. Poor motivation <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any of the following: | 30. Routine boring work <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Excessive physical or mental exertion <input type="checkbox"/> Yes <input type="checkbox"/> No | 31. Feels frustrated with work <input type="checkbox"/> Yes <input type="checkbox"/> No |

Employee signature _____ **Date** _____