Indoor Air Quality Symptom Questionnaire

Name: _____ SS#: _____

Department: _____

Section I: General Demographics

1. What is your age? _____

2. What is your sex? _____

3. Job category? Management ☐ Clerical ☐ Physician ☐ Nurse ☐
   Allied health professional ☐ Maintenance ☐
   Other/specify: _____

4. Primary work location (Where is your office or work area?) _____

5. Typical work shift: Day ☐ Evening ☐ Night ☐ Other ☐

6. Typical work week: (check all that apply)
   Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun ☐

7. How long at this location? _____

8. How long in current job? _____

9. Does your workplace have a window: Yes ☐ No ☐

10. If the answer to question #9 was yes, does that window open? Yes ☐ No ☐

11. Is your work location:(check all that apply)
    Too hot ☐ Too cold ☐
    Too damp ☐ Too dry ☐
    Too drafty ☐ Too stuffy ☐
    Too dusty ☐ Too bright ☐
    Too poorly lit ☐
    Too noisy ☐ Has odor (describe, if possible) _____

12. Do you work with any chemicals in your job? Yes ☐ No ☐
    If yes, please list if known: _____

13. In general, are you satisfied with your job? (check one)
    Yes, very satisfied ☐ Yes, somewhat satisfied ☐ Neutral ☐
    No, somewhat dissatisfied ☐ No, very dissatisfied ☐

14. Do you work with video display terminals (computers)? Yes ☐ No ☐
    If yes, how many hours per day? _____

15. How many people typically share your workspace? (check one)
    None ☐ 1-3 ☐ 4-7 ☐ 8-10 ☐ More than 10 ☐

16. Smoking status: Currently smoke (check one)
    Cigarettes ☐ Pipe ☐ Cigar ☐
    If you smoke cigarettes, how many packs per day? _____
    Smoked previously: Not now ☐ Stopped when? _____ Never smoked ☐

Section II **Medical History**

1. Most of the time, you feel: Excellent ☐ Very good ☐ OK ☐ Bad ☐ Terrible ☐

2. Do you have any of the following conditions?
   A. Hay fever ☐ Yes, confirmed by Physician ☐ Yes, not confirmed by Physician ☐ No
   B. Asthma ☐ Yes, confirmed by Physician ☐ Yes, not confirmed by Physician ☐ No
   C. Bronchitis/emphysema ☐ Yes, confirmed by Physician ☐ Yes, not confirmed by Physician ☐ No
   D. Other allergies ☐ Yes, confirmed by Physician ☐ Yes, not confirmed by Physician ☐ No

3. Are you taking any medications on a regular basis? Yes ☐ No ☐
   If yes, please list: _____

4. In general, do you feel better at home or work? Home ☐ Work ☐

5. If you experience symptoms or discomfort, where are you when the symptoms become most noticeable:
   Specific location _____ ☐
   N/A (no specific symptoms) ☐
   Symptoms do not change in intensity ☐

Select the number that most closely describes your response for each question and write in the boxes below.

Symptoms	**How often do you have this symptom? 1 = rarely/ never 2 = < 3 X/ week 3 = > 3 X/ week**	**Have you seen your Physician about this symptom? 1 = yes 2 = no**	**At its worst, how bad is this problem? 1 = mild 2 = moderate 3 = severe**	**Time of day? 1 = start of shift 2 = end of shift 3 = all of shift**	**Symptoms present? 1 = only at home 2 = only at work 3 = at home and at work**	**Time of year? 1 = spring 2 = summer 3 = winter 4 = fall**
1. Eye redness						
2. Eye burning or itching						
3. Blurred vision						
4. Dryness of eyes						
5. Other eye symptoms						
6. Nosebleeds						
7. Nasal/sinus congestion						

Symptoms	How often do you have this symptom? 1 = rarely/ never 2 = < 3 X/ week 3 = > 3 X/ week	Have you seen your Physician about this symptom? 1 = yes 2 = no	At its worst, how bad is this problem? 1 = mild 2 = moderate 3 = severe	Time of day? 1 = start of shift 2 = end of shift 3 = all of shift	Symptoms present? 1 = only at home 2 = only at work 3 = at home and at work	Time of year? 1 = spring 2 = summer 3 = winter 4 = fall
8. Runny nose						
9. Dry or scratchy throat						
10. Sore throat						
11. Breathlessness						
12. Wheezing						
13. Coughing						
14. Chest tightness						
15. Unusual tastes						
16. Dryness/thirst						
17. Dry/itching skin						
18. Rashes						
19. Indigestion						
20. Nausea/vomiting						
21. Diarrhea						
22. Constipation						
23. Stomach aches/cramps						
24. Headaches						
25. Backaches						
26. Muscle aches						
27. Fever						
28. Chills						
29. Joint pain						

Symptoms	How often do you have this symptom? 1 = rarely/ never 2 = < 3 X/ week 3 = > 3 X/ week	Have you seen your Physician about this symptom? 1 = yes 2 = no	At its worst, how bad is this problem? 1 = mild 2 = moderate 3 = severe	Time of day? 1 = start of shift 2 = end of shift 3 = all of shift	Symptoms present? 1 = only at home 2 = only at work 3 = at home and at work	Time of year? 1 = spring 2 = summer 3 = winter 4 = fall
30. Weakness/ general						
31. Anxiety (nervousness)						
32. Irritability						
33. Sleeplessness						
34. Exhaustion						
35. Depression						
36. Feeling of panic						
37. Drowsiness						
38. Trouble concentrating						
39. Menstrual irregularities						
40. Dizziness						
41. Numbness/ tingling in any part of body						
42. Fainting						
43. Visual problems						
44. Paralysis						
45. Other symptoms (list) _____						

Note any comments or concerns you have relative to this investigation.

_____

_____

Source: This form was adapted from a version on the Medical Center Occupational Health web site, which is no longer an active site.