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INDOOR AIR QUALITY QUESTIONNAIRE

Instructions:

- Answer all questions
- Complete this form electronically and press the "SUBMIT" button on the top right corner
  - Use the mouse, tab, or scroll (*page up/down arrows will not work)*
- If you are a MAC user submit the electronic document, with any applicable supporting documentation, to EHSO @ **indhyg@emory.edu**

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1. **Indicate if you frequently have any of the following complaints concerning the indoor air quality at this building** *(check all that apply)*

- ☐ Temperature too cold
- ☐ Temperature too hot
- ☐ Stuffy air
- ☐ Moldy odors
- ☐ Other odors (please describe) _____
- ☐ Poor lighting
- ☐ Other
- ☐ Dusty
- ☐ Noisy
- ☐ Too dry
- ☐ Too humid
- ☐ Drafty
- ☐ Crowded work area
- ☐ Vibration
- ☐ No Complaints

2. **Indicate if any of the following apply to you.** *(check all that apply)*

- ☐ Wear contact lenses
- ☐ Operate video display terminals at least one hour/average day
- ☐ Use any chemical substance such as cleaners, white out, etc.
- ☐ Use carbonless copy paper
- ☐ Smoke tobacco products
- ☐ None of the above

3. **Since you have worked in this building, have you ever been diagnosed with any of the following?** *(check all that apply)*

- ☐ Allergic Rhinitis
- ☐ Asthma
- ☐ Allergies
- ☐ Conjunctivitis
- ☐ Sinusitis
- ☐ Emphysema
- ☐ Laryngitis
- ☐ Bronchitis
- ☐ Other chest conditions
- ☐ None

4. **During the last year while working in the building, have you experienced any of the following symptoms?** *(check all that apply)*

- ☐ Frequent cough
- ☐ Wheezing (except colds)
- ☐ Multiple colds (more than four)
- ☐ Shortness of breath
- ☐ Migraines
- ☐ Burning or irritated eyes
- ☐ Nasal congestion
- ☐ Sinus infections
- ☐ Sore throat
- ☐ Hoarse voice
- ☐ Headaches (at least 2/month)
- ☐ Sneezing attacks

☐None of the above ☐Other (please specify) _____

5. Please check all medications you are currently taking on a daily or weekly basis:

☐ Pain relievers (aspirin, Tylenol, etc.) ☐ Antidepressants
☐ Decongestant ☐ Antihistamines
☐ None ☐ Other (please specify) _____

6. How would you rate the indoor air quality at this building?

☐ Good ☐ Average ☐ Poor

7. If you feel that there is an indoor air quality problem, does the problem occur more frequently during specific seasons of the year?

☐ Yes ☐ No ☐ Don't Know ☐ Not Applicable

8. If you answered yes to #7, rank each season from one to four as follows:

1 – season least likely to be associated with indoor air quality problems and
4 – season most likely to be associated with indoor air quality problems

☐ **Winter** (Dec.–Feb) ☐ **Spring** (Mar–May) ☐ **Summer** (June–Aug) ☐ **Fall** (Sept – Nov)

9. If you answered yes to #7, when do indoor air quality problems seem to be most notable?

☐ Morning ☐ Afternoon ☐ All day ☐ Not applicable

10. Which of the following symptoms have you experienced that you feel may be related to your work environment? *(check all that apply)*

☐ Headache ☐Sinus congestion ☐ Sinus infection
☐ Eye irritation ☐ Sore throat ☐ Hoarseness
☐ Runny nose ☐ Dizziness ☐ Sneezing
☐ Fever (>100.5 °F) ☐ Fatigue/Drowsiness ☐ Eyes red/watery
☐ Cough ☐ Wheezing ☐ Shortness of breath
☐ Skin problems ☐ Muscle aches ☐ Other _____

11. Do most of the symptoms checked above go away within 1 hour after leaving work?

☐ Yes ☐ No ☐ Not applicable

12. If no, do they go away by the morning?

☐ Yes ☐ No ☐ Not applicable

13. If no, do they go away when you are on vacation?

☐ Yes ☐ No ☐ Not applicable

14. Which of the following symptoms have you experienced within the last week and feel are related to your work place? *(check all that apply)*

☐ Headache	☐ Sinus congestion	☐ Sinus infection
☐ Eye irritation	☐ Sore throat	☐ Hoarseness
☐ Runny nose	☐ Dizziness	☐ Sneezing
☐ Fever (>100.5 °F)	☐ Fatigue/Drowsiness	☐ Eyes red/watery
☐ Cough	☐ Wheezing	☐ Shortness of breath
☐ Skin problems	☐ Muscle aches	☐ Other _____

15. Do you have any health problems or allergies that might account for the above symptoms?

☐ Yes ☐ No ☐ Not applicable

16. What percentage of your work day do you typically spend in your building?

☐ 0 – 25% ☐ 26% – 50% ☐ 51% – 75% ☐ 76% – 100%

17. What percentage of your work day do you typically spend in your office/cubicle?

☐ 0 – 25% ☐ 26% – 50% ☐ 51% – 75% ☐ 76% – 100%

18. Are any of the following items located within your workroom or area? (check all that apply)

☐ Photo copier ☐ Laser printer ☐ Windows ☐ Plants

19. Please rank the lighting at your work area?

☐ Too bright ☐ Little too bright ☐ Just right ☐ Little too dim ☐ Too dim

20. Has there been any renovation/demolition related activities occurring in or near your work environment? (i.e., new carpet, painting, new office furniture HVAC work, etc.)

☐ No ☐ Yes – specify: _____

21. Has there been any evidence of water leaks or visible signs of moisture in and around your area? ☐ Yes ☐ No

22. If yes, please describe: _____

23. Is your office near a laboratory? ☐ Yes ☐ No

24. If yes, list the known chemicals used. _____

Your Name *(Optional):* _____

Telephone Number (Optional): _____

Gender: ☐ Male ☐ Female

Age *(Optional):* ☐ under 30 ☐ 30-40 ☐ 41-50 ☐ over 50

Job Title: _____

Name of building: _____

Suite #: _____