INDOOR AIR QUALITY QUESTIONNAIRE

Please complete this form, save a copy, and mail or fax to:
EHS@asu.edu / fax 480-965-0736 / mail code: 6412
Phone: 480-965-1823

GENERAL INFORMATION
Building Name: Date:
Room Number: Name:
Work Location: Title:
Department: Phone No:

SYMPTOM PATTERNS
What kind of symptoms or discomfort are you experiencing?
Are you aware of other people with similar symptoms or concerns? If so, what are their names and work locations?

Do any of these apply to you?
- Wear contact lenses
- Chronic neurological problems
- Allergies
- Chronic respiratory disease or asthma
- Do you smoke
- Immune system suppressed by disease/other
- Chronic cardiovascular disease
- Undergoing chemotherapy or radiation therapy

TIMING PATTERNS
How long have you been in your current work location?
When did your symptoms start?
When are your symptoms most irritating?
Do they go away? If so, when?
Have you noticed any other 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?

SPACIAL PATTERNS
Where are you when you experience symptoms or discomfort?
Where do you spend most of your time in the building?
Do any of the following apply to you?
- Operate video display terminal at least 10% of the workday
- Operate photocopier machines at least 10% of the workday
- Use or operate other special office machines or equipment? Specify:
- Work-station located near a copy machine
- Work in a carpeted office

ADDITIONAL INFORMATION
Do you have any observations about the building conditions that might need attention or might help explain your symptoms (e.g., temperature, humidity, drafts, stagnant air, odors)?
Is there a history of flooding or water damage? If so, please list dates, locations, and circumstances:
Briefly describe your primary job tasks:
Have you sought medical attention for your symptoms?
Do you have any other comments?