

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?

- | | | | |
|--------------------------|--------------------------------|--------------------------|--|
| <input type="checkbox"/> | Wear contact lenses | <input type="checkbox"/> | Chronic neurological problems |
| <input type="checkbox"/> | Allergies | <input type="checkbox"/> | Chronic respiratory disease or asthma |
| <input type="checkbox"/> | Do you smoke | <input type="checkbox"/> | Immune system suppressed by disease/other |
| <input type="checkbox"/> | Chronic cardiovascular disease | <input type="checkbox"/> | 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?

- | | |
|--------------------------|---|
| <input type="checkbox"/> | Operate video display terminal at least 10% of the workday |
| <input type="checkbox"/> | Operate photocopier machines at least 10% of the workday |
| <input type="checkbox"/> | Use or operate other special office machines or equipment? Specify: _____ |
| <input type="checkbox"/> | Work-station located near a copy machine |
| <input type="checkbox"/> | 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?