Appendix B
Indoor Air Quality Survey – Employees

Name:_____ Date:_____

Department:_____ Job Title: _____

Email:_____ Phone number: _____

Area of Concern: ☐ Office ☐ Classroom ☐ Other _____

Area of Concern Address (Campus Building & Room #): _____

1. How long have you been working in the Area of Concern? _____
2. How long have you been working in your current office? _____
3. Are you concerned about any of the following in the Area of Concern? (check all that apply)

☐ Temperature too hot	☐ Smoky air	☐ Peculiar odors
☐ Temperature too cold	☐ Stale air	☐ Chemicals, fumes/mists
☐ Stuffy air	☐ Soot by air vents	☐ Drafts

4. Is there a particular time of day you notice the air quality issue in the Area of Concern? (check all that apply)

☐ Mornings	☐ Afternoons	☐ Nights
☐ All day long	☐ No noticeable pattern	

5. Common indoor air quality issues are listed below. Please check all that apply to the Area of Concern:

☐ Lack of ventilation	☐ Odor(s) If so, please describe: _____
☐ Dust in the air	☐ Visible mold
☐ Other, specify: _____	

6. Has there been a flood or any water damage recently in the Area of Concern? ☐ Yes ☐ No

   If yes, please describe: _____
7. Number of persons (estimate) working in the same office if it is the Area of Concern: _____
8. Number of windows in the same office: _____ Do the windows open? ☐ Yes ☐ No

9. Does working in the Area of Concern result in your experiencing any of the following health conditions? (Check all that apply)

☐ Skin rash	☐ Nausea
☐ Chills or fever	☐ Skin irritation/itching
☐ Headache	☐ Sneezing or coughing
☐ Dizziness	☐ Chest tightness
☐ Hearing disturbances	☐ Eye or nose irritation
☐ Dry cough	☐ Sinus congestion or runny nose
☐ Heartburn	☐ Fatigue/drowsiness
☐ Dry skin	☐ Sore or dry throat
☐ Shortness of breath	☐ Nasal irritation or nosebleeds

Other: _____

10. When do these symptoms occur in the Area of Concern? (check all that apply)

☐ Mornings ☐ Afternoons ☐ Nights

☐ All day long ☐ No noticeable pattern

11. Are these symptoms when in the Area of Concern worse on some days than others (e.g., Tuesdays are bad; Thursdaysare not)? Please specify: _____

12. Where in the Area of Concern do these symptoms occur? (Check all that apply)

☐ At my desk ☐ In the lavatory

☐ In the lobby ☐ No particular place

☐ Other _____

13. When did you first notice these symptoms? _____

14. Do you suffer from allergies? ☐ Yes ☐ No

If yes, please specify: _____

If yes, what time of year are you most affected? _____

15. When do you experience these symptoms?

☐ Only at work ☐ Only at my residence ☐ At work and at home

16. Has anything happened recently at your workplace or residence that could affect the air quality? (e.g., new carpeting, new furniture, new equipment, etc.) _____

17. What do you think is the cause of your symptoms or illness?

☐ Other people smoking ☐ Cleaning and maintenance

☐ Temperature/ventilation ☐ Renovations/construction

☐ Presence of toxic chemicals or gas ☐ None of the above

18. Have you or someone brought furniture from elsewhere into your office?

☐ Yes ☐ No

19. Have any alarms, such as smoke or carbon monoxide, activated recently? ☐ Yes ☐ No

Other comments about the indoor air quality situation in the Area of Concern: _____

_____