INITIAL INDOOR AIR QUALITY QUESTIONNAIRE

1. Name: ________________________________ Date: ___________
   Building: ______________ Room: _________ Extension: ___________
   Department: ________________________________ Union: _______________

2. Have you notified your supervisor? Yes __ Name of supervisor: ________________
   No __ If no, the supervisor must be notified by the employee as soon as possible.

3. How long have you worked in this area? ________________________________
   How many people (including yourself) work in your area? ________________

4. A) What health problems are you experiencing? _______________________
   __________________________________________________________________
   __________________________________________________________________

   B) When did these problems first occur? ________________________________
   __________________________________________________________________
   __________________________________________________________________

5. When do these problems usually occur?
   Morning? ________________ All day? __________________________
   Afternoon? ________________ Every day? _________________________
   Specific days of the week? ________________________________
   No trend? ________________

6. When do these problems get better or worse (explain)?
   __________________________________________________________________
   __________________________________________________________________
7. A) Are you allergic to anything? If yes, list and indicate symptoms.

____________________________________________________________

____________________________________________________________

B) Do you suffer from a chronic respiratory problem? (e.g. asthma, emphysema, bronchitis). Please explain.

____________________________________________________________

____________________________________________________________

8. What electrical equipment and chemicals do you use in your work area? (e.g. glues, solvents, photocopier)

________________________________________________________________

________________________________________________________________

9. A) Is there a visible vent in your work area? __________________________

B) Is this vent blocked? __________________________________________

C) Can you feel any air movement? ________________________________

10. Can you control your temperature and air movement?

________________________________________________________________

11. Is the temperature/humidity comfortable in your office?

Yes? _________________

No? ___ Comments: ______________________________________________

________________________________________________________________

12. Describe the window coverings in your office: __________________________

13. a) Is your office carpeted? _________________________________

b) Has it been recently cleaned and shampooed? ______________________

14. Describe any upholstery (cloth, leather or vinyl) or furnishings (desks, chairs) brought into your office within the last year.
15. Are there any odours in your office? No ___ Yes ___
   
   If yes, do you know what they are? ________________________________

16. Is there anybody else in your area experiencing a problem with the air quality?
   Please explain and list anyone who is experiencing problems:
   ___________________________________________________________
   ___________________________________________________________