

To be completed by individuals with physical complaints.

Thank you for providing this information as accurately and completely as possible!

Individuals responsible for reviewing information on this form will treat it as confidential, and will provide this information only to parties responsible for correcting IAQ problems.

Building and Occupant Information

Your Name _____ Title _____

Phone _____ Email _____

Your Workspace Location _____ Survey Date _____

Business Name _____ Building Name _____

Address _____

Symptom Patterns

What kind of symptoms or discomfort are you experiencing?

Are you aware of other people with similar symptoms or concerns? Yes No

If so, what are their names and working locations? _____

Please check if you have any of these conditions that may make you susceptible to air quality problems.

- | | | |
|--|---|---|
| <input type="checkbox"/> contact lenses | <input type="checkbox"/> chronic cardiovascular disease | <input type="checkbox"/> chronic respiratory disease |
| <input type="checkbox"/> allergies | <input type="checkbox"/> undergoing chemotherapy | <input type="checkbox"/> undergoing radiation therapy |
| <input type="checkbox"/> chronic neurological problems | <input type="checkbox"/> immune system suppressed by disease or other causes | <input type="checkbox"/> asthma |
| | | <input type="checkbox"/> other _____ |

Timing Patterns

When did your symptoms start? _____

When are they generally worst? _____

Do they go away? If so, when? _____

Have you noticed that any events (such as weather events, temperature or humidity changes, or activities in the building) tend to occur around the same time as your symptoms?

Spatial Patterns

Where are you when you experience symptoms or discomfort? _____

Where do you spend most of your time in the building? _____

Additional Information

Please share any observations about conditions in your building that might help explain your symptoms.

For example: temperature, humidity, drafts, stagnant air, odors. _____

Have you sought medical attention for your symptoms? _____

Do you have any other comments? _____
