

Cal State San Marcos Indoor Air Quality Survey

Survey Questionnaire Occupant Interview

Survey Date: _____ Building Name/Number: _____ Floor Number: _____
Room/Office Number: _____ Work Location (Dept.): _____
Employee Name (optional): _____ Job Title: _____

This section is used to help Risk Management and Safety (RM&S) resolve Indoor Air Quality (IAQ) related complaints and concerns. IAQ problems can include one or more of the following: temperature control, ventilation, moisture, and air pollutants Employee (occupant) concerns, complaints, observations, and comments are often a vital source of information leading to the solution of an IAQ issues Please use the space provided below to describe as accurately as possible the nature of your complaint or concern and feel free to include what your thoughts are on the cause of the problem (additional space on back side of this page)

Please complete the remainder of this questionnaire to assist in the investigation of your work Environment. Responses to the questions should be based on personal experiences only, without interferences or suggestive information from others.

1. How long have you been employed here? ____yr. ____mo.
2. Has this department recently moved here from another location? Yes ____ No ____ If yes from where and how long ago? _____
3. Are you aware of other people with similar concerns or complaints? Yes ____ No ____ If yes, do they work in your department? Yes ____ No ____ If no, where do they work?
4. Have there been any recent changes in the office? Describe the changes and when they occurred.
5. Are you aware of any recent cleaning activities i.e., rug shampoo, floor stripping/waxing, or painting in the area? If yes provide approximate dates and times.

SYMPTON PATTERNS

1. Do you Smoke cigarettes? Yes ____ No ____
2. Does cigarette smoke bother you? Yes ____ No ____
3. Do you wear contact lenses? Yes ____ No ____
4. What kind of symptoms or discomforts are you experiencing? Are you experiencing any of the following? Check all that apply if any.

- | | |
|---|--|
| <input type="checkbox"/> Hay fever, Allergies | <input type="checkbox"/> Colds |
| <input type="checkbox"/> Skin allergies, Dermatitis | <input type="checkbox"/> Flu |
| <input type="checkbox"/> Other allergies | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Respiratory disease |

5. Select all of the following symptoms, if any, that you may feel are related to your work!g ! under the condition you have previously described.

- | | |
|--|---|
| <input type="checkbox"/> Aching body joints | <input type="checkbox"/> Sinus congestion |
| <input type="checkbox"/> Muscle twitching | <input type="checkbox"/> Sneezing |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Chest tightness |
| <input type="checkbox"/> Dry, Flaking skin | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Discolored skin | <input type="checkbox"/> Hearing disturbances |
| <input type="checkbox"/> Skin irritation, Itching | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Fatigue, Drowsiness |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Unstable temperatures Hot ____ Cold ____ |
| <input type="checkbox"/> Contact lens problems, Irritation | <input type="checkbox"/> Unstable air humidity Dry ____ Damp ____ |
| <input type="checkbox"/> Eye irritation | <input type="checkbox"/> Room light: Dim ____ Ok ____ Bright ____ |
| <input type="checkbox"/> Noticeable odors | <input type="checkbox"/> Other (Specify) _____ |

TIMING PATTERNS

1. When did you first notice these symptoms and how often have they occurred since then?

2. Has there been a change in symptoms and patterns? Yes ____ No ____ Explain: _____

3. Do your symptoms continue after work? Yes ____ No For how long? _____

4. Do you have allergies? Yes ____ No ____ Explain: _____

5. Have you seen a doctor? Yes ____ No ____ What was the diagnosis and was medication prescribed? _____

6. When do the symptoms occur?

? Morning

? Daily

- Noon
- Afternoon
- Specific day(s) of the week

- All day every day
- No noticeable trend

7. Have you noticed any other events (such as weather, temperature or humidity changes, drafts, stagnant air, odors, or activities) in the building that tend to occur around the same time as your symptoms? _____

8. In your opinion, what approach would be best in removing the source of concern or complaints? (What would you suggest and or recommend as a corrective measure?)

SPATIAL PATTERNS

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

2. Where are you when you experience symptoms or discomfort?

Thank you for your cooperation!