



Indoor Air Quality Questionnaire

Industrial Hygiene Program

Office of Health and Safety – MS A-17

Atlanta, GA 30333

FAX: 404-639-0883



Campus	Bldg	Room(s)	Date
Occupant	Phone No.	Supervisor	Phone No.

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 locations?

Timing Patterns

How long have you been in your current work location?

When did your symptoms start?

When do these complaints occur?

Morning

Afternoon

All day

Daily

Specific days of week (Specify: _____)

No noticeable trend or time

When do you experience relief from these symptoms?

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

Spatial Patterns

Where are you in the building when you experience symptoms or discomfort?

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

Additional Information

Do you have any observations about building conditions that might need attention or might help explain your symptoms (e.g., water leaks or moisture, temperature, humidity, drafts, stagnant air, and odors)?

Has there been recent remodeling or have there been any changes in your work environment (e.g., painting, new carpet and/or furniture)? Please explain.

Have you notified your Supervisor of your symptoms or discomfort? If yes, what actions have been taken?

Have you sought medical attention for your symptoms?

Do you have any other comments?