UNIVERSITY of MASSACHUSETTS
Environmental Health & Safety
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INDOOR AIR QUALITY

Building Occupant Report Form

Name: **Date:**

Department:

Job Title:

Campus Building and Room #:

Phone number:

Email:

Gender: ___ Male ___ Female

Overall are you ___ satisfied or ___ dissatisfied with the indoor air quality within your work area. If dissatisfied, please continue with the rest of this form.

Please complete this form to the best of your ability and return it to Yung Morgan at EH&S, 117 Draper Hall or email it to: pmorgan@ehs.umass.edu.

Feel free to give the form to others in your office who are also dissatisfied with the indoor air quality. EH&S will evaluate the indoor air quality issues after receiving the completed form.

1. When did you begin working in this **building**?

2. When did you begin working at your present **office location**?

3. Are any of these a problem in the **building**? (circle all that apply)

Temperature too hot	Smoky air
Temperature too cold	Stale air
Peculiar odors (musty, sweet, cheesy)	Soot by air vents
Stuffy air	Drafts

When are these a problem? Please describe where and when they are found (e.g., does it occur only in the mornings; is the problem seasonal, or only on Mondays, etc.).

4. _____ Number of persons working in the same room (estimate)

5. _____ Number of windows in the same room

6. Do the windows open? _____ Yes _____ No

7. Do you have any of the following health complaints? (This is a list of symptoms that result in buildings with air quality problems. Not all of these may be present in your building.)

____ Aching joints	_____ Nausea
____ Back pain	_____ Skin irritation/itching
____ Muscle twitching	_____ Sneezing or coughing
____ Dizziness	_____ Chest tightness
____ Hearing disturbances	_____ Eye or nose irritation
____ Dry cough	_____ Headache
____ Heartburn	_____ Fatigue/drowsiness
____ Dry skin	_____ Sore or dry throat
____ Shortness of breath	_____ Nasal irritation or nosebleeds
____ Sinus congestion or runny nose	
____ Skin rash	_____ Menstrual irregularities
____ Chills or fever	

Other (fill in): _____

_____

8. When do these symptoms occur?

_____ Mornings	_____ Afternoons
_____ All day long	_____ No noticeable pattern

9. Are these symptoms worse on some days than others? (e.g., Tuesdays are bad; Thursdays are not)

Specify which days of the week: _____

_____

10. Where in the building do these symptoms occur? (check all that apply)

_____ At my desk _____ In the lavatory

_____ In the lounge _____ No particular place

Other: _____

11. When did you first notice these symptoms?

12. Do you suffer from allergies, like hay fever? _____Yes _____No

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

14. When do you experience these symptoms?

_____Only at work _____At work and at home

15. Have you had to leave work early or miss work because of these symptoms?

_____ No _____Yes _____ How many times in the past month?

How long were you out of work? (# of days): _____

16. When do you experience relief from these symptoms?

17. Has a doctor told you that you have any of the following health problems? (check all that apply)

____Hay fever, pollen allergies ____Asthma

____Chronic bronchitis ____Chronic sinus problems

____Skin allergies, dermatitis

18. Have any of these gotten worse lately?

_____Yes _____No If yes, which ones? _____

_____

20. Do you smoke tobacco?

_____Yes _____No Amount per day _____

19. Do you seem to be getting more colds or flu than you normally might?

_____Yes _____No

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

21. 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

Other comments about the situation: _____

_____