IAQ Questionnaire

Personal Information

First Name **Last Name** **ID #**

Status **Email** **Phone**

- Faculty
- Staff
- Students

Location of Concern

Campus **Building Name** **Room Number**

- Medical Center
- Pearland Campus
- UHCL

Briefly describe your air quality concerns, including the specific location(s) of the concern.

Some common IAQ problems are listed below. Please check any that apply to your situation.

- Lack of fresh air
- Moldy odor
- Chemical odors
- Dust in the air
- Visible mold
- Other

If "Other," please explain:

When did this problem/these problems begin? (Date)

What time of day do you notice the problem(s)?

- Morning
- Afternoon
- All Day

Are there specific days of the week that you notice the problem(s) at work?

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Is there a specific time of year that you notice the problem(s) more?

- Yes
- No
- Don't know

If yes, please specify

Indicate the symptoms that you have experienced (if any) in your building, and mark the appropriate column for when those symptoms occur.

***This is a random list of symptoms commonly associated with air quality concerns. Not all of these symptoms have been experienced in buildings. Please do not check boxes if you have NOT experienced these symptoms at work.**

	Occasionally	Frequently	Not related to building	Appears after arrival in building	Increases after arrival in building
Difficulty breathing					
Dry or sore throat					
Dizziness					
Dry, flaking skin					
Skin irritation					
Itching					
Nausea					
Noticeable odors					
Sinus congestion					
Sneezing					
Chest tightness					
Eye irritation					
Fainting					
Hyperventilation, shortness of breath					
Problems with contact lenses					
Headache					
Fatigue/drowsiness					
Temperature too hot					
Temperature too cold					
Other					

If "Other" is marked in previous page, specify here:

Do these symptoms clear up within 1-2 hours after leaving work?

Yes
No

If no, do they clear up overnight or over the weekend?

Yes
No

If all symptoms do not clear up when you're away from the building, which symptoms persist when you're away from your workplace throughout the week?

Have you sought medical attention for your symptoms?

Yes
No

Do you have any confirmed allergies or other health problems that may account for any of the symptoms you indicated above?

Yes
No

If yes, please describe:

Have any of your symptoms reduced your ability to perform your job functions, caused you to stay home from work, or caused you to leave work early?

Yes
No

If yes, please explain:

How many hours per day do you spend in your building?

How many hours per day do you spend at your workstation?

Do any of your co-workers have similar symptoms that you are aware of?

Yes
No

Please check any of the following that apply to you:

I wear contact lenses.
I operate photocopier machines at least 10% of the day.

Briefly describe your primary job tasks:

Do any of your primary job tasks produce dust or odors, or use any chemical or toxic substances that you are aware of?

Yes
No

If yes, please list or describe:

Do you have any home-related exposure to dust, odors or chemical substances (i.e. additional jobs, hobbies, farming, auto repair, etc.)?

Yes

No

If yes, please list or describe:

Do you have any idea about what might be causing the symptoms you experience in your workplace?

Please provide any other comments or observations that may be helpful in determining the environmental condition of your workplace: