

**INDOOR AIR QUALITY REQUEST FORM AND QUESTIONNAIRE**

**Instructions:**

* Answer all questions or indicate if the question does not apply to your situation. Provide as much information as you feel necessary to adequately describe your indoor air quality situation.
* After completing this form, forward the information via email to Clemson OES Help oeshelp@clemson.edu and title the email as “IAQ request” or send by interoffice mail to OES.

**Your Name *(Optional):***

**Job Title:**

**Department: Building & Floor #:**

**Room Number: Phone*:* Email*:***

1. **Briefly describe your air quality concerns including the specific location(s) of the concern:**
2. **Indicate if you frequently have any of the following complaints concerning the indoor air quality**

**at your building.** *(circle all that apply)*

Dusty Too hot

Noisy Too cold

Stuffy Air Too dry

Moldy or musty odors Too humid

Visible mold Drafty

Other odors (please describe) Stuffy Air

 Vibration Crowded work area

Other

1. **When did these problems begin and when do they occur?**
* Month/year when problem began:
* What time of day do you experience the problem? *(circle one)*  morning / afternoon / all day
* Are there specific day(s) of the week that you experience the problem?

 *(circle all that apply)*  Monday / Tuesday / Wednesday / Thursday / Friday / Saturday / Sunday

* Is there a specific time of year that you experience the problem?

Specify when:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* If there is no noticeable trend to the times that you experience the problem, check

here:\_\_\_\_\_\_\_

1. **What health symptoms have you experienced?** Check any symptoms you are experiencing in your building.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Symptom** | **Occasionally** | **Frequently** | **Not related to building** | **Appears after arrival** | **Increases after arrival** |
| Difficulty in concentrating |  |  |  |  |  |
| Dry or sore throat |  |  |  |  |  |
| Aching joints |  |  |  |  |  |
| Muscle twitching |  |  |  |  |  |
| Back pain |  |  |  |  |  |
| Hearing problems |  |  |  |  |  |
| Dizziness |  |  |  |  |  |
| Headache |  |  |  |  |  |
| Dry, flaking skin |  |  |  |  |  |
| Discolored skin |  |  |  |  |  |
| Skin irritation |  |  |  |  |  |
| Itching |  |  |  |  |  |
| Heartburn |  |  |  |  |  |
| Nausea |  |  |  |  |  |
| Noticeable odors |  |  |  |  |  |
| Sinus congestion |  |  |  |  |  |
| Sneezing |  |  |  |  |  |
| Wheezing |  |  |  |  |  |
| High stress levels |  |  |  |  |  |
| Chest tightness |  |  |  |  |  |
| Eye irritation |  |  |  |  |  |
| Fainting |  |  |  |  |  |
| Hyperventilation, shortness of breath |  |  |  |  |  |
| Problems with contacts |  |  |  |  |  |
| Fatigue/drowsiness |  |  |  |  |  |
| Temperature too hot |  |  |  |  |  |
| Temperature too cold |  |  |  |  |  |
| Other (specify) |  |  |  |  |  |

* Do these symptoms clear up within 1-2 hours after leaving work? Yes / No

If no, do they clear up overnight? Yes / No

If no, do they clear up over the weekend? Yes / No

If no, do they clear up after vacation? Yes / No

* If all symptoms do not clear up when away from the building, which symptoms persist when away from your workplace throughout the week?
* Have you sought medical attention for your symptoms? Yes / No

If yes, please describe:

* Do you have any allergies or other health problems that may account for any of the listed health

 symptoms? Yes / No If yes, please describe:

* Have any of your symptoms reduced your ability to work, 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 typically spend in this building?
* How many hours per day are you at your workstation?
* Do any of your co-workers have similar symptoms of which you are aware? Yes / No
1. **Indicate if any of the following apply to you.** *(circle all that apply)*

Wear contact lenses

Operate video display or computer terminals How many hours per day?

Operate photocopier machines at least 10% of the work day

Operate other office machines or equipment List:

Use any chemical substances such as cleaners, white out, etc.

1. **Have there been any renovation/demolition-related activities occurring in or near your work area within the past week?** (i.e., new carpeting, painting, new office furniture, HVAC work, etc.) Yes / No

Yes / No If Yes, Please list:

1. **Has there been any evidence of water leaks or visible signs of moisture in and around your area?**

Yes / No If Yes, Please describe:

1. **Is your office near a laboratory?**

Yes / No If Yes, Please describe:

1. **Briefly describe your primary job tasks:**

Do any of these tasks produce dust or odor or use toxic substances? Yes / No

If Yes, please list or describe:

Yes / No If Yes, Please describe:

1. **Do you have an idea as to what is the cause of symptoms in your workplace?** Yes / No

 If Yes, Please describe:

1. **Can you offer any other comments or observations that may be helpful in determining the environmental condition within your workplace?**

**In addition to this form, you may also want to maintain a daily log as found at**

**Thank you for completing this form.**

**We will use your information to assist with investigating your IAQ concerns in your workplace.**