# IAQ questionnaire

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.

# Contact information (optional)

**Your Name** RUSS REYNOLDS

**Job Title:** SHOP SUPERVISOR

**Department:** PHYSICS

**Building/room #:** DANIEL ANNEX

**Phone:** 864-656-5311

**Email:** RREYNOZ@CLEMSON.EDU

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

HAVE BREATHING PROBLEMS THAT NEVER HAD BEFORE.

2. **Indicate if you frequently have any of the following complaints concerning the indoor air quality at your building.** *(circle all that apply)*

- Dusty
- Noisy
- Stuffy Air
- Moldy or musty odors
- Visible mold
- Stuffy Air
- Crowded work area
- Other PARTICLES IN AIR AT TIMES

- Too hot
- Too cold
- Too dry
- Too humid
- Drafty
- Vibration

3. **When did these problems begin and when do they occur?**

- Month/year when problem began: ALL YEAR

- 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? Yes/No

Specify when: _____

4. **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 50%

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? HEADACHE, SNEEZING CONGESTION, SINUS PROBLEMS

- ❖ Have you sought medical attention for your symptoms? (Yes) / No

If yes, please describe: ALLERGIST

- ❖ 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: POLLEN, DUST, MOLD

- ❖ 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: HEADACHE

- ❖ How many hours per day do you typically spend in this building? 9

- ❖ How many hours per day are you at your workstation? 9

- ❖ Do any of your co-workers have similar symptoms of which you are aware? (Yes) / No

**5. 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? 6.0

Operate photocopier machines at least 10% of the work day

(Operate other office machines or equipment) List: CALCEQUIPMENT, SHOP TOOLS, WOOD

(Use any chemical substances such as cleaners, solvents, etc.)

6. **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: _____

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

(Yes) / No If Yes, Please describe: ROOF LEAKS

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

(Yes) / No If Yes, Please describe: SHOP IS CONSIDERED A LAB

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

SUPERVISE SHOP, MACHINE PARTS, MAKE DESIGN DRAWINGS TALK WITH CLIENTS. ORDER MATERIALS AND PARTS

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

If Yes, please list or describe: MACHINING, GRINDING, WELDING

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

If Yes, Please describe: AIR FILTRATION, DUCTWORK IS IN BAD CONDITION

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

DUCTWORK VENTS AND RETURNS ARE EXTREMELY DIRTY, DUSTY AND POSSIBLY MOLDY. THEY RELEASE PARTICLES EVERY TIME AIR COMES ON. DUCTWORK MAKES NOISE AS IF AIR IS STRUGGLING TO PASS.

**Thank you for completing this form.**

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