1. Do you frequently have any of the following complaints concerning the indoor air quality at this building? (check all that apply)
   - Temperature too cold
   - Temperature too hot
   - Stuffy air
   - Moldy odors
   - Other odors (please describe)
   - Poor lighting
   - Other odors
   - Dusty
   - Noisy
   - Too dry
   - Too humid
   - Drafty
   - Crowded work area
   - Vibration
   - No complaints

2. Do any of the following apply to you? (check all that apply)
   - Wear contact lenses
   - Operate video display terminals at least one hour/average day
   - Operate photo copiers for more than one hour/average day
   - Use any chemical substances such as cleaners, white out, etc.,
   - Use carbonless copy paper
   - Smoke tobacco products
   - None of the above apply

3. Since you have worked in this building, have you ever been told by a physician that you have any of the following diagnoses? (check all that apply)
   - Allergic Rhinitis
   - Asthma
   - Allergies
   - Conjunctivitis
   - Sinusitis
   - Conjunctivitis
   - None
   - Emphysema
   - Laryngitis
   - Bronchitis
   - Other chest conditions

4. During the last year while working in the building, have you experienced any of the following symptoms? (check all that apply)
   - Frequent cough
   - Wheezing (except colds)
   - Multiple colds (more than four)
   - Shortness of breath
   - Migraines
   - Burning or irritated eyes
   - None of the above
   - Nasal congestion
   - Sinus infections
   - Sore throat
   - Hoarse voice
   - Headaches at least 2/month
   - Sneezing attacks
   - Other attacks
   - Other (please specify)

5. Please check all medications you are currently taking on a daily or weekly basis:
   - Pain relievers
   - Decongestant
   - None
   - Aspirin, Tylenol, ibuprofen, etc.
   - Antihistamines
   - Other (please specify)

6. How would you rate the indoor air quality at this building?
   - Good
   - Average
   - Poor
7. If you feel that there is an indoor air quality problem, does the problem occur more frequently during specific seasons of the year?
   ____ Yes  ____ No  ____ Don't know  ____ Not applicable

   A. If yes, rank the seasons from one to four by increasing likelihood of indoor air problems. As an example, 1=season least likely to be associated with indoor air quality problems; 4=season most likely to be associated with indoor air problems.
   ____ Winter (Dec.-Feb.)  ____ Spring (March-May)  ____ Summer (June-Aug.)  ____ Fall (Sept.-Nov.)

   B. Also if yes, when do indoor air problems seem to be most notable.
   ____ Morning  ____ Daily  ____ Afternoon  ____ Specific Days (i.e. Mon, Tues, etc)
   ____ All day  Please specify ______________________  ____ Not applicable

8. Which of the following symptoms have you experienced that you may feel may be related to your work environment? (check all that apply)
   ____ Headache  ____ Sinus congestion  ____ Sinus infection
   ____ Eye irritation  ____ Sore throat  ____ Hoarseness
   ____ Runny nose  ____ Dizziness  ____ Sneezing
   ____ Fever (>100.5°F)  ____ Fatigue/Drowsiness  ____ Eyes red/watery
   ____ Cough  ____ Wheezing  ____ Shortness of breath
   ____ Skin problems  ____ Muscle aches  ____ Other ______________________

   (rash)

9. Do most of the symptoms checked above go away within 1 hour after leaving work?
   ____ Yes  ____ No  ____ Not applicable

   If no, do they go away by the next morning?
   ____ Yes  ____ No  ____ Not applicable

   If no, do they go away when you are on vacation?
   ____ Yes  ____ No  ____ Not applicable

10. Which of the following symptoms have you experienced within the last week that you feel are related to your workplace? (check all that apply)
    ____ Headache  ____ Sinus congestion  ____ Sinus infection
    ____ Eye irritation  ____ Sore throat  ____ Hoarseness
    ____ Runny nose  ____ Dizziness  ____ Sneezing
    ____ Fever (>100.5°F)  ____ Fatigue/Drowsiness  ____ Eyes red/watery
    ____ Cough  ____ Wheezing  ____ Shortness of breath
    ____ Skin problems  ____ Muscle aches  ____ Other ______________________

    (rash)

11. Do you have any health problems or allergies that might account for the above symptoms?
    ____ Yes  ____ No  ____ Not applicable

12. Please rank your workplace as to health and safety conditions.
    ____ Excellent  ____ Good  ____ Average  ____ Poor  ____ Bad

13. Please rank the stress level of your job.
    ____ Very Stressful  ____ Somewhat stressful
    ____ Not very stressful  ____ Not at all stressful
14. Please rank your overall satisfaction with your job.
   _ Very satisfied __ Somewhat satisfied
   _ Dissatisfied __ Very dissatisfied

15. What percentage of your typical work day do you spend in your building?
   _ 0%-25% __ 26%-50% __ 51%-75% __ 76%-100%

16. What percentage of your typical work day do you spend in your office/cubicle?
   _ 0%-25% __ 26%-50% __ 51%-75% __ 76%-100%

17. Are any of the following items located within your workroom or area? (check all that apply)
   _ Photo copier __ Laser printer __ Windows __ Plants

18. How much control do you have over the air quality in your work environment? (temperature, air, movement, etc.)
   _ Very good control __ Some control __ No control

19. Which of the following can you individually control?
   _ Temperature __ Air movement __ Light intensity __ No control

20. Please rate the lighting at your work area.
   _ Too bright __ Little to bright __ Just right __ Little too dim __ Too dim

21. Has there been any renovation/demolition related activities occurring in or near your work environment? (Ex. New carpet, painting, new office furniture, HVAC work, etc). If so, please specify below.
   __________________________________________________________
   __________________________________________________________

22. Has there been any evidence of water leaks or visible signs of moisture in and around your area. _ Yes ___ No

   A. If the answer is yes, please describe (eg. Location & duration) ______________________
      __________________________________________________________
      __________________________________________________________

23. Is your office space near or in a laboratory that uses chemicals?
   _ Yes __ No

   A) If you answered yes to the above, list the substances known to be used.
   ___________________________________________________________________
   ___________________________________________________________________

Your Name (optional)_________________________________________________________

Telephone # (optional) _______________________________________________________

Gender: Male__ Female___          Age:(optional)__________

Job Title/Position?_________________________  Name of Building:___________________
   Suite #:___________________________

Note: _The information you provide will remain confidential._