



THE CATHOLIC UNIVERSITY OF AMERICA

Department of Environmental Health and Safety

Occupant Questionnaire – Indoor Air Quality

Date: _____

Name: _____

Building/Room: _____

Office

Classroom

Laboratory

Residence

Other: _____

How long have you occupied the space mentioned above? _____

Approximately how many hours per week do you spend in the affected space? _____

Are there any other areas within the building which you frequent on a routine basis? If so, describe in detail below.

Personal Information:

What kind of symptoms or discomfort are you experiencing? Please mark all that apply:

Coughing

Sneezing

Eye Irritation

Lethargy

Congestion

Skin Irritation

Headache

Dizziness

Nausea

Other flu-like symptoms: _____

Other respiratory symptoms: _____

Which would you rate as the most severe?

Are the above symptoms experienced only within your work/living space or other locations within the building as well? Please list other locations if appropriate.

Are you aware of other people with similar symptoms or concerns? Yes No

If you answered yes to the above question and are so willing, please share their names and locations:

If willing to share, please note whether you have any of the following health conditions:

contact lenses

asthma

suppressed immune system

allergies

chronic respiratory disease

chronic cardiovascular disease

Other: _____

Are you currently taking any medication for your symptoms?

Have you sought professional medical attention for your symptoms?

Are you a cigarette/cigar/pipe smoker or vaper or do you live with a smoker?

Timing Patterns:

Approximately how often do you experience any or all of the symptoms noted above?

Once a day

Once a week

Once a month

Other: _____

When did your symptoms start?

When are they generally at their worst? For example, morning, afternoon, a particular day of the week, summer, winter, etc.

Do they go away? If so, when?

Have you noticed any other events (such as weather events, temperature or humidity changes, or activities in the building) that tend to occur around the same time as your symptoms?

Building Conditions:

Is your work/living area carpeted or tiled? Please rate the condition of the flooring. For example, is the carpet worn, floor tile damaged, etc.

Do you have operable windows in your work/living area?

Please list any electronic devices in your work/living area such as photocopiers, computer printers, fax machines, etc. If such devices are present, how often are they used?

Are persistent odors an issue? If so, when and how often are they noticed and can you describe the odor (i.e. chemical, oil, exhaust, etc.)?

Have you experienced any water leaks in your work/living area? If so, please describe the incident(s) including date of occurrence, impacted building materials, response actions, etc.

Have there been any recent renovation activities in the vicinity that you are aware of? If so, please describe.

Are the temperate conditions, to include temperature and relative humidity, of your work/living area satisfactory? Is it too warm, too cold, too dry, drafty, etc. on a regular basis?

How effective are custodial services operations in your work/living area? Do you notice excessive dust on a routine basis?

Are there any other conditions of note, or other comments which you would like to share? For example, evidence of pest infestation, mold growth, do occupants smoke/vape in the building, etc.

Thank you for your time in completing this questionnaire. Upon completion, please return to Kellie Hindman (hindman@cua.edu), Environmental Health & Safety, Power Plant.