

**Indoor Air Quality Questionnaire/Complaint form
Indiana University-Bloomington**

When do I use this form?

If you or others in your workplace are concerned about the indoor air quality of their work environment you can fill out this form to detail the nature of your concerns in order to start or supplement the investigation of these concerns. Some of the questions on this form are personal or related to your medical condition. All personal information that you fill out on this form will be kept confidential and will generally be shredded after it is compiled and the investigation is complete.

Name (not needed if you wish to be anonymous): _____

Job Title: _____

Department: _____ Building: _____

Room Number: _____ Phone: _____ Email: _____
(room, phone and e-mail is not needed if you wish to be anonymous):

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

Some common problems are listed below. Please circle any that apply to your situation:

lack of fresh air

mold odor

other noticeable odors

describe: _____

dust in the air

visible mold

other

specify: _____

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

Month/year when problem began: _____

What time of day do you experience the problem? morning / afternoon / all day

Are there specific day(s) of the week that you experience the problem?

Circle: M / Tu / W / Th / F / Sa / Su

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

Specify: _____

If there is no noticeable trend to the times that you experience the problem, check here: _____

3. What health symptoms have you experienced?

Select any symptoms you have experienced in your building. This is a random list - not all symptoms listed have been noted in IU buildings.

| 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 | | | | | |
| Dry, flaking skin | | | | | |
| Discolored skin | | | | | |
| Skin irritation | | | | | |
| Itching | | | | | |
| Heartburn | | | | | |
| Nausea | | | | | |
| Noticeable odors | | | | | |
| Sinus congestion | | | | | |
| Sneezing | | | | | |
| High stress levels | | | | | |
| Chest tightness | | | | | |
| Eye irritation | | | | | |
| Fainting | | | | | |
| Hyperventilation, shortness of breath | | | | | |
| Problems with contacts | | | | | |
| Headache | | | | | |
| 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 over night or over the weekend? Yes / No

If all symptoms do not clear up when away from the building, which symptoms persist 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 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 spend in this building?

How many hours per day at your work station?

Do any of your co-workers have similar symptoms that you are aware of? Yes / No

4. Circle any of the following that apply to you?

wear contact lenses

operate video display or computer terminals How many hours per day? _____

operate photocopier machines at least 10% of the day

use or operate other office machines or equipment that may lead to health problems

List: _____

currently taking medication Yes / No If yes, reason for medication: _____

5. Do you smoke? Yes / No

6. Briefly describe your primary job tasks:

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

If yes, please list or describe:

7. Do you have any non-IU related exposures such as an additional jobs, hobbies, farming, welding, auto repair, etc.? Yes / No

If yes, please list or describe:

8. Do you have an idea as to what is the cause of symptoms in your workplace?

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

Thank you for completing this form. We will use it to better investigate the symptoms in your workplace.

Mail or fax this completed form to:

**Dan Derheimer
IU EH&S
%9 %4 '9Ugh' fX`Gh
Fax: 855-7906**

If you have any questions about health related concerns in your workplace or about completing this form please email Dan Derheimer at dderheim@indiana.edu