# OCCUPANT COMFORT QUESTIONNAIRE

Name (Optional): _____

Building: _____

Telephone Number: _____

Room Where Majority of Day is Spent? _____

Other Rooms Occupied on a
Regular Basis? _____

_____

_____

How Long Have You Worked In:

This Room/Area? _____

This Building? _____

What Buildings or Rooms Have You
Worked In Prior To The Above
Stated Location:

Buildings: _____

Rooms: _____

Do you have any Indoor Air Quality
Concerns related to the building?
(If "NO", it is optional to continue) _____

Are Problems More Evident
In One Room? _____

Please prepare a log of building related symptoms for a minimum of one-week period to include a specific symptom with details on problems experienced. Please include time of day, weather and other details of environmental factors noted.

| Date | Description of Symptoms | Environmental Factors |
|---|---|---|
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Have you seen a doctor for the symptoms described: Yes _____ No _____

I have no building related symptoms. _____

Note: Make additional copies if needed.

When Do You Experience Relief From These Symptoms? _____

_____

_____

_____

When Do These Problems Usually Occur?

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Time of Day: | AM | | | PM | | | Evening | |
| Day of Week: | M | T | W | TH | F | Sat. | Sun. | |
| Month: | J | F | M | A | M | J | J | A |
| | S | O | N | D | | | | |
| Season: | Spring | | Summer | | Fall | | Winter | |

At What Time Do Symptoms Disappear, If Any? _____

_____

_____

_____

In Your Opinion, What Is The Cause of The Perceived Indoor Air Quality Problem?

_____

_____

_____

_____

Comments: Please comment on factors you consider to be important concerning the quality of your work environment: