Indoor Air Quality Questionnaire

The responses to these questions will help Occupational Health address indoor air quality (IAQ) related complaints and concerns. The responses are vital sources of information that assist in finding a solution to the IAQ issues. Please answer the following questions to the best of your ability—and as they relate to your own personal experience. The responses to this questionnaire will remain confidential and will be reviewed by Occupational Health.

If you have questions or concerns, please contact Rebecca Giannakos, NP, Occupational Health Supervisor, at: rgiannak@umd.edu

---

Date:
Building Name:
Floor:
Room/Office Number:
Employee Name:
Job Title:
Office Phone Number:
Office Email:

1. Approximately how many hours per week do you work?

2. Approximately how many hours per week do you spend in the room(s) where you are experiencing problems?

3. Approximately how many years have you been working in the building?

4. Please indicate your primary workspace:
   a. Enclosed office/room
   b. Cubicle within larger room
   c. Work throughout building

5. How many hours per day do you use a computer at work?

6. Were any of the following items regularly used at/near your workstation during the past year?
   a. Portable fan cooling unit
   b. Portable air filter or cleaner
   c. Portable space heater
   d. Portable humidifier

    e. Portable dehumidifier

7. Were any of the following items regularly used or placed at/near your workstation during the past year?
    a. Spray disinfectants/deodorizers
    b. Plug in air-refresheners?
    c. Spray cleaners
    d. Live plants
    e. Other:______

8. At any time during the past year have you noticed evidence of new or continued water leaks from the ceiling, floors, walls, or pipes near your workstation?

9. During the past year have any of the following changes taken place near your current workstation?
    a. New flooring (circle all that apply: carpet/vinyl/hardwood/other)
    b. New furniture (circle all that apply: desk/chair/drawers/other)
    c. New equipment (circle all that apply: computer/printer/other)
    d. Wall demolition or construction
    e. Walls painted

10. Please check the condition(s) below that best describes your current work area. (Note-If you /your coworkers have modified your work area [e.g., added fans or heaters, opened doors, etc.], please describe the work area before the modification.)
    During the last year…

How often was… (provide dates/ranges if applicable)	Never	Occasionally	Monthly	Weekly	Daily
The temperature too hot?					
The temperature too cold?					
The air circulation poor?					
The air dusty?					
The air too humid?					

There are distinct odors?					
There are disturbing noises?					
Other ______					

Issues and date(s):

During the last year…

Please indicate whether there is a seasonal pattern to the following conditions:	Not Related	Spring	Summer	Fall	Winter
The temperature too hot?					
The temperature too cold?					
The air circulation poor?					
The air dusty?					
The air too humid?					
There are distinct odors?					
There are disturbing noises?					
Other_____					

Issues and date(s):

11. Please check the category below that best describes the frequency of odors in your work area.

During the last year how often, if at all, did you notice any of the following odors in your work area? (provide date(s)/ranges if applicable)	Never	Occasionally	Monthly	Weekly	Daily
Tobacco smoke					
Musty, moldy, damp "basement" smell					
Food smells					
Paint and/or construction odors					
Photocopy machine/printer					
Chemical odors					
Perfumes/fragrances					
Diesel/gas or other exhaust odors					
Other_________					

Issues and date(s):

12. Can you offer any other comments or observations concerning your work area?

13. Are you experiencing any of the following physical symptoms that you think may be due to your work environment? (circle all the apply; if none, please advance to question 14)
    a. Headache
    b. Aching body joints
    c. Dry, itchy, or discolored skin
    d. Heartburn or nausea
    e. Eye redness, tearing, or irritation
        i. If so, do you wear contact lenses?
    f. Lightheadedness or dizziness
    g. Chest tightness

h. Sneezing or sinus congestion
i. Other (please describe:)

13a. In which season(s) are you bothered more by the symptoms?
j. Winter
k. Spring
l. Summer
m. Fall
n. No relation to seasons

13b. Do the above symptom(s) clear up within 1 hour after leaving your place of work?
- If not, which symptom(s) persist into the evenings/weekends?

13c. Are you currently being treated by a health care professional for any of the stated symptoms?

13d. If yes, which symptom(s)?

14. Do you believe you are or may be allergic/sensitive to any of the following? (if none, please advance to question 15)
    a. Pollen or plants
    b. Animal dander
    c. Mold
    d. Dust
    e. Chemicals
        i. If so, please specify:______
    f. Hygiene or cleaning products
        i. If so, please specify:_______
    g. Other:__________

14a. Have you been tested by a physician for any allergies?
- If so, what substances, if any, have you been confirmed to be allergic to?

15. Do you experience or have you been diagnosed with any of the following? (circle all that apply)
    a. Hay fever/allergies/sinus problems
    b. Skin allergies/dermatitis
    c. Other allergies
    d. Cardiovascular disease
    e. Respiratory/lung diseases (for example, asthma)
    f. Immune disorders or chemotherapy/radiation treatment
        i. Please describe any conditions circled above:

16. Please list all medications you take:

    a. If you take medications for allergies or a respiratory condition, have these helped or resolved your symptoms?

17. Please indicate your smoking status
    a. Never smoked (tobacco or vaping)
    b. Current smoker (circle tobacco, vaping, or both)
    c. Former smoker (circle tobacco, vaping, or both)
        i. If a current or former smoker, how many packs/day on average did you/do you smoke?

18. Are you aware of other people within your work area with similar concerns or symptoms? If so:
    a. How many?
    b. What symptoms have they reported?

Thank you for completing this questionnaire.

References

1. Northern Illinois University. Environmental Health and Safety. Indoor Air Quality – Preliminary Occupant Questionnaire Instructions. https://www.niu.edu/ehs/_files/indoor-air-quality-questionnaire.pdf

2. Northwestern University. Indoor Air Quality Survey. https://www.northwestern.edu/environmental-health-safety/docs/environmental-docs/iaq-survey.pdf

3. Amherst College. Environmental Health and Safety. Air Quality Questionnaire. https://www.amherst.edu/offices/enviro_health_safety/occupational-and-environmental-health/indoor-air-quality/air_quality

4. University of Missouri. Environmental Health and Safety. Indoor Air Quality (IAQ) Questionnaire – Employee. https://ehs.missouri.edu/sites/ehs/files/pdf/Forms/employee-indoor-air.pdf