Indoor Environmental Quality Survey

1 Agency:______________Division:______________Floor:_______________Date:________________

2 Approximately how many hours per week do you work? ________ hours

3 Approximately how many hours per week do you spend in the office? ________ hours

4 Approximately how many years have you been working in the building? ________ years

5 Please indicate your primary work space.
- ☐ Work throughout building
- ☐ Enclosed office
- ☐ Cube with tall wall (> 6 feet)
- ☐ Cube with short wall (< 6 feet)
- ☐ Other________________

6 Were any of the following items regularly used at your workstation during the past year:

	Yes	No
Portable fan	☐	☐
Portable air filter or cleaner	☐	☐
Portable space heater	☐	☐
Portable humidifier	☐	☐

7 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?
- ☐ Yes
- ☐ No

8 During the past year have any of the following changes taken place within 15 feet of your current workstation?

	Yes	No
New carpeting	☐	☐
New furniture (chairs, desks)	☐	☐
New equipment (computer)	☐	☐
Wall construction	☐	☐
Walls painted	☐	☐
Cubes rearranged	☐	☐

9 Do you have any concerns with the indoor air quality that you would like to discuss?
- ☐ **Yes** (continue survey)
- ☐ **No** (please stop survey and return in self addressed envelope)

10 Please check the category below that best describes your current work area. (Note-If you or your coworkers have modified your work area through the use of fans, space heaters, humidifiers, air cleaners or other, please answer based on how you would describe the work area without the modification.)

During the last ***YEAR***. how often was....	Never	Monthly	Weekly	Daily	Always
the temp too hot					
the temp too cold					
the air circulation poor					
the air dusty					
the air too humid					
the air too dry					
there disturbing noises					
other _____________					

During the last ***YEAR***. Please indicate whether there is a seasonal correlation with the following conditions:	Not Related	Spring	Summer	Fall	Winter
the temp too hot					
the temp too cold					
the air circulation poor					
the air dusty					
the air too humid					
the air too dry					
disturbing noises					
other _____________					

please continue on back or second page

Office use:
Screened______ Entered_______ Record #_____

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?	Never	Monthly	Weekly	Daily	Always
tobacco smoke					
musty, moldy, damp basement smell					
food smells					
paint and/or construction odors					
diesel or other exhaust odors					
photo copy machine					
chemical odors					
other (describe) ____________					

12 Are you experiencing any physical symptoms that you think may be attributed to your work environment?

☐ Yes
☐ No

If none please go to question 14

13 Please describe the physical symptoms:

Symptom #1 ________________________
Symptom #2 ________________________
Symptom #3 ________________________

13-a In which season(s) are you bothered more by the symptoms you reported in question 11?

☐Winter ☐ Spring
☐Summer ☐ Fall
☐ No relation to the seasons

13-b Do the above symptom(s) clear up within 1 hour after leaving the building?

	Yes	No
Symptom #1	☐	☐
Symptom #2	☐	☐
Symptom #3	☐	☐

13-c If no, which symptom(s) persist throughout the week?

☐#1 ☐#2 ☐#3

13-d Are you currently being treated by a health care professional for any of the above symptoms?

☐ Yes
☐ No

If none please go to question 14

13-e If yes, which one(s):

☐#1 ☐#2 ☐#3

14 Do you believe you are or may be allergic to any of the following?

	Yes	No
Pollen or plants	☐	☐
Animal dander (cat, dog)	☐	☐
Mold	☐	☐
Dust (house, paper)	☐	☐
Other_______________	☐	☐

Have you been tested by a physician to verify allergies?

☐ Yes ☐ No

15 Do you wear corrective lenses?

☐ No ☐ contacts
☐glasses ☐ bifocals/trifocals

16 Have you had your eyes examined within the last two years?

☐ Yes
☐ No

17 On the average, how many hours do you use a computer at work?

☐ 0-less than 2 ☐2-less than 4
☐ 4-less than 6 ☐6 or more

18 The level of lighting at your work station is:

☐Too dim ☐ Just right ☐ Too bright

19 Do you experience reflection or glare from your computer monitor?

☐ Yes
☐ No

20 Please indicate your primary job task:

☐ Supervisor/manager ☐ Support/clerical
☐ Professional/technical ☐ Other___________

21 Can you offer any other comments or observations concerning your work area:

____
____
____

Please direct any questions regarding this survey and return the completed forms to: