

11.5.1. Sample Occupant Interview Form

Building Name and Number: _____	Dept/Floor: _____
Interviewed By: _____	Date: _____
Name: _____	Title: _____
Occupation: _____	
Work location: _____	
Typical Work Shift (working hours and days): _____	

1. How long have you worked in your current location? _____
 How long have you lived in your current location? _____

2. In what areas do you spend most of your time? _____

3. Generally, the area in which I work can be best described as :

Noise	Humidity	Temperature	Odors
<input type="checkbox"/> normal	<input type="checkbox"/> too dry	<input type="checkbox"/> just right	<input type="checkbox"/> none
<input type="checkbox"/> too loud	<input type="checkbox"/> too humid	<input type="checkbox"/> OK most of the time	<input type="checkbox"/> smoking
<input type="checkbox"/> too quiet	<input type="checkbox"/> just right	<input type="checkbox"/> too hot	<input type="checkbox"/> cooking
		<input type="checkbox"/> too cold	<input type="checkbox"/> other: _____

Generally, the area in which I live can be best described as :

Noise	Humidity	Temperature	Odors
<input type="checkbox"/> normal	<input type="checkbox"/> too dry	<input type="checkbox"/> just right	<input type="checkbox"/> none
<input type="checkbox"/> too loud	<input type="checkbox"/> too humid	<input type="checkbox"/> OK most of the time	<input type="checkbox"/> smoking
<input type="checkbox"/> too quiet	<input type="checkbox"/> just right	<input type="checkbox"/> too hot	<input type="checkbox"/> cooking
		<input type="checkbox"/> too cold	<input type="checkbox"/> other: _____

4. The stress in my life can best be attributed to:

<input type="checkbox"/> equipment used	<input type="checkbox"/> surroundings	<input type="checkbox"/> job	<input type="checkbox"/> no stress
<input type="checkbox"/> after work activities	<input type="checkbox"/> commuting	<input type="checkbox"/> personal	<input type="checkbox"/> _____

5. I consider myself to be in good health:

yes no not sure

6. If "no" or "not sure" to the question above, indicate major health complaint below:

<input type="checkbox"/> headaches	<input type="checkbox"/> skin rash	<input type="checkbox"/> nausea
<input checked="" type="checkbox"/> allergies/sinus	<input type="checkbox"/> eye irritation	<input type="checkbox"/> respiratory irritation
<input type="checkbox"/> sore throat	<input type="checkbox"/> fatigue	<input type="checkbox"/> _____

7. If you suffer from any symptoms above more than you consider to be normal, how often do they occur?

daily several times/week seasonal less frequently

8. When do the symptoms appear to "go away"?

<input type="checkbox"/> no symptoms	<input type="checkbox"/> vacations	<input type="checkbox"/> upon leaving work	<input type="checkbox"/> never
<input type="checkbox"/> after allergy season	<input checked="" type="checkbox"/> weekends/holidays	<input type="checkbox"/> upon leaving home	
<input type="checkbox"/> other: _____			

9. How often do you leave the building during a typical day?

once 2-3 times more often never

10. Do you smoke? no yes Amount/frequency: _____

11. Are you bothered by tobacco smoke while at work or at home? no yes Amount/frequency: _____

12. What office equipment do you use at work and/or home? copier computer blueprint machine laser printer other: _____

13. Is there anything you feel has a detrimental effect on your comfort while at work and/or home? _____

14. I am sensitive to the following: cats dogs pollen ragweed dust mold food allergies tobacco smoke perfumes other: _____

15. Have you ever been diagnosed with allergies? yes no
If so, what allergies? dogs cats birds dust hay fever mold fungus ragweed red cedar other: _____
Who is your Doctor? _____ When were you diagnosed? _____
Do you take medications for allergies? yes no
If so, what medications and for how long? _____
Do you take anything specifically to relieve symptoms experienced in the building? _____

16. Do you have pets? dog cat bird reptile other: _____

17. What kind of symptoms or discomfort are you experiencing? _____

18. Are you aware of other people with similar symptoms? yes no

19. Do you have any health conditions that may make you particularly susceptible to environmental problems? contact lenses chronic cardio-vascular disease undergoing chemotherapy allergies chronic respiratory disease suppressed immune system pregnancy medication: _____ other: _____

20. What kind of household and/or school related chemicals are in your residence? air fresheners potpourri incense photo chemicals candles detergents bleach hair spray perfume/cologne deodorant cosmetics paints solvents contact lens items drain cleaner gasoline/oil cleansers deodorizers other: _____
Have you or anyone persons sharing your residence recently switched brands of any the chemicals or products listed above? no yes If so, what: _____

21. Timing Patterns

a. When was the first occurrence of your symptoms? _____

b. When do your symptoms occur?

morning

afternoon

all day

no noticeable trend

daily

specific days of the week {M T W T F S S }

c. When are they generally worst? _____

d. Are you relieved of these symptoms? If so, when? _____

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

22. Where are you when you experience symptoms or discomfort? _____

23. Have you observed any conditions or occurrences that may explain your symptoms? If so, please describe them? _____

24. What do you believe to be the cause of your symptoms? _____

25. Other information: _____
