HEALTH COMPLAINT FORM

SCHOOL: ____
NAME: ___________________________________ CLASS: ________ DATE: _________________

1. What symptoms did you experience today?

headache	dry, itchy eyes	inability to concentrate
nausea	sore throat	dizziness
runny nose	tiredness, sleepiness	difficulty breathing
rash or hives	other (describe below)	

____
____
____

2. At what time did these symptoms appear? ____

3. In what location did these symptoms appear? ____

4. Did these symptoms remain for the rest of the day? __ yes __ no
If not, when did they disappear? ____

5. Can you explain what might have caused these symptoms?
(Example: cold, flu, someone wearing perfume, etc.)
____
____

6. Were these symptoms severe enough to send you home for the rest of the day?
__ yes __ no

7. Did you have to take medication to help you? __ yes __ no

8. Have you ever experienced this symptom before in this building? __ yes ___ no
If yes, how often?_____comments:____

9. Did you smell any odor when your symptoms started? __ yes ___ no. If yes, describe the odor.
____
____

Additional comments:
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References:

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