OCCUPANT QUESTIONNAIRE - PRIVATE

Building Name	
Address	
Date	

SYMPTOMS

1. Please indicate any of the following symptoms you are experiencing by circling the frequency.

dry, burning or itching eyes	daily	often	occasional
fatigue or tiredness	daily	often	occasional
blurred vision	daily	often	occasional
dark circles under eyes	daily	often	occasional
runny nose	daily	often	occasional
sinus congestion	daily	often	occasional
sneezing	daily	often	occasional
nosebleeds	daily	often	occasional
sore throat	daily	often	occasional
hoarseness	daily	often	occasional
dry throat	daily	often	occasional
coughing	daily	often	occasional
shortness of breath	daily	often	occasional
wheezing	daily	often	occasional
chest tightness	daily	often	occasional
rash or hives	daily	often	occasional
headaches	daily	often	occasional
difficulty concentrating	daily	often	occasional

dizziness	daily	often	occasional
irritable	daily	often	occasional
aggressive behaviour	daily	often	occasional
hyperactivity	daily	often	occasional
muscle aches	daily	often	occasional
heart palpitations/racing heart beat	daily	often	occasional
too hot	daily	often	occasional
too cold	daily	often	occasional

2. List the three most severe symptoms that you experience.
_____
_____
_____

TIMING PATTERN

3. Please check when you experience these symptoms.
_____ morning
_____ afternoon
_____ all day
_____ only during week days
_____ only on weekends
_____ holidays
_____ no noticeable pattern

Comments?:_____

4. When do your symptoms disappear?
_____
_____

LOCATION

5. Please check where you experience these symptoms.
_____ classroom (please identify _____)
_____ library
_____ cafeteria
_____ office area
_____ gymnasium
_____ lab areas (please identify _____)

_____ playground
_____ on the bus
_____ at home
_____ other buildings

6. If these symptoms are different at home and at school, please explain the difference.

_____
_____
_____
_____
_____
_____

MEDICAL HISTORY

7. Do you smoke? ___ yes ___ no

8. Have you been diagnosed with asthma? ___ yes ___ no

9. In the last three months, has your asthma worsened? ___ yes ___ no

10. Have you been diagnosed with allergies? yes ___ no __

11. In the last three months, have your allergies worsened? ___ yes ___ no

S. Moser
CASLE (Canadians for A Safe Learning Environment)
287 Lacewood Drive, Unit 103, Suite 178
Halifax, Nova Scotia, Canada, B3M 3Y7

References:

Schmidt Etkin, Dagmar, Dr. (1996). Indoor Air Quality in Schools. Cutter Information Corp. Arlington, MA.
Indoor Air Quality Tools for Schools Action Kit.(1995). US EPA, Washington, DC.
White, Curtis. Aegis Environments. (1999). Midland, MI.