SEVEN OAKS SCHOOL DIVISION
community begins here

WORKPLACE SAFETY AND HEALTH

INDOOR AIR QUALITY QUESTIONNAIRE

EMPLOYEE'S NAME: _____

LOCATION: _____ **DATE:** _____

Check all symptoms or discomforts you are experiencing

Headache	☐	Coughing	☐
Nausea	☐	Sneezing	☐
Dizziness	☐	Wheezing	☐
Tiredness/Fatigue	☐	Shortness of Breath	☐
Irritation of eyes, nose, throat	☐	Blurred Vision	☐
Breathing Problems	☐	Sinus Congestion	☐

Which specific area/areas within your work location are symptoms more noticeable?

_____

Have there been any changes within this area recently? (renovations, equipment, products)

_____

How long have you been experiencing the symptoms?

_____

On average, how long are you at work when you notice the symptoms?

_____

Do the symptoms occur only at work and disappear when you go home?

_____

When do the symptoms go away?

_____

Are there other individuals within your work location with similar concerns/symptoms?

_____

Voluntary Question:

Have you seen a doctor for your symptoms? Did they give you any feedback that may help us relate the cause?

_____

_____

Employee Signature