Appalachian State University

AIR QUALITY OCCUPANT SURVEY

Building Name and Location:	Building Area(s) Affected:	
Department/Area:	Occupant Name (optional):	Today's Date:

CONCERNS

	Seasonal Concern					*Noted Time Of Day*							*Comments*
	No Concern	Summer	Fall	Winter	Spring	No Trend	Morning	Afternoon	Evening	Nights	First Day of Week	All Day	Other important information, e.g. *description of odor or dust*, day of week, weather, temperature, trends, etc.
Too Cold													
Too Hot													
Lack of circulation													
Noticeable Odors													
Visible Dust in Air													
Disturbing Noise													
Other:													

SYMPTOMS

	First Noted					*Comments*
Check Applicable Symptoms	Last 6 Months	Last 6 - 12 Months	More than 1 Year ago	More than 2 Years ago	Clears within 1 hour of leaving work	Other important information that should be considered, e.g. known health concerns, family history, home issues, etc. which might account for the symptoms *Known Allergies (circle) YES NO*
None Noted						
Wheezing						
Cough						
Dry Throat						
Runny Nose						
Dry Nose						
Dry Eyes						
Stuffy Nose						
Fatigue						
Headache						
Sneezing						

MEDICATIONS

Please describe any medications you are presently taking and specify the reason

(NOTE: all personal information is kept ***confidential*** *unless you specifically authorize its release)*

OTHER

Please check mark appropriate boxes

Medical Attention	
I have seen a physician due to noted health concerns	I am currently in treatment for noted health concerns

Main Job Function				
Faculty/Instructor	Maintenance/ Custodial	Health Services	Administrative	Other:

Health	
I smoke	I Wear Contacts

Gloves Worn			
Powdered latex	Non-powdered latex	Vinyl	Other:

Status	
Full Time	Part Time