### 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 |
|---|---|---|---|
| ☐ normal | ☐ too dry | ☐ just right | ☐ none |
| ☐ too loud | ☐ too humid | ☐ OK most of the time | ☐ smoking |
| ☐ too quiet | ☐ just right | ☐ too hot | ☐ cooking |
| | | ☐ too cold | ☐ other: ____________ |

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

| Noise | Humidity | Temperature | Odors |
|---|---|---|---|
| ☐ normal | ☐ too dry | ☐ just right | ☐ none |
| ☐ too loud | ☐ too humid | ☐ OK most of the time | ☐ smoking |
| ☐ too quiet | ☐ just right | ☐ too hot | ☐ cooking |
| | | ☐ too cold | ☐ other: ____________ |

4. The stress in my life can best be attributed to:
   ☐ equipment used ☐ surroundings ☐ job ☐ no stress
   ☐ after work activities ☐ commuting ☐ personal ☐ ________

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:
   ☐ headaches ☐ skin rash ☐ nausea
   ☐ allergies/sinus ☐ eye irritation ☐ respiratory irritation
   ☐ sore throat ☐ fatigue ☐ ____________

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"?
   ☐ no symptoms ☐ vacations ☐ upon leaving work ☐ never
   ☐ after allergy season ☐ weekends/holidays ☐ upon leaving home
   ☐ 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? ______________________

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25. Other information: ______________________

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