University of Louisville
Department of Environmental Health & Safety

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INDOOR AIR QUALITY REQUEST FORM AND QUESTIONNAIRE

Instructions:

- Answer all questions or indicate if the question does not apply to your situation. Provide as much information as you feel necessary to adequately describe your indoor air quality situation.
- After completing this form, forward the information via email to dehsih@louisville.edu and title the email as "IAQ request". (Preferred) or fax to 852-0880 or send by interoffice mail to DEHS.

Your Name: ***(Optional)*** _____ **Date:**_____

Job Title: _____

Department: _____ **Building & Floor #:** _____

Room Number:_____ **Phone***:*_____ **Email***:*_____

1. **Briefly describe your air quality concerns including the specific location(s) of the concern:**

2. **Indicate if you frequently have any of the following complaints concerning the indoor air quality at your building.** *(circle all that apply)*

Dusty	Too hot
Noisy	Too cold
Stuffy Air	Too dry
Moldy or musty odors	Too humid
Visible mold	Drafty
Other odors (please describe)_____	Stuffy Air
Vibration	Crowded work area
Other _____	

3. **When did these problems begin and when do they occur?**
   - ❖ Month/year when problem began:_____
   - ❖ What time of day do you experience the problem? *(circle one)* morning / afternoon / all day
   - ❖ Are there specific day(s) of the week that you experience the problem?

(circle all that apply) Monday / Tuesday / Wednesday / Thursday / Friday / Saturday / Sunday

- ❖ Is there a specific time of year that you experience the problem?
  Specify when:_____
- ❖ If there is no noticeable trend to the times that you experience the problem, check here:_____

4. **What health symptoms have you experienced?** Check any symptoms you are experiencing in your building.

Symptom	Occasionally	Frequently	Not related to building	Appears after arrival	Increases after arrival
Difficulty in concentrating					
Dry or sore throat					
Aching joints					
Muscle twitching					
Back pain					
Hearing problems					
Dizziness					
Headache					
Dry, flaking skin					
Discolored skin					
Skin irritation					
Itching					
Heartburn					
Nausea					
Noticeable odors					
Sinus congestion					
Sneezing					
Wheezing					
High stress levels					
Chest tightness					
Eye irritation					
Fainting					
Hyperventilation, shortness of breath					
Problems with contacts					
Fatigue/drowsiness					
Temperature too hot					
Temperature too cold					
Other (specify)					

- ❖ Do these symptoms clear up within 1-2 hours after leaving work? Yes / No
  If no, do they clear up overnight? Yes / No
  If no, do they clear up over the weekend? Yes / No
  If no, do they clear up after vacation? Yes / No

- ❖ If all symptoms do not clear up when away from the building, which symptoms persist when away from your workplace throughout the week? _____

- ❖ Have you sought medical attention for your symptoms? Yes / No
  If yes, please describe: _____

- ❖ Do you have any allergies or other health problems that may account for any of the listed health symptoms? Yes / No If yes, please describe: _____

  _____

- ❖ Have any of your symptoms reduced your ability to work, caused you to stay home from work Or caused you to leave work early? Yes / No
  If Yes, please explain: _____

- ❖ How many hours per day do you typically spend in this building? _____

- ❖ How many hours per day are you at your workstation? _____

- ❖ Do any of your co-workers have similar symptoms of which you are aware? Yes / No

5. **Indicate if any of the following apply to you.** *(circle all that apply)*

   Wear contact lenses

   Operate video display or computer terminals How many hours per day?_____

   Operate photocopier machines at least 10% of the work day

   Operate other office machines or equipment List: _____

   Use any chemical substances such as cleaners, white out, etc.

6. **Have there been any renovation/demolition-related activities occurring in or near your work area within the past week?** (i.e., new carpeting, painting, new office furniture, HVAC work, etc.) Yes / No
   Yes / No If Yes, Please list: _____

7. **Has there been any evidence of water leaks or visible signs of moisture in and around your area?**
   Yes / No If Yes, Please describe: _____

8. **Is your office near a laboratory?**
   Yes / No If Yes, Please describe: _____

9. **Briefly describe your primary job tasks:**

Do any of these tasks produce dust or odor or use toxic substances? Yes / No
If Yes, please list or describe: _____

Yes / No If Yes, Please describe: _____

10. **Do you have an idea as to what is the cause of symptoms in your workplace?** Yes / No
If Yes, Please describe: _____

11. **Can you offer any other comments or observations that may be helpful in determining the environmental condition within your workplace?**

In addition to this form, you may also want to maintain a daily log as found at
https://louisville.edu/dehs/ohs/indoor-air-quality

Thank you for completing this form.
We will use your information to assist with investigating symptoms in your workplace.