OCCUPANT INTERVIEW FORM

Location:_____

Occupant name:_____

Date:_____

SYMPTOMS

What kind of symptoms or discomfort are you experiencing?

Are you aware of other people with similar symptoms or concerns? Yes___ No___

If so, what are their names and locations?_____

Do you have any health conditions that make you particularly susceptible to environmental problems?

___Wear contact lenses ___Chronic respiratory problems

___ Allergies ___ Immune system suppressed

TIMING PATTERNS

When did your symptoms start?

Do they go away? If so, when?

Have you noticed any other events (such as weather events, temperature or humidity changes, or activities in the building) that tend to occur around the same time as your symptoms?

SPATIAL PATTERNS

Where are you when you experience symptoms or discomfort?

Where do you spend most of your time in the building/office/lab?

ADDITIONAL INFORMATION

Do you have any observation about building conditions that might need attention or might help explain your symptoms (e.g., temperature, humidity, drafts, stagnant air, odors)?

Have you sought medical attention for your symptoms?