

Occupant Interview

9.2.24

School/Facility: _____
Occupant Name: _____
Completed By: _____

Date: _____
Work Location: _____
Title: _____

Symptom Patterns

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 may make you particularly susceptible to environmental problems?

- | | |
|---|---|
| <input type="checkbox"/> contact lenses | <input type="checkbox"/> chronic neurological problems |
| <input type="checkbox"/> allergies _____ | <input type="checkbox"/> undergoing chemotherapy or radiation therapy |
| <input type="checkbox"/> chronic cardiovascular disease | <input type="checkbox"/> suppressed immune system |
| <input type="checkbox"/> chronic respiratory disease | |

Timing Patterns

When did your symptoms start?

When are they generally worse?

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?

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Spatial Patterns

Where are you when you experience symptoms or discomfort?

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

Additional Information

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

Have you sought medical attention for your symptoms?

Do you have any other comments?

Please read the interview answers back to the interviewee.