Occupyant Information

Occupant Name: ____________________________ Phone Number: ____________________________
Building Name: ____________________________ Email Address: ____________________________
Room Number: ____________________________ Date: ____________________________

Symptom Patterns

What kind of symptom/discomfort or concerns are/did you experience?
Are you aware of other people with similar symptoms or concerns?
   Yes ☐ No ☐
   If so, what are their name(s) and contact information?
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

Timing Patterns

When did your symptoms start?
When are they generally worst? Day of week? ____________________________ Time of day? ____________________________
Do symptoms go away? Yes ☐ No ☐ 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?
Do you have any allergies that you are willing to share?
Do you wear contact lenses? Yes ☐ No ☐
Do the symptoms coincide with activities, events, seasons?
Has there been any activities that you feel may have contributed to the symptoms (such as construction, mowing, change in building/office use, cleaning, increase/decrease in occupancy)?
   ________________________________________________________________
   ________________________________________________________________
Special 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 (i.e. temperature, humidity, drafts, stagnant air, odors, etc.)? __________________________________________
Have you sought medical attention for your symptoms? Yes ☐ No ☐
What do you think is the source or cause of your symptoms? __________________________________________
Do you have any other comments? __________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________