



OCCUPANT INTERVIEW

Building Name: _____ Reference Number: _____

Address: _____

Occupant Name: _____ Work Location: _____

Completed by: _____ Title: _____ Date: _____

SYMPTOM PATTERNS

What kind of symptoms or discomforts 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?

- | | | |
|--|---|--|
| ☐ contact lenses | ☐ chronic cardiovascular disease | ☐ chronic respiratory disease |
| ☐ undergoing chemotherapy or radiation therapy | ☐ chronic neurological problems | |
| ☐ immune system suppressed by disease or other causes | ☐ allergies | |

TIMING PATTERNS

When did your symptoms start? _____

When are they generally worst? _____

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?

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, or odors)?

Have you sought medical attention for your symptoms?

Do you have any other comments?