TENNESSEE TECHNOLOGICAL UNIVERSITY
BUILDING CONDITION

Name: _____ Title: _____
Today's Date: _____
Primary location in the building: _____ Phone: _____
Date started in building: _____ At current location since: _____
Equipment used regularly in job: _____

1. Do any of the following apply to you? If so, please describe (attach additional sheets if needed):

   (a) History of allergies: _____
   (b) History of respiratory diseases: _____
   (c) Other pre-existing health conditions causing increased sensitivity to environmental pollution: _____
   (d) Wear contact lenses? _____ If yes, for how long? _____
   (e) Eye strain at work? (If yes, explain) _____

2. Check the best answers in this section as they apply **only to the main symptoms** you have experienced that you feel may be related to the building. Include **only those symptoms that generally occur at the same time.** Other symptoms should be noted in question #3 below.

	(a) Symptom	Date Started	Relief Overnight	Relief During Vacation	Never Clears Up
	Back Pain				
	Chest Tightness				
	Congestion				
	Coughing				
	Dizziness				
	Dry Mouth				
	Eye Irritation				
	Fatigue				
	Fever				
	Headache				
	Hearing Loss				
	Heartburn				
	Hoarseness				
	Itching				
	Muscle Aches				
	Nausea				
	Nose Irritation				
	Runny Nose				
	Sinus Problems				
	Skin Rash				
	Sneezing				
	Swelling				
	Throat Irritation				
	(other):				

2. (continued)

(b) Symptoms occur (circle the best answer)
- (i) almost every day when in the building
- (ii) about half the time
- (iii) several days per month
- (iv) infrequently
- (v) other

(c) When are symptoms generally worst? (circle best answers)

DAILY	WEEKLY	YEARLY
morning	beginning	spring
afternoon	middle	summer
all day	end	fall
no pattern	all week	winter
	no pattern	all year
		no pattern

(d) Worst events may be associated with:
- (i) Odors (describe): _____
- (ii) Dust (describe): _____
- (iii) Activity/Event (describe): _____
- (iv) Weather (describe): _____
- (v) Specific Dates: _____

(e) Was a physician consulted? (circle answer) YES NO
If Yes, what was the physician's opinion regarding the symptoms?
- (i) Not building-related (describe diagnosis) _____
- (ii) Building-related (describe diagnosis) _____
- (iii) Not Sure

(f) Further comments on main symptoms:

3. Describe other symptoms that you believe may also be related to the building but, do not always occur at the same time as the symptoms mentioned in question #2.

4. Circle any complaints you have about building conditions:

Odors	Poor Ventilation	Tobacco Smoke	Too Hot
Noise	Poor Lighting	Dust	Too Cold
Other (describe)			