

---

# Occupant Interview

Building Name: \_\_\_\_\_ File Number: \_\_\_\_\_

Address: \_\_\_\_\_

Occupant Name: \_\_\_\_\_ Work Location: \_\_\_\_\_

Completed by: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Sections 4 discusses collecting and interpreting information from occupants.

## **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 cardiovascular disease | <input type="checkbox"/> undergoing chemotherapy or radiation therapy        |
| <input type="checkbox"/> allergies      | <input type="checkbox"/> chronic respiratory disease    | <input type="checkbox"/> immune system suppressed by disease or other causes |
|   | <input type="checkbox"/> chronic neurological problems  |  |

## **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?