A Union of Professionals

Indoor Air Quality Survey

How is your health at work? Please indicate which of the following symptoms you experience at work, as well as the frequency of their occurrence?

	Frequency of Occurrence		
	Never	**Once a week or less**	**More than once a week**
Dry skin/skin irritation?			
Eye irritation?			
Headache?			
Fatigue?			
Drowsiness?			
Sinus congestion/infection?			
Throat irritation?			
Runny Nose?			
Chest tightness/wheezing?			
Allergies?			
Difficulty breathing?			

Have you been diagnosed by a healthcare provider with any of the following since beginning work at your present facility? (Check all that apply)

	Yes	**Dates**	**No**
Asthma			
Chronic bronchitis			
Chronic sinusitis or sinus infection			
Allergies			
Other illness you associate with your workplace			