INDOOR CLIMATE

Work environment - Office

ENGLISH VERSION

MM 040 NA Office

Date

1-6 year month day |__|__|__|__|__|__|

Company/Institution (important information)

7-11 Group |__|__|__|__|__|

12-21 Place of work |__|__|__|__|__| Dept. |__|__|__|__|__|

Filled in by investigator

Department (important information)

Occupation

This questionnaire concerns your indoor climate at your place of work and possible symptoms you may be experiencing.

BACKGROUND FACTORS

22-26 The work place is located at floor |__|__| House number |__|__|__|

27 Type of work place: own room ☐1 shared room ☐2 office landscape ☐3 other ☐4

28 Type of work: mostly at the office ☐1 assignment outside the office more than 2 d/w ☐2

29-32 For how long time have you been at your present work place? Since year |__|__|__|__| (e.g. 1998)

33 Position: supervisor/head ☐1 other ☐2

34 Post: permanently employed ☐1 deputy ☐2 project employed ☐3 other ☐4

35 Working-hours: full-time (at least 30 h/w) ☐1 part-time ☐2

36 Overtime work: seldom ☐1 less than 20 h/month ☐2 more than 20 h/month ☐3

WORK ENVIRONMENT

Have you been **bothered** during **the last three months** by any of the following factors **at your work place**? (Answer every question even if you have not been bothered!)

		Yes, often (every week) (1)	Yes, sometimes (2)	No, never (3)
37	Draught	☐	☐	☐
38	Room temperature too high	☐	☐	☐
39	Varying room temperature	☐	☐	☐
40	Room temperature too low	☐	☐	☐
41	Stuffy "bad" air	☐	☐	☐
42	Dry air	☐	☐	☐
43	Unpleasant odour	☐	☐	☐
44	Static electricity, often causing shocks	☐	☐	☐
45	Passive smoking	☐	☐	☐
46	Noise	☐	☐	☐
47	Light that is dim or causes glare and/or reflections	☐	☐	☐
48	Dust and dirt	☐	☐	☐

75-80

Andersson K. Epidemiological approach to indoor air problems. Indoor Air 1998;suppl 4:32-9.
Dept of Occup and Environm Med, Örebro University Hospital, Sweden.

Please turn

WORK CONDITIONS

		Yes, often (1)	Yes, sometimes (2)	No, seldom (3)	No, never (4)
1	Do you regard your work as interesting and stimulating?	☐	☐	☐	☐
2	Do you have too much work to do?	☐	☐	☐	☐
3	Do you have any opportunity to influence your working conditions?	☐	☐	☐	☐
4	Do your fellow-workers help you with problems you may have in your work?	☐	☐	☐	☐
5	Are you worried that your work situation will change?	☐	☐	☐	☐

PRESENT SYMPTOMS

During the **last three months**, have you had any of the following symptoms?
(Answer every question even if you have not had any symptoms!)

					If Yes, do you believe that it is due to your work environment?		
		Yes, often (every week) (1)	Yes, sometimes (2)	No, never (3)	Yes (1)	No (2)	Don´t know (3)
6-7	Fatigue	☐	☐	☐	☐	☐	☐
8-9	Feeling heavy-headed	☐	☐	☐	☐	☐	☐
10-11	Headache	☐	☐	☐	☐	☐	☐
12-13	Nausea/dizziness	☐	☐	☐	☐	☐	☐
14-15	Difficulties concentrating	☐	☐	☐	☐	☐	☐
16-17	Itching, burning or irritation of the eyes	☐	☐	☐	☐	☐	☐
18-19	Irritated, stuffy or runny nose	☐	☐	☐	☐	☐	☐
20-21	Nose-bleeding	☐	☐	☐	☐	☐	☐
22-23	Hoarse, dry throat	☐	☐	☐	☐	☐	☐
24-25	Cough	☐	☐	☐	☐	☐	☐
26-27	Dry or flushed facial skin	☐	☐	☐	☐	☐	☐
28-29	Scaling/itching scalp or ears	☐	☐	☐	☐	☐	☐
30-31	Hand dry, itching, redskin	☐	☐	☐	☐	☐	☐
32-33	Suffering from stress	☐	☐	☐	☐	☐	☐
34-35	Easily irritated about small matters	☐	☐	☐	☐	☐	☐
36-37	Difficulties to sleep	☐	☐	☐	☐	☐	☐
38-39	Other .....….....	☐	☐	☐	☐	☐	☐

COMPLEMENTARY QUESTIONS

		Yes (1)	No (2)
1	Do you regard that the **physical work environment** has an influence on your possibilities to do good work?	☐	☐
2	Do you regard that the **psychosocial work environment** has an influence on your possibilities to do good work?	☐	☐
3	During the **last 12months** have you been on the sick-list because of symptoms you assign the work environment?	☐	☐
4	During the **last 12 months** have you been to the doctor because of symptoms you assign the work environment?	☐	☐

ABOUT TEMPERATURE CONDITIONS

		Very good (1)	Good (2)	Acceptable (3)	Bad (4)	Very bad (5)
5	What do you think about the **temperature** at the work place?	☐	☐	☐	☐	☐

6 **Problems** concerning the temperature:
7 (there can be more than one answer)

- 6 ☐ far too cold during the winter
- 7 ☐ far too cold other times
- 8 ☐ far too warm during the summer
- 9 ☐ far too warm other times

10 Are there rooms with temperature problems? Yes ☐1 No ☐2

If Yes, state what rooms: .....

CLEANING

		Very good (1)	Good (2)	Acceptable (3)	Bad (4)	Very bad (5)
11	What do you think about the **cleaning** at the work place?	☐	☐	☐	☐	☐

12 **Problems** concerning the cleaning:
13 (there can be more than one answer)

- 12 ☐ cleaning insufficient
- 13 ☐ cleaning badly executed
- 14 ☐ dust and dirt on lockers and the like
- 15 ☐ insufficient cleaning of the toilets

16 Do you regard your work place as easy to clean? Yes ☐1 No ☐2 Don't know ☐3

ABOUT NOISE

		Very good (1)	Good (2)	Acceptable (3)	Bad (4)	Very bad (5)
17	What do you think about the **noise situation** at the work place?	☐	☐	☐	☐	☐

18 **Problems** concerning noise:
19 (there can be more than one answer)

- 18 ☐ the ventilation is disturbing
- 19 ☐ noise from outside (traffic and the like)
- 20 ☐ bad acoustic
- 21 ☐ disturbance from other´s talk/telephone

Please turn

ABOUT AIR QUALITY

		Very good (1)	Good (2)	Acceptable (3)	Bad (4)	Very bad (5)
1	What do you think about **the air quality** at the work place?	☐	☐	☐	☐	☐

2 **Problems** with air quality:
(there can be more than one answer)

- ☐ worse early mornings
- ☐ worse in the afternoons
- ☐ different in different areas
- ☐ not possible to air out rooms/areas
- ☐ odours

If odours occur, specify what type and where from: ……

7 Are there rooms with bad air quality? Yes ☐1 No ☐2

If Yes, specify : .....

BACKGROUND INFORMATION

8-12 Year of birth: |___|___|___|___| (e.g. 1976) Sex: male ☐1 female ☐2

13 Do you smoke? yes ☐1 no ☐2

15 Education: nine-year school ☐1 upper secondary school ☐2 university/ college ☐3 other ☐4

16 How long do you work with computer/day? 0-2 h/day ☐1 2-4 h/day ☐2 more than 4 h/day ☐3

17 Do you use eye lenses? yes ☐1 no ☐2

18 How do you regard your work place? spacious ☐1 enough space ☐2 not enough space ☐3

				If Yes, during the last year?	
		Yes (1)	No (2)	Yes (1)	No (2)
19-20	Have you ever had asthmatic problems?	☐	☐	☐	☐
21-22	Have you ever suffered from hay fever?	☐	☐	☐	☐
23-24	Have you ever suffered from other allergic symptoms from eyes or nose?	☐	☐	☐	☐
25-26	Have you ever suffered from eczema?	☐	☐	☐	☐
27	Do you easy irritate in your eyes or respiratory airways from tobacco smoke, strong odours or exhausts?	☐	☐		
28	Do you often get colds or other infections?	☐	☐		

FURTHER COMMENTS

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THANK YOU!