INDOOR CLIMATE **Work environment - Office** **ENGLISH VERSION**	**MM 040 NA Office** Date year month day |___|___|___|___|___|___|	Name (voluntary information)
		Company/Institution (important information)
Group |___|___|___|___|___|		Department (important information)
Place of work |___|___|___|___|___| Dept. |___|___|___|___|___| Filled in by investigator		Occupation

1-6 7-11 12-21

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 ☐☐☐☐☐☐

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The questionnaire is free to use in research and non-commercial activities.

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!)

		Yes, often (every week) (1)	Yes, sometimes (2)	No, never (3)	**If Yes,** do you believe that it is due to your work environment? 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?	☐	☐	☐	☐	☐

Problems concerning the temperature:
(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?	☐	☐	☐	☐	☐

Problems concerning the cleaning:
(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?	☐	☐	☐	☐	☐

Problems concerning noise:
(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?	☐	☐	☐	☐	☐

2–6 **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

		Yes (1)	No (2)	**If Yes,** during the last year? 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!