

Patient Questionnaire Electrosensitivity

Name: _____ Date: _____ Age: _____

Address _____

a) List of Symptoms: How often have you experienced the following health problems in the last 30 days? Please mark the appropriate box in every line.

Symptoms	Never	Rarely	Sometimes	Often	Very Often	Since when? Month/Yr
Anxiety						/
Tightness Chest						/
Depression						/
Difficulty Concentration						/
Restlessness						/
Hyperactivity						/
Irritability						/
Exhaustion						/
Fatigue						/
Difficulty finding words						/
Forgetfulness						/
Headaches						/
Dizziness						/
Sleep Problems						/
Noise Sensitivity						/
Pressure in ears						/
Ear ringing						/
Burning eyes						/
Nervous bladder						/
Heart palpitations						/
Blood pressure						/
Muscle tension						/
Joint pain						/
Skin rashes						/
Other (write)						/
Other (write)						/

b) Variation of health problems depending on time and location

Which health problems do you perceive to be the most severe?	
Since when have you been experiencing these health problems?	
At what times of the day or week or month do the health problems appear?	
Is there a place where the health problems increase?	
Is there a place where the health problems increase or are particularly severe? (e.g. at home, work)	
Is there a place where the health problems recede or disappear altogether? (at work, home, vacation, friends house, parks)	
Do you have an explanation for these health problems?	
Are you experiencing stress, e.g. due to changes in your personal life?	
Please list any environmental assessments made, measurements made or any measures taken up to now.	
Please list any environmental medicine diagnosis and treatments given up to now.	

c) Assessment of EMF exposure at home and work

1) Do you use a cell phone at home or at work? _____
How long have you been using it? _____
How much do you use it to make calls per day? (hours/minutes) _____
Have you noticed any relation to your health problems? _____

2) Do you have a cordless phone (DECT base station) at home or at work? _____

How long have you had it? Months/years. _____
How much do you use it to make calls per day? _____
Have you noticed any relation to your health problems? _____

3) Do you use wireless internet access? (Wi Fi, WLAN, WiMax, UMTS) at home or at work? _____
How long have you been using it? Months/years. _____
How much do you use it per day? Hours/minutes _____
Have you noticed any relation to your health problems? _____

4) Do you use energy efficient light bulbs in your immediate vicinity? (desk lamp, dining table lamp, reading lamp, bedside lamp) at home or at work? _____

If yes, how long have you been using it? Months/years. _____
How much do you use it per day? Hours/minutes _____
Have you noticed any relation to your health problems? _____

5) Is there a cell tower near your home or your workplace? (specify) _____

If yes, how long has it been there? Months/years. _____
At what distance is it from your home? _____
Have you noticed any relation to your health problems? _____

6) Are there any power lines, transformer stations or railway lines near your home or your workplace? _____
If yes, for how long are you exposed to them per day? _____
Have you noticed any relation to your health problems? _____

7) Do you use Bluetooth in your car? _____
If yes, how long have you been using it? Months/years. _____
Have you noticed any relation to your health problems? _____

