Questionnaire to register health damage from high frequency electromagnetic fields

(Mobile phone transmitters, DECT, W-LAN, mobile handsets and others)

Name, First Name ....

Date of Birth ....

Occupation ....

Address ....

City / Post Code ....

Resident since ....

Telephone ....

1. Exposure to High Frequencies

1.1 Where are you or have you been exposed to electromagnetic fields?

At home ☐ at work ☐ other ☐ ....
How many hours per day do you spend on average in rooms exposed to high frequencies? ....

1.2 High frequency exposure at home

☐ Mobile phone transmitter Sites (road, town, post code)	Distance in meters:	since:
....	....	....
....	....	....
....	....	....
....	....	....
☐ TV or Radio transmitters	Distance in meters:	since: ......
☐ Point-to-point radio relay systems	Distance in meters:	since: ......
☐ Own cordless telephone (DECT) Manufacturer and type designation of DECT phone:	Position in house: .... Total duration of phone calls per day:	since:.......
☐ cordless phone (DECT) at neighbours	Position:	since: ......

☐ W-LAN (own)	Position:	since: ......
☐ W-LAN (at neigbours)	Position:	since: ......
☐ Mobile use	Total duration of phone calls per day:	since: ......

1.3 High frequency exposure at work or at school

☐ Mobile phone transmitter Sites (road, town, post code)	Distance in meters:	since: ....
☐ Radio or TV transmitter	Distance in meters:	since:.......
☐ Point-to-point radio relay systems	Distance in meters:	since: ......
☐ Cordless telephone (DECT) Manufacturer and type designation:	Position: .... Total duration of phone calls per day:	since: ......
☐ W-LAN	Position:	since:......
☐ Mobile use (own)	Total duration of phone calls per day:	since:.......
☐ Mobile use (Colleagues/fellow students)	☐ seldom ☐ often	since:.......

1.4

Have you had the electromagnetic fields measured? (if yes, please enclose copies of the measurement results)

No Yes, with the following results:

☐ ☐ ....

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2. Symptoms, Description of Illness, Progression of Illness

2.1 List of Symptoms

Symptoms *if possible, describe in more detail under 2.2	never	seldom	some-times	often	always	since ca.
1. Difficulty to fall asleep						
2. Frequent waking during the night						
3. Waking up tired, hung-over						
4. Chronic exhaustion						
5. Increased need for sleep						
6. Lethargy						
7. Listnessness						
8. Headaches						
9. Pressure in the head						
10. Drowsiness						
11. Nervousness						
12. Agitation						
13. Unwellness						
14. Hot flushes (cardio vascular problems)						
15. Chills (cardio vascular problems)						
16. Inner Trembling						
17. Inner Burning						
18. Irritability						
19. Aggressivity						
20. Depressive mood						
21. Feeling of helplessness						
22. Panic attacks						
23. Compulsive repetitive thoughts						
24. Lack of concentration						
25. Mistakes when writing						
26. Learning difficulties						
27. Forgetfulness						
28. Anomia (inability to find the right word)						
29. Speech defects						
30. Joint pain (which joints?)*						
31. Muscle pain (where?)*						
32. Neck pain						
33. Pain of the soft tissue (where?)*						
34. Nerve pain (where?)*						
35. Toothache						
36. Sinusitis						
37. Infections						
38. Changes of the voice						
39. Sore throat						
40. Swollen lymph nodes						
41. Slow healing of wounds						
42. Skin complaints (which?)*						
43. Burning of the skin						

Symptoms *if possible, describe in more detail under 2.2	never	seldom	some-times	often	always	since ca.
44. Prickling of the skin						
45. Numbness						
46. Itching						
47. Allergic reaction						
48. Tachycardia (Heart palpitations)						
49. Heart pains						
50. Arrythmia (which)*						
51. Spells of high blood pressure						
52. Permanent high blood pressure						
53. Shortness of breath						
54. Episodes of collapse						
55. Dizziness						
56. Disturbance of Equilibrium						
57. Ringing in the Ears (Tinnitus)						
58. Noise in the Head						
59. (Acute) loss of hearing						
60. Noise sensitivity						
61. Eye pain						
62. Swollen Eyes						
63. Rings under the Eyes						
64. Impaired vision						
65. Inflammation of the eyes						
66. Dry eyes						
67. Nosebleeds (when)*						
68. Sensitivity to smell						
69. Thyroid problems (which)*						
70. Hormonal disturbances (which)*						
71. Hair loss						
72. Growth disturbances						
73. Loss of libido						
74. Weight gain						
75. Weight loss						
76. Loss of appetite						
77. Nausea						
78. Diarrhoea						
79. Unusual feelings of hunger						
80. Increased thirst						
81. Sweating (at night)						
82. Frequent urinating (at night)						
83. Bedwetting						
84. Teeth grinding (at night)						
85.						
86.						

2.2 Comments and further descriptions of the symptoms.

Symptom-Nr. / Symptom	Comment
....	....
....	....
....	....
....	....
....	....
....	....
....	....
....	....

Please describe in your own words how and when the symptoms started, in which order they occurred and how exactly they manifest (especially with regards to impaired vision, headaches, noise in the head, skin disorders, pain in the extremities, joints, nerves and soft tissues as well as sensitivity disturbances).

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2.3
Where are you experiencing your symptoms strongest?

At home ☐ at work ☐ other ☐ ....

2.4
Do your symptoms change when you change location (in the forest, in valleys with low signal strength, overnight stays away from home, etc.)

No ☐ Yes, where and how do changes occur? ☐ ....

....

2.5
If your symptoms mainly occur at home: Do you try to reduce your exposure by staying in other places as often as possible?

No Yes, where do you go?

☐ ☐ ....

....

2.6
Have you changed the location where you sleep?

No Yes, when, where to and to what effect?

☐ ☐ ....

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2.7
Have you installed shielding to lower your high frequency exposure?

☐ No, because ....

☐ Yes, which ....

....

2.8
Did the shielding lead to a reduction or disappearance of your symptoms?

No Yes, for which symptoms?

☐ ☐ ....

....

☐ Temporarily?

2.9
Do you limit your stay in the exposed rooms or have you moved away?

☐ No, because ....

☐ Yes, where ....

When? ....

3. Diagnostics

3.1
Which doctors did you consult? (Please give name, address and specialism if known)

....

....

....

....

....

How often? ....

3.2
Which test and examinations have been conducted?
Blood, urine, X-ray, Cat scan, EEG, cardio-vascular etc.
(Please enclose copies of your results)

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3.3
Which diagnosis was found?

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3.4
Which medication have you been prescribed for your symptoms?

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3.5
Have you been recommended or undergoing psychotherapy, cognitive behavioural therapy or any other psychosomatic therapy?

No	Yes	undergone	where
☐	☐	☐	....

3.6
Are you exposed to metal such as mercury, gold, palladium, titanium, lead, aluminium etc.
e.g. in the mouth, in the body or by occupational exposure?

No Yes, which and what kind of exposure?

☐ ☐ ....

3.7
Do you have dental mercury fillings?

No Yes, how many?

☐ ☐ ....

3.8
Have you had dental mercury fillings removed?

No Yes, when, how many?

☐ ☐ ....

3.9
Did you attempt to actively eliminate the mercury from your system?

No Yes, by which method?

☐ ☐ ....

3.10

Are you exposed to chemical pollutants (from the environment, within a building, occupational exposure, chemotherapy)?

No Yes, which kind, (measurements, test results)?

☐ ☐ ....

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3.11
Do you have allergies

No Yes, since when, which (test results)?

☐ ☐ ....

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4. Further Questions

4.1
When and how did you first learn of that high frequency electromagnetic fields can potentially be harmful to health?

Press ☐ Television ☐ other ☐ ....

4.2
Did other people also notice your symptoms?

No ☐ Yes, who and which symptoms? ☐ ....

....

4.3
Have other members of your family also developed symptoms?

No ☐ Yes, which symptoms? ☐ ....

....

4.4
Do other residents in your building or neighbours also suffer from similar symptoms?

No ☐ Yes, who? ☐ ....

....

4.5
Do colleagues/fellow students also suffer from similar symptoms?

No ☐ Yes, who? ☐ ....

....

4.6
Did you observe changes in animals or plants?

No ☐ Yes, which? ☐ ....

....

4.7
Did you change something in your house during the last few years? (e.g. decorating, painting, installing wood, new furniture, new carpets)

No ☐ Yes, please specify ☐ ....

....

4.8
Did something change in your residential neighbourhood during the past few years? (e.g. new buildings, arrival of a new industrial estate or unit, an agricultural business, new roads etc)

No Yes, please specify

☐ ☐ ....

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4.9
Did something change in your work environment during the past few years? (e.g. office renovation, redecoration, new equipment etc)

No Yes, please specify

☐ ☐ ....

....

4.10
Do you live in the vicinity of a waste incineration plant, a chemical plant or nuclear plant?

No Yes, please specify the kind of installation

☐ ☐ ....

5. Contact with Authorities

5.1
Did you contact any official authorities with regard to your health damage (e.g. local authority, your MP, local health authority, Health Protection Agency) or did you contact the mobile operators? (If you have any correspondence, please enclose copies of it)

No Yes, who did you correspond with and when?

☐ ☐ ....

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5.2
Are you intending or in the process to start a civil lawsuit with regard to your health damage? (If correspondence exists, please enclose copies)

No Yes, at which tribunal and when?

☐ ☐ ....

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6. Personal Data

Size	.... cm
Weight	.... kg
Smoker	No ☐ Yes, how many cigarettes per day? ☐ ....
Alcohol	never ☐ sometimes ☐ often ☐

Current blood pressure readings ....

If you have long term records, please enclose copies of them.

Prior illness, surgery and regular medication:

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Are you under great stress (privately or at work)?:

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....

(Place, Date) (Signature)

Data Use Declaration

I, ...
(First name and surname)

declare that I authorise the private medical case registry and the doctors and scientists involved in the statistical documentation and interpretation of these data to use my data

anonymously in conjunction with my name
☐ ☐ (please tick your choice)

to analyse my high frequency illness and to pass my data on to relevant bodies and authorities.

.... (Place, Date)

.... (Signature)

Declaration to Authorise the Release of Confidential Medical Information

Declaration (for the physician in charge)

I ....

Release the medical practitioners named below from their duty of confidentiality and authorise them to release my medical records to any investigating law enforcement agency:

....

....

....

....

....

....

Name and address of the doctor(s)

....

(Place, Date) (Signature)