EMF Medical History Data Entry Form

for data collection of symptomology of microwave syndrome or electrosensitivity.

Name/code: ……. Age: …….. Sex: m O f O

1. Mobile phone usage

Continuous operation (switched on throughout the day 24 h)	O
Temporarily (only during the day approx. 12h)	O
Switched on only for conversation	O
Mobile phone switched on in the bedroom at night	O
Amount of daily conversation more than 60 minutes	O
Amount of daily conversation more than 30 minutes	O
Amount of daily conversation more than 10 minutes	O
Amount of daily conversation less than 5 minutes	O

2. Dwelling

Timber building	O
House built of mineral building materials, e.g. bricks	O
House built of concrete slabs	O
House containing lots of metal	O
Reinforced concrete house	O

3. Electricity in the dwelling

Cordless telephone DECT-standard	O
Cordless telephone CT-standard	O
Computer	O
W-Lan (Wireless Lan for Internet)	O
Television	O
Satellite reception / DVB-T reception	O O
Electric heating	O
Low energy lighting (halogen bulbs)	O

Other electrical devices: ……
……

Bedroom furnishings

Wooden bed	O
Metal bed	O
Wooden bed frame	O
Metal bed frame	O
Bed frame wood-metal combined	O

Flooring

Wood	O
Cork	O
Linoleum	O

PVC/synthetic material	O
Tiles, stoneware	O
Carpet made of natural materials	O
Synthetic carpet	O

Electricity in the bedroom - which devices?

Radio -, alarm clock with mains operation	O
Electric blanket	O
Waterbed	O
Electric heating	O
Bed frame adjustable with electric motors	O
Base station for cordless telephone	O
Television / Satellite / DVBT	O O O
Socket/switch – distance from top of bed	O

Other devices: .....
.....

Transmitters (known)

Distance from dwelling	less than 100m	less than 400	over 400
	O	O	O
One			O
Several			O

Which? GSM O UMTS O DVB-T/DAB-T O WLAN O

How long have you lived in this dwelling? .....
How long has the transmitter been active? .....…

4. Workplace

Computer	O
EMF induced workplace	O
No electricity	O

5. Symptoms of microwave syndrome / electrosensitivity

In the last 4-8 weeks do you suffer from:	never	occasionally	permanently
Sleep disturbances	O	O	O
Exhaustion	O	O	O
Faintness	O	O	O
Listlessness	O	O	O
Feelings of fatigue	O	O	O
Headache	O	O	O
Loss of concentration	O	O	O
Dizziness	O	O	O
Spontaneous irritability	O	O	O
Agitation when under demand	O	O	O
Performance loss during the second half of the day	O	O	O
Heart pain	O	O	O

Unclear stomach complaints		O	O	O
Decreased performance		O	O	O
Physically		O	O	O
Mentally		O	O	O
Pain	Back	O	O	O
	Shoulders	O	O	O
	Neck	O	O	O
Tiredness during the day		O	O	O
Nerve exhaustion		O	O	O
Depressive tendency		O	O	O
Thyroid gland disorder		O	O	O
Virility disturbances		O	O	O
Libido disturbances		O	O	O
Decelerated sensory activity		O	O	O
Decelerated motor activity		O	O	O
Increased susceptibility to infection		O	O	O
Finger resting tremors		O	O	O
Tinnitus		O	O	O
Hair loss		O	O	O
Tachycardia		O	O	O
Dreamlike states		O	O	O
Trancelike states		O	O	O
Aggression		O	O	O
Irritability		O	O	O

6. Other symptoms

Weather sensitivity	O	O	O
Complaints when travelling by radio taxi	O	O	O
in underground / rapid-transit railway / tram	O	O	O

Do you have normal blood pressure?

Normal blood pressure	O
High blood pressure	O
Low blood pressure	O

Sleep problems

	fast	average	long
Falling asleep?	O	O	O

	0x	1-6	>6
How often do you wake up at night?	O	O	O

	<10	10-20	>20
How long do you lie awake at night?	O	O	O

	none	sometimes	often
How do you wake up in the morning?			
Initial problems	O	O	O

	no	sometimes	often
Can you sleep at midday	O	O	O
Have you had the need to sleep, and not to be able to	O	O	O

7. Nutrition

Vegetarian O lots of fat O lots of meat O lots of butter/cheese O

8. Recreational Drugs

Nicotine O Alcohol O other? which.....

This questionnaire is to be filled out by the physician during the interview procedure.

Total ratings:

		temporary	long-term
1. Mobile phone usage		O	O
2. Dwelling		O	O
3. Electricity in the dwelling		O	O
4. Workplace		O	O
5. Number of symptoms		O	O
6. Other symptoms	n = ...		
7.		O	O

Evaluation:

If more than 10 symptoms, with sleep disturbance as core symptom, are long-term in sections 5 and 6, or more than 20 symptoms, with sleep disturbance as core symptom, are specified as temporary in connection with sections 1,2,3,5,6, then electrosensitivity or microwave symptomology is present (as inclusion criteria for this study).

Total results:

Please send this form to:

ES Questionnaire

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or email to:

ESQuestionnaire@aol.com

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