

Patient questionnaire

Last name, first name, Mr/Ms

Place, date

a) List of symptoms

How often have you experienced the following health problems in the past 30 days?
Please mark the appropriate box in every line.

Symptoms	Never	Rarely	Someti mes	Often	Very often	If yes, since when (month/year)
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Tightness in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Restlessness, tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Anomia (difficulty finding words)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Noise sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Sensation of pressure in the ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Ear noises, tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Burning sensation in the eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Nervous bladder, urinary urgency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Blood pressure problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Muscle tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Skin conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Other (please state)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/
Other (please state)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	/

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 do the health problems occur?	
Is there a place where the health problems increase or are particularly severe? (e.g. at work, at home)	
Is there a place where the health problems recede or disappear altogether? (e.g. at work, at home, other places, at the home of a friend, on holiday, at your weekend home, in the woods)	
Do you have an explanation for these health problems?	
Are you experiencing stress, e.g. due to changes in your personal life or at work?	
Please list any environmental assessments made, measurements or measures taken up to now.	
Please list any environmental medicine diagnoses and treatments given up to now.	
Other	

c) Assessment of EMF exposure at home and at work

1. Do you use a cell phone at home or at work?

How long have you been using it (years/months)? _____
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 (H) or at work (W)?

How long have you had it (years/months)? _____
How much do you use it to make calls per day (hours/minutes)? _____
Have you noticed any relation to your health problems?

3. Do you use wireless internet access (WLAN, WiMAX, UMTS) at home (H) or at work (W)?

If yes, how long have you been using it (years/months)? _____
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 (H) or at work (W)?

If yes, how long have you been using them (years/months)? _____
For how long are you exposed to them per day (hours/minutes)? _____
Have you noticed any relation to your health problems?

5. Is there a cell tower (mobile phone base station) near your home (H) or your workplace (W)?

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

6. Are there any power lines, transformer stations or railway lines near your home (H) or your workplace (W)?

If yes, for how long are you exposed to them per day (hours/minutes)? _____
Have you noticed any relation to your health problems?

6. Do you use Bluetooth devices in your car?

If yes, how long have you been using them? _____
Have you noticed any relation to your health problems?
