Questionnaire to register adverse health effects caused by high frequency electromagnetic fields (HF EMF)

Please complete and send to:

Doctors' Initiative „Bamberger Appeal"
Private Medical Case Registry
c/o Dr. med. C. Waldmann-Selsam
Karl-May-Str.48
96049 Bamberg
Germany

Questionnaire to register adverse health effects caused by high frequency electromagnetic fields (HF EMF)

(Mobile phone base stations, 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 frequency electromagnetic fields (HF EMF)

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

at home ☐ at work ☐ other ☐ .....
How many hours per day do you spend on average in rooms exposed to HF-EMF? .....

1.2 Exposure to HF EMF 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 systems (Dish Antennae)	Distance in meters:	since: .....
☐ Own cordless telephone (DECT)	Position in house:	since:.....

Manufacturer and type designation of DECT phone:	Duration of phone calls in total per day:	
☐ cordless phone (DECT) at neighbours	Position:	since: .....
☐ W-LAN (own)	Position:	since: .....
☐ W-LAN (at neigbours)	Position:	since: .....
☐ Mobile use	Duration of phone calls in total per day:	since: .....

1.3 Exposure to HF EMF 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: ..... Duration of phone calls in total per day:	since: .....
☐ W-LAN	Position:	since:.....
☐ Mobile use (own)	Duration of phone calls in total 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:

☐ ☐ .....

.....

.....

.....

.....

.....

2. Symptoms, Description of Illness, Progression of Illness

2.1 List of Symptoms

Symptoms *if possible, describe in more detail under 2.2	never	some-times	often	very often	since ca.
1. Difficulty to fall asleep					
2. Frequent awaking during the night					
3. Waking up tired, hung-over					
4. Chronic exhaustion, fatigue					
5. Increased need for sleep					
6. Lethargy					
7. Listnessness					
8. Headaches					
9. Pressure in the head					
10. Drowsiness					
11. Nervousness					
12. Restlessness					
13. Feeling of discomfort					
14. Hot flushes					
15. Chills, cold hands and feet					
16. Inner Trembling, vibration					
17. Inner Burning					
18. Irritability					
19. Aggressiveness					
20. Depressive tendency					
21. Feeling of helplessness					
22. Panic attacks					
23. Compulsive repetitive thoughts					
24. Concentration difficulties					
25. Mistakes when writing					
26. Learning difficulties					
27. Loss of memory					
28. Anomia (inability to find the right word)					
29. Frequent slips of the tongue					
30. Joint pain (which joints?)*					
31. Muscle pain, muscle weakness					
32. Neck pain					
33. Pain of the soft tissue (where?)*					
34. Nerve pain (where?)*					

Symptoms *if possible, describe in more detail under 2.2	never	some-times	often	very often	since ca.
35. Toothache					
36. Sinusitis					
37. Infections					
38. Alteration of the voice					
39. Sore throat					
40. Swollen lymphatic glands					
41. Slow healing of wounds					
42. Skin alterations (which?)*					
43. Burning of the skin					
44. Prickling sensation in the skin					
45. Numbness					
46. Itching skin					
47. Allergic reaction					
48. Tachycardia (Heart palpitations)					
49. Heart pains					
50. Arrythmia (what kind)*					
51. Spells of high blood pressure					
52. Permanent high blood pressure					
53. Temporary shortness of breath					
54. Episodes of collapse					
55. Dizziness, vertigo					
56. Disturbance of equilibrium					
57. Buzzing or ringing in the ears (Tinnitus)					
58. Noise or sounds in the head					
59. Hearing defect, acute loss of hearing					
60. Hypersensitivity to noise					
61. Pain in the eyes					
62. Swollen eyes					
63. Rings under the eyes					
64. Impaired Vision					
65. Inflammation of the eyes					
66. Dry eyes					
67. Nosebleeds (when)*					
68. Hypersensitivity to smell					
69. Thyroid gland disorder (which kind)*					
70. Other hormonal disturbances*					
71. Loss of hair					
72. Disturbance of growth					
73. Loss of libido					
74. Weight gain					
75. Weight loss					
76. Loss of appetite					

Symptoms *if possible, describe in more detail under 2.2	never	some-times	often	very often	since ca.
77. Nausea					
78. Diarrhoea					
79. Abnormal sensation 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 given above

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

Please describe in your own words how and when the symptoms started, in which order they occurred and how they manifest (especially with regard to impaired vision, the kind of headaches, noise in the head, skin alterations, pain in the limbs, joint paints, pains in the soft tissue, neuralgia as well as sensitivity disturbances).

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

2.3
Where do symptoms occur particularly?

At home	at work	other	
☐	☐	☐	.....

2.4
Do your symptoms change when you go to other places (in the forest, in valleys with low EMF-exposure, 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
Did you move your sleeping place?

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

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, I did not, because .....

☐ Yes, I moved to .....

When? .....

3. Diagnostics

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

.....

.....

.....

.....

.....

How often? .....

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

.....

.....

.....

.....

.....

.....

.....

3.3
Which diagnosis was found?

.....

.....

.....

.....

3.4
Which medication have you been prescribed for your symptoms?

.....

.....

.....

.....

3.5
Were you recommended to undergo psychotherapy, cognitive behavioural therapy or any other psychosomatic rehabilitative 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)?
☐	☐ .....
	.....

3.11
Do you have allergies

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

4. Supplementary Questions

4.1
When and how did you first learn of that high frequency electromagnetic fields might 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 anything 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

☐ ☐ .....

.....

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

☐ ☐ .....

4.11 Exposure to extremely low frequency fields (ELF)

Do you live in the proximity to high voltage power lines? Distance in meters: ……

Do you live in the proximity to an electrical sub-station? Distance in meters: ……

Do you live in the proximity to a railway line? Distance in meters: ……..

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?

☐ ☐ .....

.....

.....

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?

☐ ☐ .....

.....

.....

6. Personal Data

Size	..... cm
Weight	..... kg
Smoker	No ☐ Yes, how many cigarettes per day? ☐ .....
Alcohol	Never ☐ Yes, how many units per week? ☐ .....
Current blood pressure readings ..... If you have long term records, please enclose copies of them.	
Prior illness, surgery and regular medication: .... Are you under great stress (privately or at work)?	

....
(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 "microwave sickness" 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 physicians 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)