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	Sometimes	Often	Very often	If yes, since when (month/year)
Anxiety	☐	☐	☐	☐	☐	/
Tightness in chest	☐	☐	☐	☐	☐	/
Depression	☐	☐	☐	☐	☐	/
Difficulty concentrating	☐	☐	☐	☐	☐	/
Restlessness, tension	☐	☐	☐	☐	☐	/
Hyperactivity	☐	☐	☐	☐	☐	/
Irritability	☐	☐	☐	☐	☐	/
Exhaustion	☐	☐	☐	☐	☐	/
Fatigue	☐	☐	☐	☐	☐	/
Anomia (difficulty finding words)	☐	☐	☐	☐	☐	/
Forgetfulness	☐	☐	☐	☐	☐	/
Headaches	☐	☐	☐	☐	☐	/
Dizziness	☐	☐	☐	☐	☐	/
Sleep problems	☐	☐	☐	☐	☐	/
Noise sensitivity	☐	☐	☐	☐	☐	/
Sensation of pressure in the ears	☐	☐	☐	☐	☐	/
Ear noises, tinnitus	☐	☐	☐	☐	☐	/
Burning sensation in the eyes	☐	☐	☐	☐	☐	/
Nervous bladder, urinary urgency	☐	☐	☐	☐	☐	/
Heart palpitations	☐	☐	☐	☐	☐	/
Blood pressure problems	☐	☐	☐	☐	☐	/
Muscle tension	☐	☐	☐	☐	☐	/
Joint pain	☐	☐	☐	☐	☐	/
Skin conditions	☐	☐	☐	☐	☐	/
Other (please state)	☐	☐	☐	☐	☐	/
Other (please state)	☐	☐	☐	☐	☐	/

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?

_____

8. Do you have mercury amalgam dental fillings, crowns, or root canals?

_____

9. Vaccination history can be a factor as they contain heavy metals such as aluminum and mercury as thimerosal. How many and when and did your sensitivity start after these injections? _____

_____

10. What brand/model of phone do you use if applicable and have you recently upgraded? From what to what: _____

_____

11. Do you live in a dense multi-residential environment such as an apartment or condo?

_____

12. What measures have you taken to remedy the issue/s: _____

_____

_____

_____

_____

_____

_____

_____

13. What kind of diet and lifestyle do you have? Carnivore, Vegetarian, Vegan?

_____

Heavy on oxalates? _____

Lots of carbs? _____

14. Provide a list of nutritional supplements and Rx medication for review:

_____

_____

_____

_____