SWI – ES Survey:

A Health Study On The

Prevalence of Electro-Sensitivity Conditions

(Email Response Option)

1 November 2007

Dear Participant:

The Safe Wireless Initiative – UK, a project under the non-profit Science and Public Policy Institute based in Washington, D.C., is conducting a study in the United Kingdom, Ireland, and the Channel Islands during the **month of November.**

The purpose of the study is to assess the prevalence of Electro-Sensitivity (ES) conditions associated with exposure to Electro-Magnetic Radiation (EMR) from wired and wireless technology. Our main purpose is to derive accurate estimates of the magnitude of this problem.

All personal information gathered in this study remains ***confidential***. Your name will not be disclosed to any outside party, nor will any information you provide. The findings will be published only in aggregate as compiled data.

It is important for this study to include people who feel they are electro-sensitive, and people who feel they are not. After you have completed the survey, please ask two other friends, family members, or associates, who do not believe they are affected by these exposures, to complete the survey as well.

It is only through your participation that we are able to find clues for the prevention and treatment of these conditions.

Thank you for your help.

Dr. Heather McKinney
Director of Research
Safe Wireless Initiative

Dr. Kerry Crofton
Director of Registries and Surveillance
Safe Wireless Initiative

By November 30, please email your completed survey to: **surveys@safewireless.org**

SWI – ES Survey: UK, Ireland, and Channel Islands

Today's Date: _____

Before you begin the rest of this survey, please answer the following questions:

Question A.

Do you consider yourself to be Electro-Sensitive (ES) - having adverse reactions to wired equipment, wireless devices, and/or wireless networks? *Please check.*

1. Yes ___

   If yes, how are you affected? a) Mildly___ b) Moderately ___ c) Severely ___

2. No ___
3. I don't know ___

Question B.

Have you previously completed the SWI ES-Survey? *Please check.*

1. Yes _____

   If yes, which version: a.) mail-in:_____ b.)email: ____ c.) online _____

   d.) Estimated Date (if possible): _____

2. No_____

This Survey consists of the following:

Section I:	Symptoms
Section II:	Electro-Magnetic Radiation (EMR) Exposure – Wireless (Wi-Fi) Devices
Section III:	Electro-Magnetic Radiation (EMR) Exposure – Electric Devices
Section IV:	Related Conditions
Section V:	Primary Source of Symptoms
Section VI:	Further Information

Disclaimer - The information contained within this survey does not provide medical advice and is not intended to be used for medical diagnosis or treatment. In the case of any disease, you should always consult your health care practitioner.

Section I – Symptoms:

Please check those that may affect you when you are exposed to wired, and/or wireless, devices.
*For the rest of this Survey, the following list will be referenced as **'Symptoms from Section I'**:*

1. Abdominal pain ___
2. Aggressive moods ___
3. Allergies ___
4. Cold or flu (persistent) ___
5. Depressive moods ___
6. Dry or painful eyes ___
7. Erratic blood pressure ___
8. Excessive sweating at night ___
9. Fatigue ___
10. Hair loss ___
11. Headaches ___
12. Heart palpitations/irregular heartbeat ___
13. Inability to focus ___
14. Irritability ___
15. Learning difficulties ___
16. Libido disturbances ___
17. Light-headedness/dizziness ___
18. Loss of appetite ___
19. Memory loss ___
20. Menstrual flooding/irregularities ___
21. Metallic taste in mouth ___
22. Nausea ___
23. Nightmares ___
24. Pain/discomfort in the heart area ___
25. Pain in the head, neck, shoulders, back ___
26. Panic attacks ___
27. Poor concentration ___
28. Ringing of the ears ___
29. Sensitivity to noise and/or light ___
30. Sleep problems ___
31. Skin rashes/bumps/dryness ___
32. Tingling – in the head, hands and/or feet ___
32. Vision problems ___

Section II – Electro-Magnetic Radiation Exposure – Wireless (Wi-Fi) Devices:

Please check 'Yes', or 'I don't know', as appropriate. ***Leave an item blank to signify 'No'.***

1. Do you regularly use – or previously used – a mobile phone? Yes___

   a) If yes:

      i) More than 5 hours daily? Yes___

      ii) More than 2500 minutes per month? Yes___

      iii) More than 500 minutes per month? Yes___

      iv) In your car? Yes___

      v) Prior to 1996? Yes___

      vi) Do you experience any Symptoms from Section I with use? Yes____I don't know___

   b) If no, do you experience any Symptoms from Section I around mobile phones? Yes____I don't know___

2. Do you regularly use – or previously used – a hand-held PDA (personal digital assistant) as a mobile phone or for other wireless communication? Yes___

   a) If yes:

      i) More than 5 hours daily? Yes___

      ii) More than 2500 minutes per month? Yes___

      iii) More than 500 minutes per month? Yes___

      iv) In your car? Yes___

      v) Do you experience any Symptoms from Section I with use? Yes____I don't know___

   b) If no, do you experience any Symptoms from Section I around PDA's? Yes____I don't know___

Do you:

3. Have your mobile phone and/or PDA switched on at night? Yes___

4. Use a headset or ear piece with your mobile? Yes___

   If yes, check the type/s you use:

   a) Wireless ___ b) Wired ____ c) Hollow air tube ____

5. Use a Wi-Fi (wireless) Internet phone? Yes___

6. Regularly use a wireless game station, or wireless video box? Yes___

7. Use a communication/entertainment device with Internet access, or that downloads music, movies or other wireless transmitted data? Yes___

8. Use a portable satellite, or wireless broadband, radio? Yes___

9. Have a GPS, satellite radio, or wireless system, in your car? Yes___

10. Drive a commercial truck, or taxi, with a satellite/GPS locator? Yes___

11. Regularly use a laptop computer? Yes___

    a) If yes, is it often connected to Wi-Fi (wireless) Internet? Yes___

12. Regularly use a personal or desktop computer? Yes___

    a) If yes, is it often connected to Wi-Fi (wireless) Internet? Yes___

13. Have Wi-Fi (wireless) Internet access in your home? Yes___

    a) In your workplace or school? Yes____I don't know___

    b) In your neighborhood? Yes____I don't know___

    c) Is your city wireless? Yes____I don't know___

14. Live or work near a mobile tower, or mast? Yes____I don't know___

    If yes:
    a) Within 100 metres? Yes____I don't know___

    b) Within 200 metres? Yes____I don't know___

15. Work with, or live near, radar devices or systems? Yes____I don't know___

16. Use an amateur radio, 2-way or CB radio? Yes___

17. Have a DECT (cordless) phone? Yes___

    If yes:
    a) In your home/office/school? Yes___

    b) In your bedroom? Yes___

    c) Your total number of DECT (cordless) phones, and/or baby monitors is:
    1_____2 3_____4_____Other (please enter) _____

18. When you are around wireless (Wi-Fi) "hot spots", or devices,
    do you experience Symptoms from Section I? Yes____I don't know___

Other exposures:

19. Are you an airplane pilot or flight attendant? Yes___

20. Do you travel often and pass through security body scanners? Yes___
    a) If yes, do you experience any Symptoms from Section I with exposure? Yes____I don't know___

21. Do you work at supermarket checkouts/libraries near scanners? Yes___
    a) If yes, do you experience any Symptoms from Section I with exposure? Yes____I don't know___

22. Have you had a CT scan? Yes___
    a) If yes, did you experience any Symptoms from Section I with exposure? Yes____I don't know___

23. Have you had an MRI? Yes___
    a) If yes, did you experience any Symptoms from Section I with exposure? Yes____I don't know___

24. Have you had medical and/or dental x-rays? Yes___
    a) If yes, did you experience any Symptoms from Section I with exposure? Yes____I don't know___

25. Have you had a long-term hospital stay – more than one week?
    a) If yes, did you experience any Symptoms from Section I? Yes____I don't know___

Section III – Electro-Magnetic Radiation (EMR) Exposure – Electric Devices:

Please check 'Yes', or 'I don't know', as appropriate. ***Leave an item blank to signify 'No'.***

Do you:

1. Use an electric blanket, and/or heating pad? Yes___
2. Sleep on a/an:
    a) Electric adjustable bed? Yes___
    b) Metal bed frame? Yes___
    c) Coiled mattress/box springs? Yes___
    d) Electrically-heated water bed? Yes___
3. Sleep within 2 metres/6 feet of electric devices, including:
   a clock, radio, compact fluorescent, or low voltage halogen, lights? Yes___
4. Sleep within 6 metres/20 feet of an electrical fuse panel? Yes___
5. Stay in a hotel more than five nights per month? Yes___
6. Regularly use a hairdryer and/or electric shaver? Yes___
7. Use a microwave oven? Yes___
8. Are you often by the front burners of an electric stove,
   or near electric room heaters, while they are operational? Yes___
9. Are you often near "off-peak" or "overnight" electric storage heaters? Yes___

Do you:

10. Live/work/school near high-tension power lines? Yes____I don't know___
11. Live in a rural area? Yes___
12. Live in a densely populated urban area? Yes___
13. Work/live near electrical transformers? Yes____I don't know___
14. Work/live near a electrical sub-station? Yes____I don't know___
15. Live/work near an airport? Yes___
    <u>If yes</u>:
    a) Within 0-5 km? Yes___
    b) Within 5-15 km? Yes___

16. Work/live in a brightly lit room more than 5 hours daily? Yes___

17. Work with power tools? Yes___

18. Work with other electrical, or high frequency, equipment? Yes___

19. Does your home/work have dimmer switches on any lights? Yes___

20. Do you have low voltage halogen, tube or compact fluorescent, lights at work and/or at home or school? Yes___

21. Do you live or work in an area with high radon gas? Yes____I don't know___

22. Do you drive/ride in a gas/electric hybrid car? Yes___

23. Do you experience Symptoms from Section I around electric devices? Yes____I don't know___

Section IV – Related Conditions:

*Please check the items that apply only to **your personal** health history.*

1. Adrenal overload ___
2. MND ___
3. Alzheimer's Disease ___
4. Autism Spectrum Disorder ___
5. Brain aneurism ___
6. Cancer
   a) Eye ___
   b) Ear ___
   c) Brain (adult or child) ___
   d) Breast ___
   e) Testicular ___
   f) Leukaemia (adult or child) ___
   g) Lymphoma ___
   h) Other:_____ ___
7. Candidiasis ___
8. Cataracts ___
9. Cardiovascular disease ___
10. Chronic Fatigue Syndrome ___
    ME (myalgic encephalomyelitis) ___
11. Dementia ___
12. Fibromyalgia ___
13. Food sensitivities ___
14. Heart attack ___
15. Heavy metal toxicity ___
16. High blood pressure ___

17. Infertility ___
18. Insomnia ___
19. Irritable Bowel Syndrome ___
20. Leaky gut syndrome ___
21. Learning Disorder ___
    a) ADD ___
    b) ADHD ___
22. Lupus ___
23. Lyme Disease ___
24. Migraine, or other severe headaches ___
25. Miscarriage ___
26. Multiple Chemical Sensitivities (MCS) ___
27. Multiple-sclerosis ___
28. Parkinson's Disease ___
29. Sleep disorder ___
30. Stroke ___
31. Systemic infection ___
32. Thyroid gland disorders ___
33. TIA (Transient Ischemic Attack) ___

33. Do any of these conditions feel worse when you are exposed to wired, and/or wireless, devices?

Yes____I don't know___

Section V – Primary Source of Symptoms:

Select the item/s you think most triggered your Symptoms from Section I.
Please check "Yes", or "I don't know", as appropriate. ***Leave an item blank to signify 'No'.***

1. Bacterial infection Yes____I don't know___
2. Viral infection Yes____I don't know___
3. Brain injury Yes____I don't know___
4. Emotional stress Yes____I don't know___
5. Chemical or other environmental exposure Yes____I don't know___
6. High Electro-Magnetic Radiation (EMR) exposure incident Yes____I don't know___
7. Prolonged Electro-Magnetic Radiation (EMR) exposure Yes____I don't know___
8. Prolonged use of mobile phone, PDA or other wireless devices Yes____I don't know___
9. Living near a mobile phone tower, or mobile phone mast(s) Yes____I don't know___

10. Other – please specify _____

Section VI – Further Information:

Required Data: *To use your survey as part of this study, we need the following essential information.*

Please circle:

1. Gender: Male Female
2. Age: over 80 60 – 80 40 – 59 20 – 3910 – 19 under 10

Please enter:

3. City/State: _____ 4. Country: _____
5. Occupation: _____

OPTIONAL Information

If you are willing to help us gather further information on Electro-Sensitivity (ES), please provide the following:

*NOTE: Your name, email and address **will NOT be shared** with any business, or other organization.*

6. Your name: _____
7. E-mail and/or mailing address: _____

Please check your item/s of interest:

8. Yes, I am willing to provide further information regarding this Survey, if needed. _____
9. Yes, I am willing to participate in follow up studies with Safe Wireless Initiative. _____

Your Practitioner's Contact Information

The Safe Wireless Initiative maintains a Clinician Database for research and referral purposes. Providing us with this information is very important to our goal of helping solve this serious problem. If you can, please provide us with contact information for any clinician you have seen about your condition so that we may contact him or her concerning our database and the results of this study. Inclusion of this data is optional.

10. Practitioner's name/title: _____
11. Type of practitioner: _____
12. E-mail: _____ 13. Mailing Address:_____

We Want to Hear to Your Personal Story

14. If you have insights and personal experiences to share regarding Electro-Sensitivity (ES), please do so in your own words on the next page. If you believe you are ES, you may want to include further details on your symptoms, how you developed these symptoms, how ES has affected you, how you have adapted, treatments that are helpful and/or not helpful, challenges you face, and any additional details. Please use the following provided space, and any further space necessary, to elaborate and share your complete story. Inclusion of this data is optional.

By November 30, *please email your completed survey to***: surveys@safewireless.org**

Thank you for your generous time and participation.

We Want to Hear to Your Personal Story

If necessary, use additional space to share your ***complete, personal story*** *with us.*
You are welcome to expand on additional pages or to use the blank back pages of this survey.
Please number your pages so we may accurately, and chronologically follow your experience.

Thank you.

14.