UCSD Genetics of Oxidative-Stress Detoxification, and Environmental Sensitivity Study

Electrosensitivity-- Questionnaire

(If you prefer to complete the survey electronically,go to:
https://golombgroup.az1.qualtrics.com/SE/?SID=SV_bBkSl2GWMqT5w7b)

PERSONAL INFORMATION:

Name: This information will be kept in a separate database to protect confidentiality

Last_____ First_____ Middle_____

Birth date: ☐☐ / ☐☐ / ☐☐☐☐
Month Day Year

Today's date: ☐☐ / ☐☐ / ☐☐☐☐
Month Day Year

Contact Information:

Phone Number: _____ Email Address: _____

Country: _____
State/Province: _____
Postal Code: _____
City: _____
Street Address: _____
_____

Residential Information:

Residential Information: The following questions may provide information relevant to our EMF studies, such as distance to electromagnetic field sources.

Residence Type:

1☐ House
2☐ Apartment
3☐ Other _____

Is there citywide Wi-Fi where your home/residence is located? 0☐No 1☐Yes

Is/ are there smart meter(s) on your residence? These emit periodic radio/microwave signals to track energy use. 0☐No 1☐Yes 2☐Don't know

If yes, number of smart meter(s) (approximate): _____
Distance from bed to smart meter(s) (approximate): _____
Distance to smart meter(s)from location in home where you spend the most time during the day (approximate): _____

Occupational Information:

Education level:

0☐ K-8 only
1☐ Some high school
2☐ High school or GED
3☐ Technical School
4☐ Some college or Associate's Degree
5☐ College graduate
6☐ Master's degree
7☐ Other postgraduate degree
8☐ Doctoral degree
9☐ Decline to state
10☐ Other _____

Occupation: _____ Is there Wi-Fi in the work place? 0☐No 1☐Yes

Do you work with computers or have other exposure to EMF (electromagnetic fields) in the workplace? If yes, specify:

_____
_____

Is/ are there smart meter(s) on your work building? 0☐No 1☐Yes 2☐Don't know
If yes, number of smart meter(s) (approximate): _____
Distance from work area to smart meter(s) (approximate):_____

Where did you learn about this study?

1☐ Flyer
2☐ Word of mouth
3☐ Internet (specify): _____
4☐ Media (specify): _____
5☐ Other (specify): _____

RISK FACTORS:

Age: _____

Gender: Female ☐ Male ☐ Other (please explain) ☐ _____

Ethnicity: Which of the following categories describe your ethnic background? Check "yes" for all categories that apply. (We ask this because there are certain groups that may be at a higher genetic risk.)

Do you consider yourself Hispanic or Latino?	0☐ No 1☐ Yes

If **YES** for Hispanic, Latino, or of Spanish Origin

0☐No 1☐Yes Central American
0☐No 1☐Yes Chicano/Mexican American
0☐No 1☐Yes Cuban/Cuban American
0☐No 1☐Yes Puerto Rican
0☐No 1☐Yes South American
0☐No 1☐Yes Other Hispanic/Latino or of Spanish Origin

Do you consider yourself African American or Black?	0☐ No 1☐ Yes

If **YES** for African American or Black

0☐No 1☐Yes U.S./ African American
0☐No 1☐Yes African (from African continent)
0☐No 1☐Yes Caribbean
0☐No 1☐Yes Central or South American
0☐No 1☐Yes Other African Ancestry

Do you consider yourself American Indian or Alaska Native?	0☐ No 1☐ Yes
Do you consider yourself Asian /Asian American?	0☐ No 1☐ Yes

If **YES** for, Asian American/Asian

0☐No 1☐Yes Chinese/Chinese American (including Taiwanese)
0☐No 1☐Yes Filipino/Filipino American
0☐No 1☐Yes Japanese/Japanese American
0☐No 1☐Yes Korean/Korean American
0☐No 1☐Yes South Asian (India, Pakistan, Sri Lanka, Bangladesh, ...)
0☐No 1☐Yes Vietnamese/Vietnamese American
0☐No 1☐Yes Other South East Asian (Cambodia, Laos, Thailand, ...)
0☐No 1☐Yes Other Asian/Asian American

Do you consider yourself Native Hawaiian or Other Pacific Islander?	0☐ No 1☐ Yes

If **YES** for, Native Hawaiian or Other Pacific Islander

0☐No 1☐Yes Guamanian/Chamorro
0☐No 1☐Yes Native Hawaiian
0☐No 1☐Yes American Samoa Native
0☐No 1☐Yes Other Pacific Islander

Do you consider yourself White/ Caucasian?	0☐ No 1☐ Yes

If **YES** for, White/Caucasian

0☐No 1☐Yes European/European Descent
→ Specify countries if known: _____
0☐No 1☐Yes Scandinavian (Denmark, Sweden, Norway, Finland, Iceland)
→ 0☐Mother's side 1☐Father's side
0☐No 1☐Yes Scandinavian Influence Nations (Scotland, Netherlands, Germany, Ireland, England)
→ 0☐Mother's side 1☐Father's side
0☐No 1☐Yes Middle Eastern or North African
0☐No 1☐Yes Other White/Caucasian (specify) _____

Other Ethnicity?	0☐ No 1☐ Yes

If **YES**, please specify other ethnicity:_____

Do you **Decline to State**?	0☐ No 1☐ Yes

HEALTH HISTORY:

Metabolic Conditions: Have you ever had any of the following metabolic conditions?

0☐No 1☐Yes Hypertension
0☐No 1☐Yes Diabetes
0☐No 1☐Yes High triglycerides
0☐No 1☐Yes Obesity or BMI > 30

Overlap Conditions: Have you had any of the following conditions prior to your EMF sensitivity?

0☐No 1☐Yes Chronic fatigue syndrome
Comment (optional):_____
0☐No 1☐Yes Irritable bowel syndrome
Comment (optional):_____
0☐No 1☐Yes Fibromyalgia
Comment (optional):_____
0☐No 1☐Yes Multiple chemical sensitivity, or sensitivity to a number of chemicals
Comment:_____
0☐No 1☐Yes Mold sensitivity
Comment (optional):_____

Exposures:

0☐No 1☐Yes Have you ever been electrocuted?
→ Comment (optional): _____
0☐No 1☐Yes Have you ever had mold poisoning?
→ Comment (optional):_____

0☐No 1☐Yes Have you ever had one or more metal fillings?
Comment (optional):_____

Have you ever had metal fillings removed? If yes, why and what were the effects?
0☐No
1☐Yes (describe): _____

0☐No 1☐Yes Have you ever had any other toxicity?
Comment:_____

0☐No 1☐Yes Do you have any autoimmune conditions (E.g. lupus, Graves, multiple sclerosis, type 1 diabetes)? If yes, describe.
_____
_____

Medications: Prior to your EMF sensitivity, had you taken any of the following medications?

0☐No 1☐Yes Cholesterol medications- e.g. Lipitor, Zocor, Crestor, Pravachol, Mevacol, Lescol, (i.e. atorvastatin, simvastatin, rosuvastatin, pravastatin, lovastatin, pitavastatin, fluvastatin, gemfibrozil, fenofibrate …)
Did you have an adverse effect? 0☐No 1☐Yes (describe): _____

0☐No 1☐Yes Fluoroquinolone antibiotics- e.g. , ciprofloxacin (Cipro), levofloxacin (Levaquin), moxifloxacin, other "floxacin" drugs
Did you have an adverse effect? 0☐No 1☐Yes (describe): _____

0☐No 1☐Yes amiodarone, dronedarone
Did you have an adverse effect? 0☐No 1☐Yes (describe): _____

0☐No 1☐Yes quetiapine, risperidone, olanzapine, or aripiprazole (Abilify)
Did you have an adverse effect? 0☐No 1☐Yes (describe): _____

0☐No 1☐Yes Other medications to which you had an adverse reaction (please specify which medications and describe the reaction)
Medication: _____
Adverse Effect: _____

Medication: _____
Adverse Effect: _____

Medication: _____
Adverse Effect: _____

Estimate how many days total you have taken antibiotics (if two antibiotics for one week, count this as two weeks): _____

FAMILY HISTORY:

0☐No 1☐Yes Do any 1st degree relatives also have/had electromagnetic field sensitivity, or electro-hypersensitivity
_____
_____

Do any 1st degree relatives (immediate biological family: parents, siblings, or children) have any of the conditions specified below.

Metabolic Conditions:

0☐No 1☐Yes Hypertension
0☐No 1☐Yes Diabetes
0☐No 1☐Yes High triglycerides
0☐No 1☐Yes Obesity or BMI > 30

Overlap Conditions:

0☐No 1☐Yes Chronic fatigue syndrome

0☐No 1☐Yes Irritable bowel syndrome

0☐No 1☐Yes Fibromyalgia

0☐No 1☐Yes Multiple chemical sensitivity

0☐No 1☐Yes Mold sensitivity

0☐No 1☐Yes Any autoimmune conditions (E.g. lupus, graves, multiple sclerosis, type 1 diabetes? Please describe.

_____

_____

Exposures:

0☐No 1☐Yes Did any 1st degree relatives ever have **medication** adverse event(s) or intolerance? If yes, please describe:_____

0☐No 1☐Yes Did any 1st degree relatives ever have **chemical** adverse event(s) or intolerance? If yes, please describe:_____

0☐No 1☐Yes Did any 1st degree relatives ever have **mold** adverse event(s) or intolerance? If yes, please describe:_____

Have you ever had electromagnetic field **(EMF)** sensitivity (sometimes called "electro-hypersensitivity"), a condition characterized by experiencing symptoms upon exposure to electromagnetic fields?	0☐ Currently have problem 1☐ Formerly (but not currently) had problem 2☐ Never → Thank you, you are done with the survey 3☐ Other (describe): _____ _____ _____

Please share your history of EMF problems below.

ONSET:	**Describe.**	
1. If you recall, how long ago do you believe you first had a reaction to an EMF exposure (year, month if known)? E.g. If 13 months ago (1 year + 1 month), check the box labeled year and write "1" next to it, **AND ALSO**, check the box labeled months and write "1" next to it.	☐ YEARS AGO: _____ (number of years) + ☐ MONTHS AGO: _____ (number of months) + ☐ DAYS AGO: _____ (number of days) ☐ EXACT DATE: _____ (if known)	
2a. When you first developed symptoms that you now believe were due to EMF, were you aware that others had similar problems with EMF?	0☐NO 1☐YES	Comment.
2b. When you first became aware that your symptoms **were due to** EMF, were you aware that others had similar problems with EMF?	0☐NO 1☐YES	Comment.
3. What led you to first be aware you had a reaction to EMF?		

4. Was there a triggering event?	0☐NO 1☐YES	If yes, what was the triggering event?

5. What was/were the original symptoms?

0☐ Chest pain	7☐ Eye/vision	14☐ Irritability- short temper
1☐ Joint Pain	8☐ GI symptoms	15☐ Heart rhythm
2☐ Muscle pain	9☐ Headache	16☐ Shortness of breath
3☐ Confusion	10☐ Lightheadedness	17☐ "Internal pressure"
4☐ Ear pain	11☐ Sweats	18☐ Numbness or tingling
5☐ Tinnitus	12☐ Attention	19☐ Tendon/ligament pain
6☐ Hearing loss	13☐ Memory	20☐ Mood changes

19☐ Other: _____

20☐ Other: _____

21☐ Other: _____

6a. What led you to *initially* connect the symptoms to the exposure?

6b. How long after the 1st reaction did it take before you connected the symptoms to EMF exposure?

0☐ No time	4☐ Days
1☐ Seconds	5☐ Weeks
2☐ Minutes	6☐ Months
3☐ Hours	7☐ Years

7. Had you been sensitive to chemicals prior to or concurrent with your EMF sensitivity?	0☐NO 1☐YES	If yes, to what chemicals have you been you sensitive? 0☐ Pesticides 1☐ Herbicides 2☐ Solvents 3☐ Fragrances 4☐ Paints 5☐ Cleaning products 6☐ Other: _____ 7☐ Other: _____ 8☐ Other: _____ If yes, for how long have you been sensitive to chemicals? *(E.g. If 13 months ago (1 year+1 month), check the box labeled year and write "1" next to it, **AND ALSO**, check the box labeled months and write "1" next to it.)* 0☐ Years_____ 1☐ Months_____ 2☐ Weeks_____ 3☐ Days_____

GENERAL:	
FOR THE FOLLOWING QUESTIONS: If you are *no longer sensitive*, answer the questions as they would have applied, when you were sensitive.	
8. What EMF exposures do you react to?	0☐ Smart meters 1☐ Cell phones 2☐ Cell towers 3☐ Computers 4☐ Wi-Fi 5☐ Radio 6☐ Microwaves 7☐ Television 8☐ Power lines 9☐ Other: _____ 10☐ Other: _____ 11☐ Other: _____
9. On a scale of 0-10, how affected are you from EMF-related symptoms **in general**?	No effect on quality of life or function, no restriction of activities Profound effect on quality of life or function, restriction of activities 0 1 2 3 4 5 6 7 8 9 10

10. Once exposed to EMF, symptoms can persist for how long after you are **no longer exposed**?	0☐ Few Minutes 1☐ Hours 2☐ Days 3☐ Weeks 4☐ Months 5☐ Years 6☐ Symptoms do not extend beyond the period of exposure
11. What have been the worst **specific exposure events or occurrences** arising from your EMF-related problems? (List and describe as many as you like.)	
12a. Which **type or category** of EMF exposures produces the worst problems?	0☐ Smart meters 1☐ Cell phones 2☐ Cell towers 3☐ Computers 4☐ Wi-Fi 5☐ Radio 6☐ Microwaves 7☐ Television 8☐ Power lines 9☐ Other: _____ 10☐ Other: _____ 11☐ Other: _____
12b. What symptoms/ problems are produced from the exposure that produces the worst problems?	0☐ Chest pain 1☐ Joint Pain 2☐ Muscle pain 3☐ Confusion 4☐ Ear pain 5☐ Tinnitus 6☐ Hearing loss 7☐ Eye/vision 8☐ GI symptoms 9☐ Headache 10☐ Lightheadedness 11☐ Sweats 12☐ Attention 13☐ Memory 14☐ Irritability- short temper 15☐ Heart rhythm 16☐ Shortness of breath 17☐ “Internal pressure” 18☐ Numbness or tingling 19☐ Tendon/ligament pain 20☐ Mood changes 19☐ Other: _____ 20☐ Other: _____ 21☐ Other: _____
12c. On a scale of 0-10, how affected were you from EMF-related symptoms, **at their worst**?	No effect on quality of life or function, no restriction of activities Profound effect on quality of life or function, restriction of activities 0 1 2 3 4 5 6 7 8 9 10

13. What electromagnetic exposures do you tolerate?	0☐ Smart meters 3☐ Computers 6☐ Microwaves 1☐ Cell phones 4☐ Wi-Fi 7☐ Television 2☐ Cell towers 5☐ Radio 8☐ Power lines 9☐ Other: _____ 10☐ Other: _____ 11☐ Other: _____	
14. Are the symptoms with each type of EMF exposure the same?	0☐NO 1☐YES	If different types of exposures lead to different symptoms, please clarify in what way. Comment:
15. Can you always immediately tell if you are exposed?	0☐NO 1☐YES	If yes, please describe.
16. What leads you to connect the symptoms to the exposure?		
17. Have there been times when you had your EMF symptoms, recognized them as specific to your EMF symptoms, despite being **initially** unaware there was an exposure.	0☐NO 1☐YES	If yes, please describe.
18. Do you use a multi-meter or EMF meter to measure EMF around you?	0☐NO 1☐YES	If yes, what kind? If yes, is it helpful? Please comment 0☐No 1☐Yes

19. From the time you first became aware of symptoms, did the condition evolve in any way?	0☐ Got better 1☐ Got Worse 2☐ Episodes of improvement, followed by worsening (or vice versa) 3☐ Other (specify): _____ _____ _____	
20a. *Exacerbating factors:* Is there anything (non-EMF) you have noticed that aggravates your EMF symptoms in the **short-term**?	0☐NO 1☐YES	If yes, please specify.
21. Are there specific events or factors that you believe led to **sustained** worsening in your symptoms or reaction?	0☐NO 1☐YES	If yes, please specify.
22a. *Ameliorating factors:* Is there anything (other than treatments) you have noticed that makes your symptoms better in the **short-term**?	0☐NO 1☐YES	If yes, please specify.
22b. Are there specific events or factors (other than treatment) that you believe led to **sustained** improvement in your symptoms?	0☐NO 1☐YES	If yes, please specify.

Treatments	**Describe.**
23. What **treatments** have you tried for your EMF-related problems?	

24a. Were/are there any **treatments** that led to **sustained** improvement? **Provide detail!**	0☐NO 1☐YES	If yes, please specify.
24b. Were/are there any treatments that made/make the condition better **in the short term**?	0☐NO 1☐YES	If yes, please specify.
25a. Were there any treatments that led to **sustained worsening** (increased sensitivity to EMF exposures)?	0☐NO 1☐YES	If yes, please specify.
25b. Were there any treatments that made the condition worse in the **short term**?	0☐NO 1☐YES	If yes, please specify.

GENERAL CONTINUED:	**Specify.**

26. Have you made modifications to your life to accommodate living with your EMF sensitivity? a) At home b) At work c) Out in society (e.g. shopping or being in public) d) In travel e) In recreation f) Other	0☐No 1☐Yes (describe): 0☐No 1☐Yes (describe): 0☐No 1☐Yes (describe): 0☐No 1☐Yes (describe): 0☐No 1☐Yes (describe): 0☐No 1☐Yes (describe):	
27. Have you delayed, suspended, or modified medical or dental care due to you EMF sensitivity?	0☐NO 1☐YES	If yes, please describe.
28a. Have you conveyed your EMF sensitivity to any **traditional** provider(s) in the medical community?	0☐NO 1☐YES	If so, who/what type of provider?
28b. If yes, how did the **traditional** provider(s) respond?	Check all that apply (for different providers): 0☐ Not applicable 1☐ Supportive or helpful 2☐ Dismissive or hostile 3☐ Neither dismissive or supportive 4☐ Other	Please comment/describe.
29a. Have you conveyed your EMF sensitivity to any **alternative** provider(s) in the medical community?	0☐NO 1☐YES	If so, who/what type of provider?

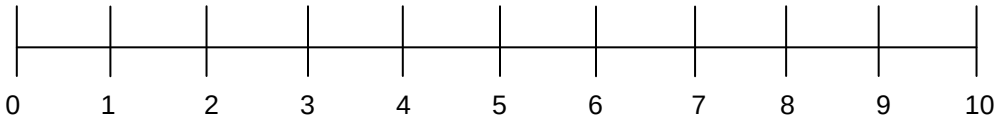
29b. If yes, how did the **alternative** provider(s) respond?	Check all that apply (for different providers): 0☐ Not applicable 1☐ Supportive or helpful 2☐ Dismissive or hostile 3☐ Neither dismissive or supportive 4☐ Other	Please comment/describe.
30. What types of health practitioners have you seen **for the purpose of** seeking help for your EMF sensitivity? Write "N/A" if you have not seen any health practitioner for your condition.	0☐ Not applicable 1☐ Family practice 2☐ Internist 3☐ Nurse practitioner 4☐ Osteopath 5☐ Naturopath 6☐ Toxicologist 7☐ Chiropractor 8☐ Neurologist 9☐ Cardiologist 10☐ Rheumatologist 11☐ Allergy/immunologist 10☐ Other (specify): _____ 11☐ Other (specify): _____ 12☐ Other (specify): _____	
31. Did you ever choose a practioner based on their presumed knowledge about EMF sensitivity?	0☐NO 1☐YES	Please comment/describe.
32a. Have you conveyed your EMF sensitivity to any family members?	0☐NO 1☐YES To whom (Check all that apply) 0☐ Father 1☐ Mother 2☐ Spouse 3☐ Child 4☐ Sibling 5☐ Aunt 6☐ Uncle 7☐ Cousin 8☐ Grandfather 9☐ Grandmother 10☐ Others (specify): 11☐ Others(specify):	How did they respond? (check all that apply) 0☐ Did not convey 1☐ Supportive or helpful 2☐ Dismissive or hostile 3☐ Neither dismissive or supportive 4☐ Both dismissive and supportive 5☐ Other Please further describe their response.
32b. Have you conveyed your EMF sensitivity to any others in your social circle or friends?	0☐NO 1☐YES To Whom? _____ _____ _____	How did they respond? (check all that apply) 0☐ Did not convey 1☐ Supportive or 2☐ Dismissive or 3☐ Neither dismissive or supportive 4☐ Both dismissive and supportive 5☐ Other Please further describe their response.

32c. Have you conveyed your EMF sensitivity to anyone in your workplace or other professional colleagues? If so, how did they respond?	0☐NO 1☐YES To Whom? _____ _____ _____	How did they respond? (check all that apply) 0☐ Did not convey 3☐ Neither dismissive or supportive 1☐ Supportive or 4☐ Both dismissive and supportive 2☐ Dismissive or 5☐ Other Please further describe their response.
33a. Have you ever requested work accommodations from your boss in relation to your EMF sensitivity?	0☐NO 1☐YES	If yes, how did he or she respond and what accommodations were made?
33b. Have you tried to request actions by your power company, other industries, or the government to reduce your exposure (e.g. removal of smart meters, cell towers)?	0☐NO 1☐YES	If yes, please describe your experience: Were your efforts successful? 0☐No 1☐Yes (please describe):
33c. Have you tried to request actions by neighbors or others to reduce your exposure (e.g. removal of smart meters)?	0☐NO 1☐YES	If yes, please describe your experience: Were your efforts successful? 0☐No 1☐Yes (please describe):
34. Have there been times that you and/or others were imperiled because of your EMF-related problems? (E.g. confusion while driving, etc.)	0☐NO 1☐YES, SELF 2☐YES, OTHERS	If yes, please describe.
35a. Have you reached out to, or communicated with other EMF affected individuals?	0☐NO 1☐YES	If yes, whom did you reach out to and how?

35b. If so, has communicating with other affected persons been helpful?	0☐NO 1☐YES 0☐N/A	Please elaborate.

36. On a scale of 0-10, how confident are you that you experience symptom(s) that are related to EMF-exposure?

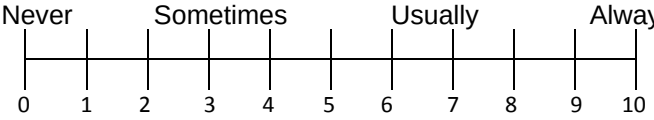
Completely unsure — Completely certain



37. If you are **not** fully confident, have you identified other things to which your symptoms might relate?	0☐NO 1☐YES	If yes, please describe.

38. Can/could you confidently distinguish your EMF-related symptom(s) from other health conditions or symptoms?

Never — Sometimes — Usually — Always



39a. If you **still** have EMF-sensitivity, how long have you had your EMF sensitivity?

E.g. If 13 months (1 year + 1 month), check the box labeled year and write "1" next to it, **AND ALSO**, check the box labeled months and write "1" next to it.

Check the box labeled "N/A" if you formerly had (but no longer have) EMF sensitivity.

☐ YEARS _____ (number of years)

\+

☐ MONTHS: _____ (number of months)

\+

☐ DAYS: _____ (number of days)

☐ N/A: _____ (comment)

39b. If you **formerly** had (but no longer have) EMF sensitivity, for how long did you have EMF sensitivity?

E.g. If 13 months (1 year + 1 month), check the box labeled year and write "1" next to it, **AND ALSO**, check the box labeled months and write "1" next to it.

Check the box labeled "N/A" if you still have EMF sensitivity.

☐ YEARS _____ (number of years)

\+

☐ MONTHS: _____ (number of months)

\+

☐ DAYS: _____ (number of days)

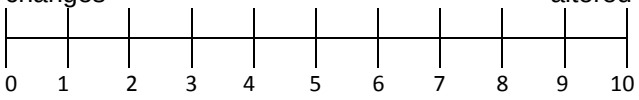
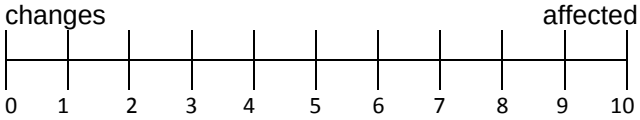
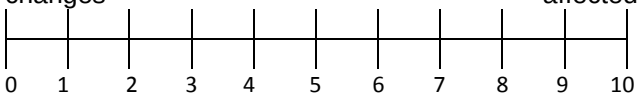
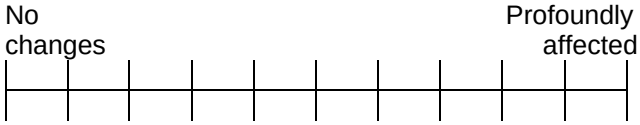
☐ N/A: _____ (comment)

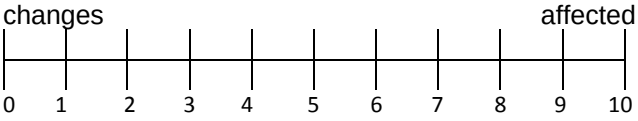
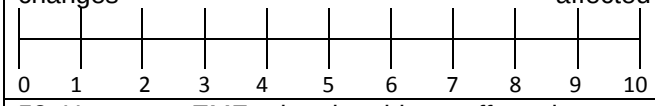
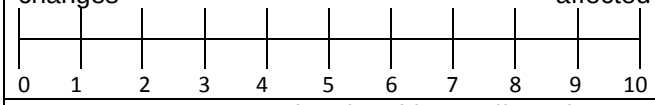
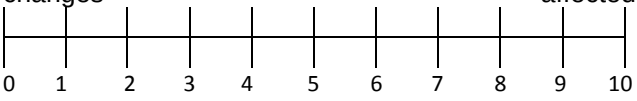
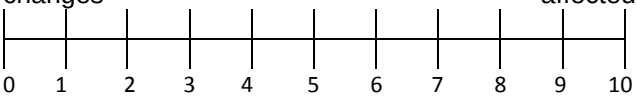
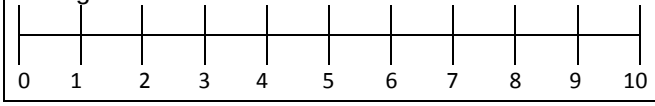
39c. If you formerly had (but no longer have) EMF sensitivity, to what do you attribute your improvement? Take as much space as you need (Feel free to continue on another sheet of paper). Write “N/A” if you still have EMF sensitivity.	

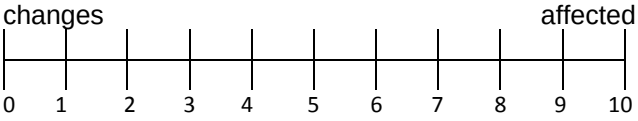
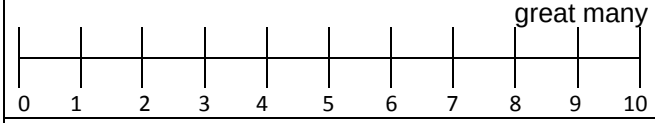
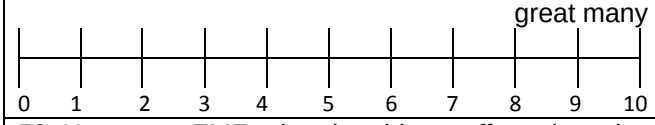
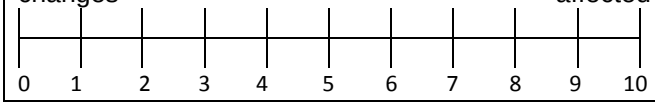
TIMECOURSE:	**Describe.**	
40a. How does intensity of relevant EMF exposures affect your symptoms?		
40b. How does duration of relevant EMF exposures affect your symptoms?		
41a. How long after onset of the exposure till your symptoms are noticeable?	**CHECK ALL THAT APPLY (for different exposures)** 0☐ No time 1☐ Seconds 2☐ Minutes 3☐ Hours 4☐ Days 5☐ Weeks 6☐ Months 7☐ Years	Comment:
41b. How is the answer to the previous question affected by exposure type, intensity, and/or duration?		

SOCIETAL CHANGE:	**Describe.**
42. What changes could society implement that would make life better for you, in relation to your EMF sensitivities?	

43. Do you feel society should implement these changes, and why?	

LIFESTYLE CHANGES:	
44. Have your EMF-related problems led you to alter your life? No changes — Profoundly altered  	Please describe.
45. Have your EMF-related problems affected you socially? No changes — Profoundly affected  	Please describe.
46. Have your EMF-related problems affected you professionally? No changes — Profoundly affected  	Please describe.
47. Have your EMF-related problems affected your family functions or family life (e.g. accompanying a child to dance class)? No changes — Profoundly affected  	Please describe.
48. Have your EMF-related problems affected you personally (separate from professional, social, and family)? No changes — Profoundly affected  	Please describe.
49. Have your EMF-related problems affected you in household functions? No changes — Profoundly affected  	Please describe.

50. Have your EMF-related problems affected you in neighborhood or civic involvement? No changes — Profoundly affected  	Please describe.
51. Have your EMF-related problems affected your religious involvement? ☐ N/A No changes — Profoundly affected  	Please describe.
52. Have your EMF-related problems affected your income? ☐ N/A, retired or had not been an income source No changes — Profoundly affected  	Please describe.
53a. Have your EMF-related problems affected you financially (other than income; eg. expenditures)? No changes — Profoundly affected  	Please describe.
53b. If there has been a financial impact, estimate the total financial impact (costs, lost income, etc.) in dollars or other currency (state the currency).	
54. Have your EMF-related problems affected your living situation? No changes — Profoundly affected  	Please describe.
55. Have your EMF-related problems affected your recreation? No changes — Profoundly affected  	Please describe.

56. Have your EMF-related problems affected you emotionally? No changes — Profoundly affected  	Please describe.
57. Have you had to decline or forego important events or invitations as a result of your EMF-related problems? None — A very great many  	Please describe.
58. Have you ever been denied a job, lost a job, declined a job, or modified a job choice based on your EMF sensitivity? None — A very great many  	Please describe.
59. Have your EMF-related problems affected you in other ways? No changes — Profoundly affected  	Please describe.

For the following questions, you will be asked questions regarding symptoms you may or may not have experienced related to EMF. Please check column "No" or "Yes" to indicate whether you have experienced a symptom. IF symptoms vary by exposure type, specify for each which exposures you are aware have triggered this.

SYMPTOMS:	NO	YES	Exposure & Comments
1. Chest pain			
2. Attention			
3. Memory			
4. Confusion			
5. Ear pain			
6. Tinnitus			
7. Hearing loss			
8. Eye/vision			
9. GI symptoms			

SYMPTOMS:	NO	YES	Exposure & Comments
10. Headache			
11. Lightheadedness			
12. Sweats			
13. “Internal pressure”			
14. Heart rhythm disturbance			
15. Irritability-short temper			
16. Joint pain			
17. Numbness or tingling			
18. Mood changes			

SYMPTOMS:	NO	YES	Exposure & Comments
19. Muscle pain			
20. Shortness of breath			
21. Sleep			
22. Tendon or ligament pain			
23. Other (specify)			
24. Other (specify)			
25. Other (specify)			

What symptom or symptoms are most problematic for you?

Are there questions we should be asking that we have missed?

If there are aspects you experience that aren't captured, please feel free to share here.

Can we contact you if additional questions arise, or for clarification?	0☐NO	1☐YES
Do you want to be informed of future studies related to EMF sensitivity?	0☐NO	1☐YES
We specifically hope to examine biological markers of risk for EMF sensitivity, and biological mechanisms of EMF sensitivity. Do you want to be informed about this study, when it occurs? (There would be no obligation to participate.)	0☐NO	1☐YES

Thank you so much for sharing your experience!