

# **SWI Health Study: Prevalence of Electro-Sensitivity Conditions**

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, the Channel Islands, and Ireland 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 mail your completed survey to: Safe Wireless Initiative – UK  
P O Box 49747  
London N20 0XR  
UK**

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

**Question A.**

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

1. Yes \_\_\_ If yes, how are you affected? a) Mildly\_\_\_ b) Moderately \_\_\_ c) Severely \_\_\_
2. No \_\_\_
3. I don't know \_\_\_

**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

## 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 \_\_\_
- If yes:  
 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 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 – 39        10 – 19        under 10
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: \_\_\_\_\_
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 and on an additional sheet of paper. Mail your writing to us with your completed Survey. 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. Inclusion of this data is optional.

NOTE: A printed copy is best but legible handwriting is acceptable, if you cannot use a computer.

*We thank you for your generous time and participation.*

**By November 30, please mail your completed survey to:    Safe Wireless Initiative – UK  
P.O. Box 49747,  
London N20 0XR  
UK**