

Children's Radiofrequency (RF) Radiation Health Survey

Child's Age: _____

Known Health Conditions Prior to Exposure: _____

Symptoms

Duration

Severity

Rare

Intermittent

Chronic

High

Medium

Low

Cardiovascular Problems

Arrhythmia -----

Blood Pressure Abnormalities -----

Heart Palpitations -----

Eye Pain, Pressure or Visual Disturbances -----

Fatigue -----

Hearing Loss, Ear Pain or Ringing in the Ears -----

Nausea -----

Neurological Problems

Anxiety -----

Behavioral Problems -----

Concentration and Memory Problems -----

Dizziness -----

Headaches -----

Hyperactivity -----

Nose Bleeds -----

Seizures -----

Skin Rashes -----

Sleep Problems -----

Tingling or Burning Sensations of the Skin -----

Other _____

	Rare	Intermittent	Chronic	High	Medium	Low
Arrhythmia -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Pressure Abnormalities -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain, Pressure or Visual Disturbances -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss, Ear Pain or Ringing in the Ears -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological Problems						
Anxiety -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Problems -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration and Memory Problems -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose Bleeds -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Rashes -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Problems -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tingling or Burning Sensations of the Skin -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Cancer

- Adrenal Gland
- Brain
- Breast
- Heart
- Parotid Gland
- Testicular
- Thyroid
- Vestibular

Exposures

- Alexa/Google/Siri
- Baby Monitors and Accessories
- Cell Phone
- Cell Tower
- Computer/Computer Components
- Cordless or DECT Phone
- Small Cell Antenna
- Smart Home Fixtures/Appliances
- Tablet
- Utility Smart Meter
- VR Headsets
- Wi-Fi Router
- Wireless Games/Toys
- Wireless Wearables (Smart Watches/
Earbuds)