Questionnaire for workers exposed to particular risks of electromagnetic radiation

Name	Social Security Number	Date

What kind of work do you have?

How long have you been working with these tasks?

Have you ever been exposed to high intensity electromagnetic fields?

If yes – what did you work with?

	YES	NO
Do you have a pacemaker?	◯	◯
Do you have a pacemaker with a defibrillator?	◯	◯
Do you have hearing implants?	◯	◯
Do you have any other kind of implant?	◯	◯
Do you have a joint prosthesis?	◯	◯
Do you have implanted plates or screws?	◯	◯
Do you have an insulin pump?	◯	◯
Do you have implanted surgical clamps?	◯	◯
Do you have any other active medical device implanted?	◯	◯
If you are a woman, are you pregnant?	◯	◯
Allergy problems	◯	◯
Stomach or intestinal disease	◯	◯